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Motivational Interviewing: A Technique for Improving Understanding

OVERVIEW

In the United States, behavioral risk factors such as substance use (tobacco, alcohol), unhealthy diet, and insufficient physical activity are a key determinant of the burden of chronic disease and unhealthy lifestyles. One of the biggest challenges that health care practitioners face is helping people change longstanding behaviors that pose significant health risks. When patients receive compelling advice to adopt a healthier lifestyle by cutting back or ceasing harmful behaviors (smoking, overeating, heavy drinking) or adopting healthy or safe behaviors (taking medication as prescribed, eating more fresh fruit and vegetables), it can be frustrating and bewildering when this advice is ignored or contested. A natural response for a practitioner who encounters such opposition or resistance is to reiterate health advice with greater authority or to adopt a more coercive style in order to educate the patient about the imminent health risks if they don't change. When these strategies don't succeed, the practitioner may characterize the patient as 'unmotivated', ‘non-compliant’ or 'lacking insight'. However, research around behavior change shows that motivation is a dynamic state that can be influenced, and that it fluctuates in response to a practitioner's style. An authoritative or paternalistic therapeutic style may in fact deter change by increasing resistance.

Motivational Interviewing (MI) has been found to be an effective and useful therapeutic intervention for strengthening the motivation for behavioral change in persons with various behaviorally influenced health problems and for promoting treatment adherence. Motivational Interviewing (MI) is often recommended as an evidence-based approach to behavior change.

The most current version of MI is described in detail in Miller and Rollnick (2013) *Motivational Interviewing: Helping people to change* (3rd edition). Key qualities include:

- MI is a **guiding** style of communication, that sits between **following** (good listening) and **directing** (giving information and advice).
- MI is designed to **empower** people to change by drawing out their own meaning, importance and capacity for change.
- MI is based on a **respectful** and **curious** way of being with people that facilitates the natural process of change and honors client autonomy.

It is important to note that MI requires the clinician to engage with the client as an equal partner and refrain from unsolicited advice, confronting, instructing, directing, or warning. It is not a way to “get people to change” or a set of techniques to impose on the conversation. MI takes time, practice and requires self-awareness and discipline from the clinician.

While the principles and skills of MI are useful in a wide range of conversations, MI is particularly useful to help people examine their situation and options when any of the following are present:

- **Ambivalence is high** and people are stuck in mixed feelings about change
- **Confidence is low** and people doubt their abilities to change
- **Desire is low** and people are uncertain about whether they want to make a change
- **Importance is low** and the benefits of change and disadvantages of the current situation are unclear.

LEARNING OUTCOME AND OBJECTIVES: Upon completion of this course, you should be able to:

- Define the stages of change and the relationship of motivational interviewing to promoting behavior change
- Identify the basic tenets and processes of motivational interviewing and apply to case examples.
- Recognize factors that influence change and describe evidence-based techniques the practitioner can use to facilitate positive health behaviors.

INTRODUCTION

The most basic definition of Motivational interviewing is a **collaborative**, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by **eliciting** and **exploring** the **person's own reasons for change** within an atmosphere of **acceptance** and **compassion**.

Motivational interviewing (MI), originated in the field of addiction treatment, is a promising concept for encouraging motivation to change in patients that are currently either unwilling or ambivalent to change, and can be used even with limited time resources. Since the first publications on the approach in the early 1980s, it has also been increasingly used in many disciplines.

The conceptual framework of motivational interviewing was originally described by William Miller as a method for helping to treat patients with alcohol use disorders in 1983. Over the years, Miller and Rollnick have further developed and broadened the original concepts of motivational interviewing to be applicable to many disciplines. Motivational interviewing techniques have been increasingly recognized as useful to help patients initiate or improve common lifestyle goals, including exercise, resistance training, nutrition, weight-management, sleep hygiene, smoking cessation, reducing alcohol consumption, or improving adherence to medication prescriptions.

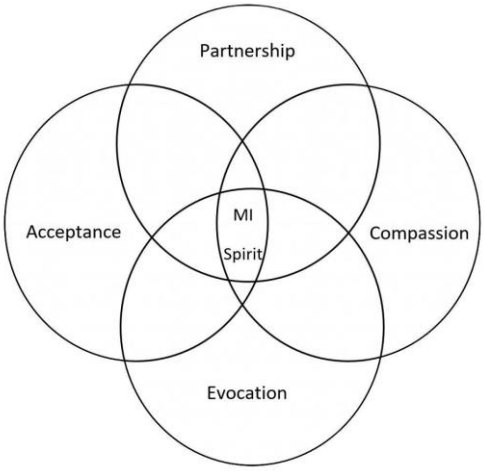
Motivational Interviewing combines a variety of evidence-based approaches from both cognitive psychology and social psychology. This therapeutic technique assumes that people with problematic behaviors have different levels of readiness for behavior change. Investigating a person's readiness to change their behavior as well as having them state in their words what may be barriers to a healthier behavior is the key component of the technique.

Motivational Interviewing is an evidence-based treatment used to explore a person's ambivalence, as well as to enhance motivation and commitment for change. It also requires that the provider and individual together explore supports (environmentally and socially) to reinforce the person's ability and desire to change. The approach allows clients to identify their reasons for change based on their own values and interests. Providers can decrease the client's resistance or defensiveness by taking a seat alongside their clients, as both are considered experts in this approach. Equal in the relationship rather than the traditional hierarchical medical approach where the provider is seen as the expert and the patient as needing to be given a definitive protocol to follow.

An acceptance of this other individual as a separate person, a respect for the other as having worth in his or her own right. It is a basic trust – a belief that this other person is somehow fundamentally trustworthy. (Rogers, 1980)

SPIRIT OF MOTIVATIONAL INTERVIEWING

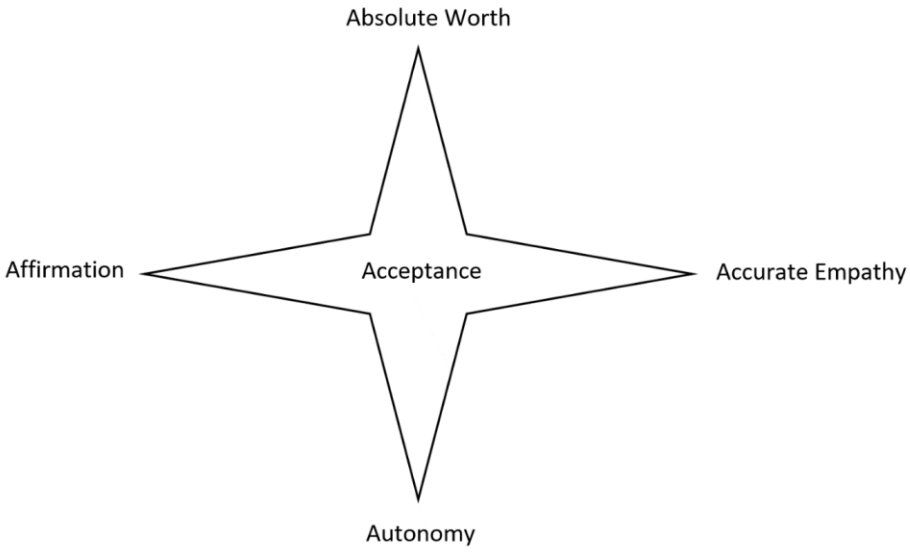
A layperson's definition of MI would be "*a collaborative conversation style for strengthening a person's own motivation and commitment to change*" (Miller & Rollnick, 2013). This collaborative conversation includes the spirit of MI which includes four aspects: **Partnership, Acceptance, Compassion, and Evocation.**



Partnership emphasizes how MI is used with and for someone to engage in an active conversation between two experts. Providers must view the partnership with the reality that they don't have all the answers and need their client's expertise on what change would look in their lives. The provider is not trying to convince, trick, or argue why a client should change. Instead, providers are guiding, listening, and trying to understand the client's circumstances. This partnership-like conversation is an unpatronizing collaboration with the patient ("communication on equal terms"), in which the clinician does not assume the role of the expert (superior to the patient).

Acceptance highlights the importance of respecting what a client contributes to the partnership. This consists of a fundamental attitude of acceptance and empathy towards the patient's needs, experiences, and points of view. In addition to unconditional regard for the patient, this includes ensuring their autonomy of choice and decision-making in relation to behavior change as well as the desired goals and methods of change (patient autonomy). There are four distinct aspects of Acceptance:

- *Absolute Worth*
- *Accurate Empathy*
- *Autonomy Support*
- *Affirmation*



Collectively, these four client-centered conditions make up the MI spirit of acceptance.
"One honors each person's absolute worth and potential as a human being, recognizes and supports the person's irrevocable autonomy to choose his or her own way, seeks through accurate empathy to understand the other's perspective, and affirms the person's strengths and efforts."

Absolute Worth and *Accurate Empathy* highlight the work of Carl Rogers and the conditions critical for change.
Absolute Worth emphasizes Rogers's concept of unconditional positive regard, such that when people are accepted without judgment, they are free to make changes.
Accurate Empathy emphasizes efforts to understand a client's perspective without feeling pity or identifying with them.
Autonomy Support highlights the importance of respecting a client's autonomy to choose, not to control, persuade, or coerce. This can facilitate change by decreasing a client's defensiveness and emphasizes the client's freedom of choice.
Affirmation emphasizes recognition of the client's strengths and efforts.

Compassion was added to the underlying spirit of MI in the third edition of Miller and Rollnick's book *Motivational Interviewing: Helping People Change* (2013) to highlight the importance of using MI to promote the wellbeing of others and not for the provider's self-interest or to exploit others. Compassion for the patient's life and experience, as characterized by the clinician not pursuing their own interests and giving highest priority to the patient's needs.

Evocation is used to assist clients in identifying the wisdom and reasons for changing their behavior. Evoking motivation to change by exploring and reinforcing the patient's reasons for change. This also includes developing discrepancy between current problem behavior and the patient's goals and values (for example, "You said that it's important to you to do more exercise again. How does that tie in with your weight goals?").

The overall spirit of MI assumes that clients want and are capable of change. The provider can ask questions from their clients as to the why and how to change by paying attention to their current strengths

and resources. The provider should be compassionate, empathetic, curious and genuine in their approach when using these techniques.

OUTCOMES OF THE APPROACH

When the technique of MI is used successfully it has shown promising outcomes including: increased likelihood of following protocols for healthy living, increased quality of care provided and increased follow- through.

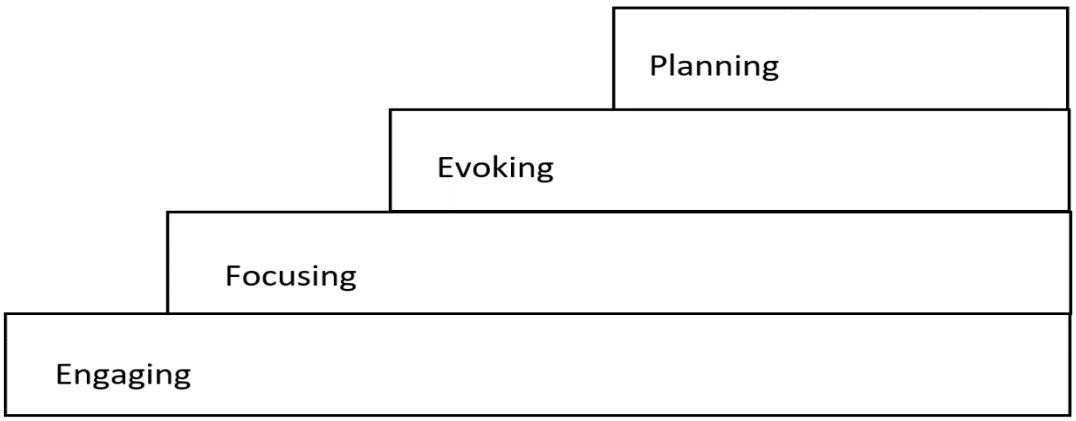
Originally, motivational interviewing was focused more on treating substance use disorders by preparing people to change addition-related behavior. Over time, however, motivational interviewing has been found to be a useful intervention strategy in addressing other health behaviors and conditions such as:

- Diabetes control
- Diet
- Obesity prevention
- Physical activity
- Sexual behavior
- Smoking

Motivational interviewing can also be used as a supplement to cognitive behavioral therapy (CBT) for anxiety disorders, such as generalized anxiety disorder, social anxiety disorder, and post-traumatic stress disorder (PTSD). This approach has even been used to reduce the fear of childbirth.

FOUR PROCESSES OF MOTIVATIONAL INTERVIEWING

The four processes of MI include ***Engaging, Focusing, Evoking, and Planning.*** They build on one another, overlap, and recur. Miller and Rollnick (2013) describe these processes as stairs:
"Each later process builds upon those that were laid down before and continue to run beneath it as a foundation. In the course of a conversation or case, one may also dance up and down the staircase, returning to a prior step that requires renewed attention."



First Step
Engaging is the process where the working partnership is established, and the focus is on building rapport with clients. It is more than being kind to clients. Providers must be in tune with assisting their clients in feeling comfortable and engaged in establishing a mutually trusting and respectful relationship. When a good working partnership is established through the engaging process, clients are more likely to return and make changes.

During this stage, rapport is developed, and a sense of connection and trust is created between the practitioner and the patient. It is important for the practitioner to remember not to ask too many questions, rather to ask a few probing questions to elicit the client to discuss the issues that are of concern. The patient or client is not looking for an expert to solve his or her problems rather they are seeking a relationship where they are heard and understood. During this time, steps should be taken to make a clear and intentional introduction as to the purpose of the intervention.

Second Step
Focusing is used to assist providers and their clients with clarifying an agreed-upon direction. Both the provider and client may have their own agendas. However, focusing allows the working partnership to collaborate on finding a common direction toward change. This can be done by presenting a clear set of possible topics to focus on during the conversation.

During this second process of motivational interviewing, like "negotiating the agenda" in medical communication literature, it can begin with a question such as: "*You've mentioned several concerns; why don't we decide together where we'll start? What concerns you most"?*

Negotiate the Agenda allows the working partnership to collaborate on finding a common direction toward change. This can be done by presenting a clear set of possible topics to focus on during the conversation. It can also cover logistics, such as the amount of time of meeting, paperwork that needs to filled out, or setting up the long term plan.

Examples:
"*Your doctor asked me to discuss your lifestyle as a means to better control your diabetes, there are many aspects we can discuss including diet, exercises, stress management, etc. Which would you like to discuss today"?*

"*This is the third time you have been admitted to the hospital for your condition, you seem to have trouble with managing your medications, can you describe what is happening that is making it difficult so we can plan supports to assist you in doing the things you enjoy most."?*

Understandably, healthcare practitioners may be tempted to try to "persuade" their patients to engage in healthier behaviors. Indeed, in support of this point of view, a recent systematic review of educational approaches in healthcare found that "persuasion" is often ineffective, Patients with ambivalence, typically react negatively to persuasion, confrontation, or even direct "advice," leading to discord in the relationship and, ultimately, decreased likelihood for healthy behavior change.

Motivational interviewing recognizes the importance of sharing expertise. To avoid arousing defensiveness, however, motivational interviewing encourages clinicians to use an "ask-tell-ask" (or "elicit-provide-elicit") approach to "persuade with permission." The initial "ask" seeks the patient's permission to discuss a health behavior. For in-stance: "*is it okay if we discuss your diet?"* Asking for permission in this way, respects and supports patient autonomy in a collaborative style, increasing trust,

sense of safety and willingness to be open. If the patient declines, or if the patient demonstrates only "half-hearted" or ambiva-lent consent, do not proceed with information exchange at that point. If the patient appears reluctant to hear more information, "advice" or "education" will be counterproductive. For those patients voicing an openness to discussion and exploration, however, clinicians can begin a collaborative process of information exchange and motivational enhancement After sharing ("telling") information relevant to health improvement, in the third step of the "ask-tell-ask" framework, clinicians return to "asking" patients what they think and feel about what they have just heard: "*I wonder what you think about all this ?"*Active listening to the patient's responses to this query often provides conversational ingredients for clinicians to actively launch the plan for change.

Third Step
Evoking Motivation is used by providers to help clients find and voice their own motivations for change. Providers can explore this with clients by asking open-ended evocative questions that elicit change talk, helping clients identify why they want or need to change, having clients voice what they can do to change, and developing discrepancy between the client's goals and values and their current behavior. ***Change talk*** *is the opposite of sustain talk.* Practitioners seek to minimize sustain talk by employing techniques to move the client toward discussing what they desire that is different than current behaviors, habits or lifestyle.

Sustain talk reflects a patient's expressed desire to stay within, or difficulty leaving their relative "comfort zone" of persistent unhealthy behaviors. Sustain talk includes expression of emotional difficulties or emotional barriers to change. Examples of sustain talk includes statements expressing difficulties to change ("*it's just too hard for me*"), denial (*'I don't believe I'm really at risk – my father smoked till he was 94)"* or references to prior failures and doubts (such as "*every time I try to lose weight, I regain it and then some*").

In general, clinicians strategically "soften" sustain talk with selective inattention, while probing for, reinforcing, and/or exploring change talk. Sustain talk, however, is often associated with strong emotional content which needs to be acknowledged and validated first, to ensure continuing connection and trust. It is always important to let your patients know that you understand their emotional frustrations. When patients feel you do not understand or you minimize their difficulties, you invite "push back," inducing further sustain talk.

Clinicians must exercise caution and judgment to avoid "too much" resonance and exploration of "sustain talk," because this invites further sustain talk, which in turn encourages "status quo" behaviors. Based on evidence, motivational interviewing principles encourage clinicians to use judgment to acknowledge difficulties, including emotional distress, *sparingly but sufficiently* before moving towards cultivating change talk.

To both soften sustain talk with empathy and compassion, while beginning to cultivate change talk, clinicians can use "double-sided" reflections. First, clinicians use empathic reflections to communicate understanding and acceptance which softens sustain talk, following by reflections or questions aimed to elicit or reinforce "change talk." In the interaction with a client about weight loss, for example, a clinician could build rapport and cultivate change talk as follows:
"I'm getting a clear picture of just how troubling and difficult this whole thing has been for you. I also heard you say quite a bit about why losing weight is important to you, let's explore this further"…

Change talk can be identified as any client speech that describes movement toward change and is linked to a specific change goal.

Change talk can be preparatory or mobilizing. *Preparatory* change talk can be elicited when providers explore clients' desires, ability, reasons, and need to change. *Mobilizing* change talk can be elicited when providers explore clients' commitment, activation (willingness, readiness, and preparation), and steps to change.

Change talk can be elicited using the five techniques:

1. Asking evocative questions
2. Using the importance ruler
3. Querying extremes
4. Looking back and looking forward
5. Exploring goals and values

Each of these techniques will be discussed in more detail in the next section titled Techniques for the Clinician.

Fourth Step

Planning can begin when a client expresses readiness to change, and the conversation becomes more about when and how to change. It involves identifying a plan of action and includes the spirit of MI and the other processes of engaging, focusing, and evoking.

Once a clinician evokes sufficient change talk around a specific area, the healthcare practitioner encourages probing for a specific behavioral action plan. This can be initiated by asking the patient, whether he or she would like to do anything for their health in the next week or two, or asking a more directional and context-specific version of Question One: e.g.: *"It sounds like you are voicing some real concerns about... (*e.g.*, smoking, exercise) ...I wonder if you'd like to make a specific plan about that?*

If the patient responds affirmatively, the next step is to help the patient make a "SMART" plan, that is specific, measurable, achievable, rel-evant, and time-based. The more specific the plan, the greater the likelihood of successful follow through. If the patient is unsure about wanting to make a plan, the clinician can offer a behavioral menu of 2–3 varied ideas, including examples of what other patients have suc-cessfully proposed. For example: *"one patient I worked with decided to do "X", another did "Y", and a third did "Z".* In this way, the patient may be offered a few behavioral ideas without feeling pressured. If the patient indicates that they do not want to make an action plan, this should be honored. The clinician is encouraged to leave the door open for change later by asking if it would be okay to raise this question during the patient's next visit.

Once a SMART plan is collaboratively developed, it is helpful to concretize a commitment on the patient's part by asking the patient to tell back the specific plan. This verbal repetition helps the patient to organize the details of the plan and reveals any misunderstanding regarding what has been planned. First-person restatement of intent by the patient himself/herself is a powerful predictor of subsequent success. Of interest, the strength of the commitment language itself is correlated with increasing likelihood of successful completion, e.g., a commitment with the language "I will," is more likely to lead to completion than a statement such as "I will try."

Fostering Accountability

The final step in the planning stage fosters patients' sense of accountability towards their newly developed SMART action plans. This might include arranging for close follow-up with the clinician and/or associated office staff to monitor and encourage patients' progress. Patients can also be asked to consider

establishing an “accountability partner”, such as one's spouse or a friend, or to foster self-accountability through calendaring or use of self-monitoring phone device or computer software.

Techniques for the Clinician
Healthcare practitioners require techniques when working with patients' to promote change talk and soften or avoid sustain talk. As the quantity and strength of a patient's sustain talk increases, the balance tips towards maintenance of the status quo. An increase in change talk, on the other hand, tips the balance towards change. *Thus, the central goal of motivational interviewing seeks to increase the amount and strength of a patient's change talk.*

Change talk can be elicited using these five techniques:

1. Asking evocative questions
2. Using the importance ruler
3. Querying extremes
4. Looking back and looking forward
5. Exploring goals and values

1. Asking evocative questions
Change talk can be identified as any client speech that describes movement toward change and is linked to a specific change goal.
Change talk can be preparatory or mobilizing. *Preparatory* change talk can be elicited when providers explore clients’ desires, ability, reasons, and need to change. *Mobilizing* change talk can be elicited when providers explore clients’ commitment, activation (willingness, readiness, and preparation), and steps to change.

To successfully navigate the hurdles of MI, you need to recognize change talk when it occurs. In the world of Motivational Interviewing, the acronym DARN CAT is used as a mnemonic to describe various types of change talk:
• **D**esire
• **A**bility
• **R**easons
• **N**eeds
• **C**ommitment language
• **A**ction (current movement)
• **T**aking steps toward change
The two parts of the acronym separate at a natural place. DARN represents “preparatory” change talk and CAT “mobilizing” change talk.

Preparatory evocative questions include exploring desire, ability, reasons, and need (DARN).

Desire questions explore what clients want or wish for life. Examples are provided below.
What do you want from therapy?
How much would you like to drink?
Tell me what you wish were different.

Ability questions explore what clients can and are able to do.
What do you think you could do to… ?

How likely are you to be able to… ?
What ideas do you have to change how much you're… ?
How confident are you that you could… ?

Reason questions explore why clients want to change.
Why do you want to… ?
What's the problem with continuing with how things are?
Tell me your top three reasons for…

Need questions explore the client's urgency for change.
What needs to occur for you to… ?
How urgently does… feel to you?
What do you think needs to change?

Mobilizing change talk can be elicited when providers explore clients' language related to change, Commitment, Activation and Taking Steps (CAT)
Commitment- Statements about the willingness of change:
"I want to "
"I could"
"I need to "

Activation- Statements about willingness to change:
"I am willing to "
"I am ready to "
"I am prepared to "

Taking Steps- Statements about action taken:
"I went to a support group meeting."
"This week, I didn't smoke a cigarette in the evening."

Providers can remember to listen for different types of change talk using the acronym **DARN-CAT: D**esire, **A**bility, **R**eason, **N**eed, **C**ommitment, **A**ctivation, and **T**aking steps.

Factors to Consider in Fostering Change
Ambivalence, or difficulty changing unhealthy behaviors, manifests itself in slightly different, sometimes overlapping forms: emotional dis-tress, discord in the clinician-patient relationship, or deep internal con-flict about change. One or more of these forms of ambivalence towards change are common and indeed, "normal," leading typically to denial, rationalization, defensiveness, anxiety and/or procrastination.

Astute observers can detect ambivalence about change by attending to the "language" individuals use when discussing their choices about their own health, wellness, and lifestyle. Motivational interviewing has discovered that individuals express their desires to change versus their proclivity to stay rooted in risky behaviors through their "change talk" and "sustain talk." Motivational interviewing research has demon-strated that clinicians can reliably influence the amount and strength of patients' change vs. sustain talk, and that these changes predict subse-quent behavior.[4]

Change talk reflects a person's aspiration for change. It may be reflected by phrases that express desire for change (e.g., "*I would like to start exercising*" or "*I wish I could keep to a regular diet*"), statements of ability to change (e.g., *'I know I can do this ifI really decided it was im-portant"*), needs to change ("*I know I need to starting walking,")* or state-ments that reflect reasons to change (e.g. "*I think I will feel more energy if I get off the sugary stuff*"). The acronym "DARNCATS" categorizes seven categories of change talk Desire, Ability, Reasons, Need, Commitment, Activation, Taking Steps. Let's look now at the Stages of Change

2. **Using the importance / confidence ruler**

An imaginary scale ranging from 0 to 10 can be used to explore the client's level of perceived importance or confidence for change. It involves the use of two questions, first having the client place a rating on the scale and the second question is meant to elicit change talk and assist the client to identify why change is important.

First Question:
"*On a scale from 0 to 10, where 0 indicates not at all important and 10 indicates the most important thing for me right now, how important is it for you to… ?*"or for confidence *0 indicates not at all confident and 10 indicates the most confident right now, how confident are you to change…. ?*"

Second Question:
"*And why are you at a… and not a (lower number)?*"
Although someone may answer the initial question with 0, it is uncommon. In the event that a client reports an importance rating of 0, other evocative questions (desire, ability, or reasons) can be used to explore ambivalence.

Importantly, regardless of the specific number the client provides, the clinician can cultivate change talk by then asking to explain why he or she gave that number and not a lower number. For instance, the cli-nician may ask:
"OK. That's interesting. Despite being so hard, you're actually giving this an importance of 7. That's really high. I wonder why you said a 7 and not a 5 or a 4?"
Patients generally respond well to the importance ruler used in this way. They find it novel, unexpected, and interesting when asked why their confidence level is not *lower* than what they stated. This evokes change talk as patients begin to consider why they did not provide a lower number.

3. **Querying extremes**

Exploring the client's worst- and best-case scenarios can elicit change talk.
"*What can happen in the long run if you continue as you are?*"
"*What worries you the most about not changing your health habits?*"
"*What could happen if you were successful in… ?*"
"*What would be the best results if you did change?*"

4. **Looking back and looking forward**

Helping clients identify how their situation was before engaging in their problematic behaviors and comparing that with their lives currently can elicit change talk. Additionally, assisting clients in visualizing how life could be different can also elicit change talk.
Looking back:
"*What was your life like before you gained 30 pounds?*"

"*How has your weight changed you or prevented you from engaging with your family?*"
"*Tell me about when things were going well. What changed?*"
Looking forward:
"*How would you want things to be different in the future?*"
"*Tell me, if you didn't have any physical pain, how would your interactions with your family change?*"
"*How would you like things to be in five years?*"

5. **Exploring goals and values**

Exploring the discrepancy between the client's current behaviors and the things that they value can elicit change talk. Assisting clients to identify that their behavior is inconsistent with what they find meaningful can enhance their motivation for change.

When we ask the client what matters most to them, it can be a good way to continue building rapport. This conversation can explore what the client really cares about and how these goals and values may guide their lives. And we also know that goals and values are aspirations, so there may be some discrepancy between where the client is currently (related to these goals and values) and where the client would like to be in the future. In a counseling session, if this exploration is done in a respectful and genuine way, it can lead to the motivation the client needs to move forward in creating change. Exploring goals and values may be discussed in the engaging, focusing, and evoking processes in order to elicit the client's own motivation for change. The key, again, is to explore and discuss the discrepancy between important goals and values and the client's current behavior.

Value Clarification is an effective technique which has readily available tools that may be useful in discussing one's goals and values. Using a basic definition: values are "fundamental attitudes guiding our mental processes and behavior" that "produce the belief that life is meaningful and serve as a measure of how meaningful one's actions are, that is, consistent with that person's value system" (Vyskocilova et al., 2015). Values clarification then is a way to have an individual identify their personal value system and create a hierarchy of values that are important to them.

Clarifying patient values is important for motivational interviewing as individuals respond much better to change when a plan of care is created with their input. People in general want to be listened to, to have their experiences validated, to be seen as a person and not just a set of symptoms, and to be given hope. Allowing time for values to be discussed can be used to set treatment goals with the patient and can help a patient exit their comfort zone and begin to change for the purpose of improving their quality of life. Lists of core or personal values generally include things like:

Core Personal Values

Authority	Determination	Kindness	Religion
Autonomy	Fairness	Knowledge	Reputation
Authenticity	Faith	Leadership	Respect
Balance	Fame	Learning	Responsibility
Beauty	Friendships	Love	Security
Boldness	Fun	Loyalty	Self-Respect
Compassion	Growth	Meaningful Work	Service
Citizenship	Happiness	Openness	Spirituality
Community	Honesty	Optimism	Stability
Competency	Humor	Peace	Success
Contribution	Influence	Pleasure	Status
Creativity	Inner Harmony	Popularity	Trustworthiness
Curiosity	Justice	Recognition	Wealth

Allowing a person to select their top five values from a list like the one above, gives a starting point for discussion as well as focus the motivational interviewing conversation on specific values meaningful to the patient. Once the client has expressed his or her goals and values the next step is to compare current behavior to future behavior. One can then progress to creating a values clarification plan.

A values clarification plan may consist of the following steps

1. Creating distance from social pressures: helping the patient distinguish between their own motivations and desires and those of the people and society around them.
2. Defining the concept of values with the patient: explaining the difference between values and goals, such as the fact that values cannot be achieved like goals, but they can be used to set goals.
3. Defining personal values: helping the patient identify their own personal values.
4. Importance (significance) of individual values: helping the patient figure out how important each of their values is, relative to the others.
5. Determining how the patient's current actions are consistent with the relevant areas of values: having the patient self-evaluate how consistent their actions are with their values.
6. Choosing immediate goals consistent with values: setting goals for the patient that are consistent with their values.
7. Behaving in accordance with objectives and values: the therapist and patient try to keep the patient on target for their goals based on their values.

Crafting goals

One of the first steps in helping a client create goals is to have them think about the results they want to see. You may tell them "before making a goal, take a closer look at what you're trying to achieve and ask yourself the following questions:

- Is this goal something you truly want?
- Does it align with your values?
- Is it important enough to put effort into it?
- If you're not willing to put in the time, it may not be worth pursuing.

If a person creates a long list of goals to pursue all at the same time, they may have a difficult time achieving any of them. Instead, use the questions above to determine which goals matter the most right now, and then focus on those few. It is also imperative to create SMART goals

Once a person has zeroed in on what they actually want, ensure the goal meets the SMART criteria:

- **S**pecific
- **M**easurable
- **A**ttainable
- **R**ealistic
- **T**ime-bound

The most important part of SMART goal setting is to make the goal specific so a person can clearly track progress and know whether the goal was achieved. The more specific the higher the chance a person can complete it.

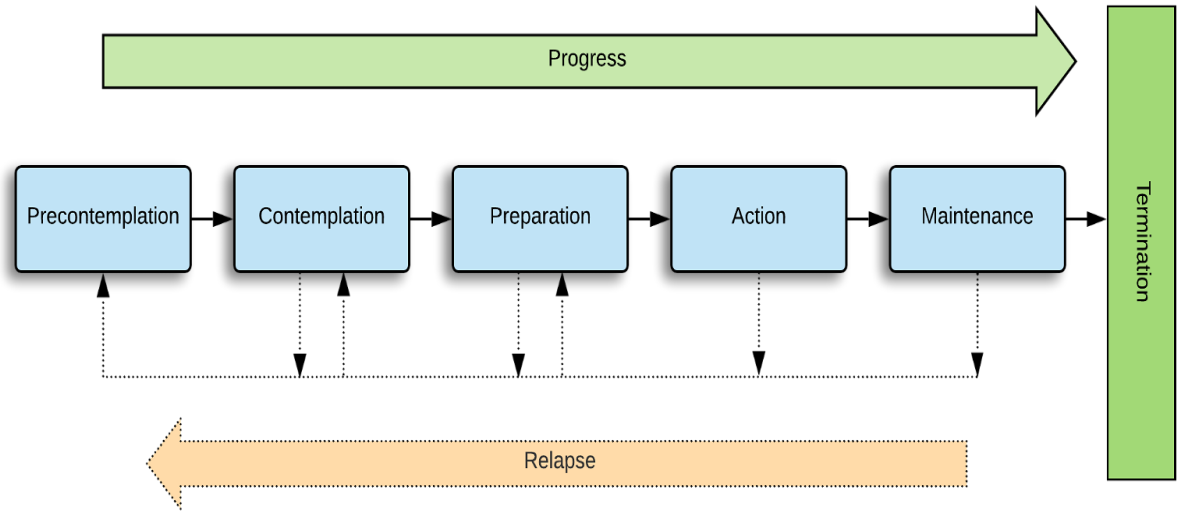
For example, many people set goals to lose weight, but they don't always decide how much weight they want to lose and when they want to accomplish this goal. A specific goal would be "I want to lose 25 pounds by the Fourth of July." This goal provides an exact amount of weight to lose and a completion date. It also has been shown that when goals are written down, they become real and tangible instead of a vague idea that resides only in a person's mind. Once the goals are written down, keep them somewhere visible—put personal goals up on a mirror or near a computer screen. This tactic reminds a person to keep working on the goals daily.

THE PROCESS OF CHANGE

Understanding the Process of Change
In order to use the techniques above effectively, the healthcare practitioner needs to understand change. Understanding how a person progresses through change, and having an awareness of the transtheoretical model which outlines six distinct stages of change will provide a framework for understanding this phenomena.

How do we progress through change?
Our perception of change – for example, altering our diet or increasing exercise –transforms over time. In earlier stages, we see more cons than pros, but over time, in later stages, the balance shifts, and we start to see increased benefits to behavioral change.

Transtheoretical Model of Change (TTM) identifies six stages of readiness experienced by an individual attempting to change (Prochaska & Velicer, 1997; Liu, Kueh, Arifin, Kim, & Kuan, 2018). The model helps us understand not only the process by which clients make an intentional change, but also the support from themselves and others that can help. As such, it provides a useful for health professionals working with clients and patients. The six stages of readiness include: Precontemplation, Contemplation, Preparation, Action, Maintenance, and Termination.



Precontemplation – failing to recognize the need for change
The Precontemplation stage occurs when the client has no intention, now, or in the future (typically seen as six months), to change their behavior.
For example, "*I have no intention of taking up a sport or going running*."
Most likely, they are either under-informed or uninformed.
The client is either completely unaware or lacking details regarding the health benefits of changing their behavior and taking up physical exercise.
Perhaps they tried previously, with little apparent success, and have become demoralized or despondent.

Contemplation – seriously considering the need for change
The client has become acutely aware of the pros of making the change, but they are also keenly aware of the cons.
For example, "*I know I need to lose weight for my health, but I enjoy fast food.*"
Balancing the costs versus the benefits can lead to ambivalence – mixed and contradictory feelings – that cause the client to become stuck, often for an extended period.

Preparation – making small changes
The client intends to move to the action stage soon – typically within the next month – but they are not there yet.
For example, "*I need to understand what support is available and put it in place before I stop smoking.*"
The client typically begins to put actions in place, for example, starting a gym membership, joining a class, or engaging with a personal trainer.

Action –The client has made good progress; they have modified their lifestyle over the last six months.
For example, "*I go to the gym on Mondays, Wednesdays, and Fridays every week, and I am following a plan set out by my trainer.*"
Their new behavior is observable by other people, whether it's exercising, eating more healthily, or no longer smoking.

Maintenance – regular exercise lasting longer than six months
Within the maintenance stage, the client becomes confident they can continue their new lifestyle, and behavioral change is embedded in their lives. Perhaps equally important, they are less likely to relapse – to fall or slip back into their old selves.
For example, "*I am confident I can make healthy eating choices at home, work, or when I go out*."
Based on data from both self-efficacy and temptation studies, maintenance can last between six months and five years

Termination
The final stage, termination, is perhaps more of a destination – an end state. At this point, even if bored or depressed, the client will not return to their former unhealthy way of coping

Relapse A relapse is a form of regression to an earlier stage. It is not a stage in itself, but a failure to maintain the existing position in behavioral change, either as a result of inaction (e.g., stopping physical activity) or the wrong activity (e.g., beginning smoking again.)
Unfortunately, relapse is typical for many health-related behavioral changes. But it is not inevitable.
For example, "*I was out the other night and started smoking. I've continued since.*"
The smoker begins smoking, the new runner gives up, the diet is over, fast food is back on the menu.

However, it is essential to note that the client's behavior through earlier stages may not be linear. Instead, it occurs in cycles; they may revisit – or *relapse* – to prior stages before moving on to the next.
An individual may maintain their diet for months, but then on vacation, return to their old ways. After several weeks, they may start re-considering returning to their new diet or seek out other options.

Many factors impact – strengthening or weakening – the client's ability to change.
Transtheoretical Theory of Change lists several processes that assist the progression between these stages; important ones include self-efficacy, decisional balance, temptations and support.

Self-efficacy – the belief in our ability to change – is crucial to planning and executing the actions required to meet the goals we set and fight the temptation to relapse
As a result, clients high in self-efficacy are better at accepting challenges and persisting in overcoming obstacles.

Decisional Balance The individual's perception of the positive and negative aspects of modifying their behavior is also crucial to success. They must balance the pros and cons to decide whether to continue the journey, fall back, or give in.

Temptations are those things you want to do or to have, even though you know you should not have or do. Temptations are most powerful when a person is tired, stressed or ambivalent about the desired change. Successful change requires the client to believe that the benefits outweigh the drawbacks.

Support can assist the person to change. Supports can come in the form of motivation through understanding change and where a person is in the process.

Ambivalence is the feeling of uncertainty or conflict about whether or not to act on a particular desire or idea. It can be a problem when people are trying to make a decision, because it can make it harder to come up with a clear plan of action. But it is the hallmark of the contemplation stage of change right after precontemplation. When people are ambivalent about a decision, they may feel like they don't know what to do. This can make it difficult to get started, because they don't feel like they have a clear goal in mind.

People can also feel conflicted when they are trying to motivate themselves. For example, they may want to do something, but they may also feel scared or uncertain about the consequences. This can make it difficult to feel motivated, because they don't feel like they can trust their own abilities, this is normal and an important part of the change process.

When people are ambivalent about a decision, motivational interviewing can help them to explore their feelings about why they want something to change and why they want things to stay the same. Essentially wanting something at the same time as not wanting something. This conversation as part of the process of MI can help them to understand why they are conflicted, and to develop a plan of action that is based on their own strengths and weaknesses.

Ambivalence can also be a problem when people are trying to motivate themselves. For example, they may want to do something, but they may also feel scared or uncertain about the consequences. This can make it difficult to feel motivated, because they don't feel like they can trust their own abilities.

Motivational interviewing can help people to develop a plan of action that is based on their own strengths and weaknesses. This can help them to feel more confident about their abilities, and to get started on the task at hand. Specific techniques called Change talk, language or things that we (clinicians) say or do that decrease the resistance and moves the client in a positive direction. The key to Motivational Interviewing involves change talk. Clinicians say and do things that will move the client in a more positive direction.

Sustain talk is language or things that we (clinicians) say or do that increase the resistance, that move the client towards resistance and staying the same.

The harder we try to pull the client toward the desired behavior, the more they are likely to resist. So, change talk is a way in which we are able to keep the conversation going move the patient from contemplation to action. And hopefully, as we do that, the client will move in a more positive direction as they are in control. Using an open-ended questioning method to explore ambivalence is often effective. Here are a few examples of open-ended questions to explore Ambivalence:

- **What is good about current behavior?**
- **What is not-so-good?**
- **What would be good about changing?**
- **What would be not-so-good?**

GUIDING PRINCIPLE -- RULE

It has been stated several times that motivational interviewing is a method or technique that involves enhancing a patient's motivation to change. As healthcare practitioners it is important that we not feel we are the expert. Educating an individual on what they should do or providing statistics which may overwhelm or scare an individual can do more harm than good in many cases. Clinicians should learn the four guiding principles, represented by the acronym RULE: Resist the righting reflex; Understand the patient's own motivations; Listen with empathy; and Empower the patient.

Resist the Righting Reflex
The righting reflex describes the tendency of health professionals to advise patients about the right path for good health. This can often have a paradoxical effect in practice, inadvertently reinforcing the argument to maintain the status quo. Essentially, most people resist persuasion when they are ambivalent

about change and will respond by recalling their reasons for maintaining the behavior. Motivational interviewing in practice requires clinicians to suppress the initial righting reflex so that they can explore the patient's motivations for change. If a well meaning professional gives advise or provides more education than the person is ready for the following results are often the outcome:

- Patients may resist your efforts
- Patients may become defensive
- Patients may not follow through with intervention
- Patients may seek help elsewhere
- Patients may abandon their care and relapse

Understand your patient's motivations

It is the patient's own reasons for change, rather than the practitioner's, that will ultimately result in behavior change. By approaching a patient's interests, concerns and values with curiosity and openly exploring the patient's motivations for change, the practitioner will begin to get a better understanding of the patient's motivations and potential barriers to change.

By seeking the reasons for change the healthcare professional is seen as empathetic and understanding. Active listening and restating what is meaningful to the client can be motivating. Restating what the client's motivations for change can provide an opportunity for the intervention plan to be created in a collaborative manner. This often results in

- Patients asking questions about their condition
- Patients becoming more actively engaged in the treatment
- Patients more involved in follow through
- Patients looking forward to further information
- Patients taking responsibility for their own care and less relapse

Listen with empathy

Effective listening skills are essential to understand what will motivate the patient, as well as the pros and cons of their situation. A general rule-of-thumb in MI is that equal amounts of time in an interaction should be spent listening and talking. Listening does not mean that the healthcare practitioner does not contribute to the conversation but rather understanding that conversations can be an opportunity to learn something new, build trust with someone, and deepen connections. This happens when we build the skill of **active** listening and learn to treat listening as an active process – not a passive one.

Active listening is a way of listening and responding to another person that improves mutual understanding. It's about being present, listening to understand (not respond), and showing active interest and engagement in the dialogue.

When you ask a question, it is important to listen carefully to what the person is saying. We can sometimes be fixated on what we are going to say next, or when it's our turn to jump back into the conversation, but try not to think about what you are going to say next.. Your focus is on the client and their perspective rather than your own. If this is difficult for any reason (time constraints, wanting to be sure you don't to tell the person important information) make an effort to try to clear your mind first of any distracting thoughts. It can help to jot down a mental or physical note of things on your mind in order to give your full attention to conversation as it is happening.

Reflect & respond to the reply: Keep the conversation going by responding in a way that connects with what they just said. You can try to restate in your own words what the person said, share what you think or feel about it, or ask another open-ended question that connects with what the person just said. Keep the

long-term goal in mind – that you want the patient to take an active part in their own care and understanding their perspective is an important part of the process.

Empower your patient
Patient outcomes improve when they are an active collaborator in their treatment. Empowering patients involves exploring their own ideas about how they can make changes to improve their health and drawing on the patient's personal knowledge about what has succeeded in the past. A truly collaborative therapeutic relationship is a powerful motivator. Patients benefit from this relationship the most when the practitioner also embodies hope that change is possible.

To empower someone means to give them the means to achieve something, for example, to become stronger or more successful. Sometimes a person needs to feel that the healthcare professional believes they can achieve something. Providing hope for a better future with a plan that is achievable and sustainable. Behavior change is not all or nothing rather it is a way to shed light on a way forward. RULE is a useful mnemonic to draw upon when implementing the spirit of MI in general practice. The essential elements of Resisting the Righting Reaction, Understanding the client's motivations, Listening with Empathy, and Empowering the Patient to be active in their own healthcare.

Here are some additional tools and techniques for the healthcare professional to use in ensuring the client is kept at the heart of the process. Much like keeping a boat moving forward one uses energy in rowing, think using an oar on a boat. The acronym OARS - Open Ended Questions, Affirmations, Reflective Listening and Summaries, allows the practitioner to steer the conversation where it needs to go..

Open-ended questions
When a practitioner asks primarily open-ended questions the patient does most of the talking and the practitioner has the opportunity to learn more about what the patient cares about (eg. their values and goals). This may be quite different from the way the patient has experienced a healthcare encounter. They may need time and permission to gain comfort in speaking freely or sharing personal information. Trust needs to be established and clear expectations need discussed, especially in the first meeting where one is trying to engage the client. Remember a few probing questions to elicit the client to discuss the issues that are of concern is most important.
Example
I understand you have some concerns about your drinking.
Can you tell me about them?
Versus
Are you concerned about your drinking? (Yes or No question) (Closed-ended)

Affirmations
The healthcare professional should consider providing verbal and non-verbal affirmations to the client. With non-verbal attention be mindful of body language such as eye contact, open posture and leaning in toward the patient as they are speaking. Verbal affirmations can take the form of compliments or statements of appreciation and understanding when a patient or client is sharing information. By actively stating appreciation of their willingness to share important information, it helps build rapport and validate the patient during the process of change. Positive movement toward the goal is most effective when the patient's strengths and efforts for change are noticed and affirmed. In verbal affirmations consider how to:

Reflect back what client is saying
There are two different techniques:

- **Simple** - Stay close to exactly what the client states
- **Amplified** - You want the client to correct you, so you add or embellish or state incorrectly

Examples
"I appreciate that it took a lot of courage for you to discuss your drinking with me today."
"You appear to have a lot of resourcefulness to have coped with these difficulties for the past few years"
"Thank you for sharing with me. I can imagine this is not easy for you to talk about and you are now on the path to recognizing that change is possible"

Reflections
When using reflections, the practitioner intentionally rephrases a statement to capture the implicit meaning and feeling of a patient's statement. By restating it encourages continual personal exploration and helps people understand their motivations more fully. When one learns to use reflections as a technique in motivational interviewing it can be an effective tool
to amplify or reinforce desire for change.

Example
"You enjoy the effects of alcohol in terms of how it helps you unwind after a stressful day at work and helps you interact with friends without being too self-conscious. But you are beginning to worry about the impact drinking is having on your health. In fact, until recently you weren't too worried about how much you drank because you thought you had it under control. Then you found out your health has been affected and your partner said a few things that have made you doubt that alcohol is helping you at all."

Summarizing
When a clinician uses summarizing, the intent is to link discussions and 'checks in' with the patient during the conversation. This is to ensure mutual understanding of the discussion so far and to point out discrepancies between the person's current situation and future goals. The use of summarizing statements demonstrates active listening and seeks to understand the patient's perspective.

Example
If it is okay with you, just let me check that I understand everything that we've been discussing so far. You have been worrying about how much you've been drinking in recent months because you recognize that you have experienced some health issues associated with your alcohol intake, and you've had some feedback from your partner that she isn't happy with how much you're drinking. But the few times you've tried to stop drinking have not been easy, and you are worried that you can't stop. How am I doing in understanding you?

Summaries bundle reflections with insights that have been gathered during the patient visit. They serve multiple purposes. In Motivational Interviewing, summaries can selectively and strategically pull together and reinforce threads of change talk, with relative inattention to sustain talk. They can be used to ensure clear communication (and accuracy), tying together numerous discussion themes. Like all reflections, summaries require and demonstrate active listening. A good summary may begin with a statement such as "*let me check to make sure I am understanding you correctly so far....".*

To maximize accuracy and deepen collaboration, effective summaries usually conclude by inviting the patient, with a sense of humility, curiosity, and partnership, to provide further input, for example: "*Did I*

miss anything?" or "*Is there anything that you would like to add or correct?*" or "*What else concerns you?".*

Challenges

One of the biggest challenges that healthcare practitioners face is helping people change longstanding behaviors that pose significant health risks. When patients receive compelling advice to adopt a healthier lifestyle by cutting back or ceasing harmful behaviors (eg. smoking, overeating, heavy drinking) or adopting healthy or safe behaviors (eg. taking medication as prescribed, eating more fresh fruit and vegetables), it can be frustrating and bewildering when this advice is ignored or contested. A natural response for a practitioner who encounters such opposition (termed 'resistance' in the psychological literature) is to reiterate health advice with greater authority or to adopt a more coercive style in order to educate the patient about the imminent health risks if they don't change. When these strategies don't succeed, the practitioner may characterize the patient as 'unmotivated' or 'lacking insight'. However, research around behavior change shows that motivation is a dynamic state that can be influenced, and that it fluctuates in response to a practitioner's style. Importantly, an authoritative or paternalistic therapeutic style may in fact deter change by increasing resistance.

This figure compares Motivational Interviewing to an Authoritative Style. As you study this illustration be sure to notice the collaborative spirit of motivational interviewing as the techniques described are meant to acknowledge the patient and professional as equal experts. The healthcare professional holds expertise in understanding diagnosis, etiology and prognosis where as the patient is an expert on their life, motivations, supports and challenges. Both viewpoints are equally important to create a long lasting, collaborative intervention plan for healthy change. Collaboration, evocation and honoring one's autonomy are important to Motivational Interviewing. Contrasting this with an Authoritative or Paternalistic style which uses confrontation, education and authority of the professional in an attempt to have the patient follow a plan of care. This style has been shown to be met with resistance and potential non-compliance from the patient who may feel unmotivated, judged, or unable to make the necessary changes, therefore remains in the status quo.

The spirit of motivational interviewing	Authoritative or paternalistic therapeutic style
***Collaboration*: a partnership between the patient and practitioner is formed. Joint decision making occurs. The practitioner acknowledges the patient's expertise about themselves**	**Confrontation:** the practitioner assumes the patient has an impaired perspective and consequently imposes the need for 'insight'. The practitioner tries to persuade and coerce a patient to change
***Evocation:* the practitioner activates the patient's own motivation for change by evoking their reasons for change. The practitioner connects health behavior change to the things the patient cares about**	**Education:** the patient is presumed to lack the insight, knowledge or skills required to change. The practitioner tells the patient what to do
Honoring a patient's *autonomy*: although the practitioner informs and advises their patient, they acknowledge the patient's right and freedom not to change. 'It's up to you'	**Authority:** the practitioner instructs the patient to make changes

Motivational Interviewing focuses on empowerment. The technique seeks to increase the power of the individual client (or community) so that the client can take action to change and prevent the problems. Empowerment proponents see paternalism as neglecting the client's natural strengths, and as focusing on the negative (the problem) instead of the positive (the client's innate abilities).

Empowerment involves collaborative partnerships with clients, an emphasis on capacities rather than incapacities, a dual focus on the individual and the environment, a view of clients as active subjects, and a conscious direction of professional energies toward allowing the client to come to realizations on one's own through open ended questioning. In empowerment, the client is seen as an 'expert', in that he understands the social and physical environment in which he finds himself. The healthcare professional assists the client in discovering his innate strengths, and how to apply those strengths to increase his power over his life and environment.

One of the main goals of social psychology is to understand how attitudes and belief structures influence behaviors. Based on frameworks from both social and cognitive psychology, many theoretical frameworks used to explain implicit bias revolve around the concept of social cognition. One branch of cognitive theory focuses on the role of implicit or nondeclarative memory. Experts believe that this type of memory allows certain behaviors to be performed with very little conscious awareness or active thought. Examples include tooth brushing, tying shoelaces, and even driving. To take this concept one step farther, implicit memories may also underlie social attitudes and stereotype attributions. This is referred to as implicit social cognition. From this perspective, implicit biases are automatic expressions based on belonging to certain social groups. The IAT is premised on the role of implicit memory and past experiences in predicting behavior without explicit memory triggering.

Case study - using the spirit of motivational interviewing
A male patient, 52 years of age, who drinks heavily and has expressed the desire to reduce drinking but continues to drink heavily and has not yet made any lifestyle changes. It is easy to conclude that this patient lacks motivation, his judgment is impaired, or he simply does not understand the effects of alcohol on his health. These conclusions may naturally lead the practitioner to adopt a paternalistic therapeutic style and warn the patient of the risks to his health. In subsequent consultations, when these strategies don't work, it is easy to give up hope that he will change his drinking, characterize him as 'unmotivated' and drop the subject altogether. In MI, the opposite approach is taken, where the patient's motivation is targeted by the practitioner. Using the spirit of MI, the practitioner avoids an authoritarian stance, and respects the autonomy of the patient by accepting he has the responsibility to change his drinking - or not.

Motivational interviewing emphasizes eliciting reasons for change from the patient, rather than advising them of the reasons why they should change their drinking. What concerns does he have about the effects of his drinking? What future goals or personal values are impacted by his drinking? The apparent 'lack of motivation' evident in the patient would be constructed as 'unresolved ambivalence' within an MI framework. The practitioner would therefore work on understanding this ambivalence, by exploring the pros and cons of continuing to drink alcohol.

They would then work on resolving this ambivalence, by connecting the things the patient cares about with motivation for change. For example, drinking may impact the patient's values about being a loving partner and father or being healthy and strong. A discussion of how continuing to drink (maintaining the status quo) will impact his future goals to travel in retirement or have a good relationship with his children may be the focus. The practitioner would emphasize that the decision to change is 'up to him', may assess the motivation to change using the importance / confidence ruler. Using Motivational interviewing, the health care provider would work with the patient to increase his confidence that he can change. Create SMART goals that are realistic and attainable and check in routinely to affirm the steps taken toward the goal.

Complementary Techniques
Besides motivational interviewing there are many other techniques, some considerably evidence-based, that can be used to foster patient motivation, execution of health goals, and/or maintenance of these goals over the long-term. Some of these techniques are:

- Inspirational Stories
- Incentives
- Measurable goals
- Self Monitoring
- Mental Contrasting
- Feedback
- Stress Management
- Social Support

For example, patients can be inspired by motivational or inspirational stories. Sharing the success of a person who has a similar life story and condition can allow a person to think that it is not impossible of someone like him or herself has overcome the same obstacle. Allowing a person to think of what would be an incentive can spark motivation. Incentives should come from the perspective of what is important to the client. Execution of action plans created to achieve measurable goals can be supported using implementation intentions ("if/when" formulations) for which there is a considerable evidence or use of time management techniques, which can be very helpful to many patients. Mental contrasting could be

considered a type of mindfulness practice. In the case of weight loss or obesity, use this example, You set the intention to pay attention to your tendency to eat too much when certain painful emotions are present.

This awareness then triggers the need for you to exercise extra will-power to refrain from eating simply as a way to soothe yourself emotionally. Another way to look at the steps in mental contrasting would be to use the WOOP acronym: Wish, Outcome, Obstacles and Plan.

W – Wish: Mental contrasting starts with a component of desire. In this first step, a person will be prompted to think about a key concern, desire, or wish pertaining to one life domain and visualize it.

O – Outcome: Next, a person is prompted to think about the ideal outcome of having their wish come true. This usually encompasses an emotional component, such as how a person will feel once their goal is accomplished or how achieving the goal would fundamentally change their life.
For example, the person who wishes for a promotion may imagine the excitement associated with the challenge of a new role. Likewise, the person looking to start dating again may imagine themselves feeling a greater sense of connectedness and joy upon meeting a prospective partner.
Importantly, the person is encouraged to really pause and allow themselves time to imagine what this outcome would feel like, energizing the mind to begin pursuing that outcome (Oettingen et al., 2009).

O – Obstacles: The third part of the process grounds the person and their goals in reality. In this step, a person reflects on the possible hurdles and difficulties they may face while striving toward their desired state. When focusing on hurdles, a person is encouraged to focus on the internal aspects of the self that may hamper goal achievement, rather than things beyond their control. For instance, the person seeking to lose weight may recognize in themselves a tendency toward low self-confidence.

Once again, the person completing the WOOP exercise is encouraged to pause and reflect fully on such impending challenges, imagining how they would play out in reality.

P – Planning: The final stage of mental contrasting involves making an if–then plan, sometimes referred to as setting implementation intentions

Long-term maintenance of health goals (e.g., sustaining a weight loss diet) can be supported by helping patients to make contingency plans, joining a social support group, or gaining assistance in stress and/or energy management issues that may impede one's pursuit of health goals. Stress Management programs serve to equip people with active strategies to use when feeling overwhelmed. Stress is a physiological and psychological response to a change in a situation the body and mind find to be overwhelming.

Simple activities can be quite beneficial. Some examples of stress management activities are:

1. Guided meditation is a great way to distract from the stress of day-to-day life. There are many guided meditations available online that can help you find five minutes of centered relaxation.
2. Deep breathing is a great way to reduce the activation of your sympathetic nervous system, which controls the body's response of fight or flight to a perceived threat. Deep breaths taken in for a count of five seconds, held for two seconds and released for a count of five seconds, can help activate your parasympathetic nervous system to rest and digest, which helps reduce the overall stress and anxiety you may be experiencing.
3. Physical exercise and nutrition are two important components in how a person responds to stress. When a body is healthy, your mind can be healthy and vice versa. Physical exercise is proven to be a great stress reliever and also helps to improve your overall quality of life. Nutrition is important because stress can deplete certain vitamins, such as A, B complex, C and E.

Maintaining proper nutrition not only helps a body feel better, but your mind as well, which allows a person to better combat stress.

4. Manage social media time. Spending time on social media sites can become stressful, not only by what you might see on them, but also because the time might best be spent enjoying visiting with friends, being outside enjoying the weather or reading a great book. In addition, many people use social media at night, which may worsen sleep due to increased stress at the exact time people are trying to wind down for the evening, resulting in fewer overall hours of quality sleep.
5. Connect with others. Humans are social beings. You need to have connections with people to feel supported. Finding a sense of community, whether at work, with a religious organization or through shared activities, such as organized sports, is important to a person's well-being. Enjoying a shared activity allows individuals to find support and foster relationships that can be supportive in difficult times.

CONCLUSION

Motivational interviewing is particularly effective because it combines various evidence-based techniques with its novel approaches to evoking intrinsic motivation. Learning and using motivational interviewing, takes time, patience, and practice. While some of the techniques and skills are relatively easy to understand and use (e.g., use of open questions, simple reflections), developing proficiency in many others such as complex reflections and eliciting change talk in a cli-mate of acceptance, partnership, and empowerment, have been shown to require opportunities for practice of skills with feedback from skilled observers, and re-practice. To re-cap, client motivation is essential to promoting change toward healthy behavior. Motivational approaches are based on the principles of person-centered counseling and effective motivational interviewing approaches can be brief. Motivational interviewing can be supplemented with therapeutic techniques like stress management, mindfulness and feedback to inspire patients to keep the course toward their set goals. MI focuses on enhancing intrinsic motivation and is especially applicable when clients are in the early stages of change, unlike other approaches that use extrinsic (reward-driven) motivators. Healthcare practitioners can use techniques such as open-ended questioning and reflecting back clients' hopes and values in contrast to the negative effects of their actual behaviors. This trusting and mutual relationship is essential for promoting awareness and internal motivation to change. The current practice of MI is based on the primary principles of eliciting change talk and strengthening the client's commitment to change.

MI involves a person-centered, non-confrontational approach in which the interviewer listens reflectively and demonstrates empathy to engage with the patient and develop rapport; help the patient to identify a goal for change (a "select behavior"); evoke and reinforce the patient's internal motivation to change; and help the patient to develop a plan of action to achieve their goal.

Many of us have been trained to direct patients in their health behaviors and practices. MI helps you collaboratively build and guide patient relationships, positively influence their healthcare behaviors and choices, and gain better insight into the social and environmental factors that impact those choices. The application of MI contributes to the enhancement of patient-healthcare worker communication, the patient's concordance and compliance. The application of MI contributes to health professionals' greater success, satisfaction, self-confidence and a sense of self-efficacy.

Specific benefits to MI include:

- Patients recognize their autonomy in choosing their own path to recovery.
- Clinicians support patients to make meaningful changes to reach a mutually agreed upon goal.

- Clinicians validate their patients' internal and external barriers for change and assist them in helping their patient overcome those barriers to pursue treatment.
- And finally, among the most obvious benefits of motivational interviewing in healthcare is its ability to improve health outcomes.

Summary of Key Points

- MI is practiced with an underlying **spirit** or way of being with people:
  - **Partnership.** MI is a collaborative process. The MI practitioner is an expert in helping people change; people are the experts of their own lives.
  - **Evocation.** People have within themselves resources and skills needed for change. MI draws out the person's priorities, values, and wisdom to explore reasons for change and support success.
  - **Acceptance.** The MI practitioner takes a nonjudgmental stance, seeks to understand the person's perspectives and experiences, expresses empathy, highlights strengths, and respects a person's right to make informed choices about changing or not changing.
  - **Compassion.** The MI practitioner actively promotes and prioritizes clients' welfare and wellbeing in a selfless manner.
- MI has **core skills** of OARS, attending to the language of change and the artful exchange of information:
  - **Open questions** draw out and explore the person's experiences, perspectives, and ideas. Evocative questions guide the client to reflect on how change may be meaningful or possible. Information is often offered within a structure of open questions (Elicit-Provide-Elicit) that first explores what the person already knows, then seeks permission to offer what the practitioner knows and then explores the person's response.
  - **Affirmation** of strengths, efforts, and past successes help to build the person's hope and confidence in their ability to change.
  - **Reflections** are based on careful listening and trying to understand what the person is saying, by repeating, rephrasing or offering a deeper guess about what the person is trying to communicate. This is a foundational skill of MI and how we express empathy.
  - **Summarizing** ensures shared understanding and reinforces key points made by the client.
  - **Attending to the language of change** identifies what is being said against change (sustain talk) and in favor of change (change talk) and, where appropriate, encouraging a movement away from sustain talk toward change talk.
  - **Exchange of information** respects that both the clinician and client have expertise. Sharing information is considered a two-way street and needs to be responsive to what the client is saying.
- MI has four fundamental **processes**. These processes describe the "flow" of the conversation although we may move back and forth among processes as needed:
  - **Engaging**: This is the foundation of MI. The goal is to establish a productive working relationship through careful listening to understand and accurately reflect the person's experience and perspective while affirming strengths and supporting autonomy.
  - **Focusing**: In this process an agenda is negotiated that draws on both the client and practitioner expertise to agree on a shared purpose, which gives the clinician permission to move into a directional conversation about change.
  - **Evoking**: In this process the clinician gently explores and helps the person to build their own "why" of change through eliciting the client's ideas and motivations. Ambivalence is normalized, explored without judgement and, as a result, may be resolved. This process requires skillful attention to the person's talk about change.

- **Planning**: Planning explores the "how" of change where the MI practitioner supports the person to consolidate commitment to change and develop a plan based on the person's own insights and expertise. This process is optional and may not be required, but if it is the timing and readiness of the client for planning is important.

MI is framed as a method of communication rather than an intervention, sometimes used on its own or combined with other treatment approaches. There are a number of benefits of learning MI amongst other approaches to helping conversations:

- MI has been applied across a broad range of settings (e.g. health, corrections, human services, education), populations (e.g. age, ethnicity, religion, sexuality and gender identities), languages, treatment format (e.g. individual, group, telemedicine) and presenting concerns (e.g. health, fitness, nutrition, risky sex, treatment adherence, medication adherence, substance use, mental health, illegal behaviors, gambling, parenting).
- MI compares well to other evidence-based approaches in formal research studies.
- MI is compatible with the values of many disciplines and evidence-based approaches.
- Although the full framework is a complex skill set that require time and practice, the principles of MI have intuitive or "common sense" appeal and core elements of MI can be readily applied in practice as the clinician learns the approach.
- MI has observable practice behaviors that allow clinicians to receive clear and objective feedback from a trainer, consultant or supervisor.

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POST-TEST

1. Motivational Interviewing is a technique for the purpose of:
   a) Strengthening personal motivation
   b) Eliciting reason for change
   c) Improving commitment toward a goal
   d) All of the above

2. Which of the following is NOT a core element of Motivational Interviewing?
   a) Develop a commitment for change
   b) Show client respect and autonomy
   c) Prepare a plan seeking complete adherence
   d) Collaborative work to enhance motivation

3. Which is the first step in the process of Motivational Interviewing?
   a) Engaging
   b) Focusing
   c) Evoking
   d) Planning

4. What is the hallmark of the contemplation stage of change?
   a) Preparation
   b) Ambivalence
   c) Action
   d) Maintenance

5. When using the technique of Querying Extremes, the therapist is trying to:
   a) Determine the client's confidence to change
   b) Explore the best and worst case scenarios
   c) Elicit statements about client's values
   d) None of the above

6. In the Acronym "RULE", the R stands for:
   a) Get the client "READY" for change
   b) Show the client the "RIGHT" way
   c) "RESIST" the Righting Reflex
   Be "REAL" about what is going to happen

7. In order to elicit behavior change a therapist should seek to
   a) Educate a client on the need to change
   b) Provide Evidence on why behaviors cause illness
   c) Document all occurrences of noncompliance
   d) Seek to understand patient motivations

8. Using the words " I am hearing" is a way to
   a) Demonstrate Reflective Listening
   b) Provide an Affirmation
   c) Ask an Open ended question
   d) Lead the client to a solution

9. When a therapist acknowledges a patient's right and freedom not to change, they are honoring
   a) Evocation
   b) Autonomy
   c) Authority
   d) Education

10. What style is being used when a therapist tries to persuade and coerce a patient to change assuming they have an impaired perspective?
    a) Confrontation
    b) Education
    c) Authority
    d) Evocation

The post-test and corresponding course evaluation can be accessed at:
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If all course requirements have been met, a certificate will be emailed from Select Rehabilitation to the email address reported in the course follow-up survey.

Any questions or issues related to this course should be directed to Dr. Kathleen Weissberg, National Director of Education for Select Rehabilitation at kweissberg@selectrehab.com