Motivational Interviewing

Module 2 Slide Transcript

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In this module, you will be introduced to the basics of Motivational Interviewing, or "MI." Bear in mind that this is an introductory training. As the Council's experts on this topic often say, "Building skills in MI requires a long view and a strong plan." The goal of this module is to enable you to understand the techniques of MI better, and to begin to create a plan for integrating these techniques into your own practice setting.

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Specifically, this module will provide you with:

The definition of Motivational Interviewing or MI

A discussion of the use of MI in the HCH setting

Descriptions of the three typical styles of communication

Description of the Six Stages of Change

and

The OARS process and its meaning in MI

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William R. Miller and Stephen Rollnick are widely recognized as the founders of the technique known as Motivational Interviewing, or MI. Their definition of MI is ‘‘a client centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.”

This method was initially developed as a means of assisting in the treatment of alcohol and drug addiction. But its style and spirit translate well into a variety of settings, including health care for the homeless. The spirit of MI is rooted in three elements: Collaboration (instead of confrontation), Evocation (instead of imposition), and Autonomy (instead of authority). This means there is a type of partnership that grows between practitioner and client, in which the perspective of the client takes the starring role, and the practitioner uses specific techniques to guide the client’s story, and assist the client in deciding for herself to make positive changes.

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In other words, this technique, Motivational Interviewing, helps clients hear their own thoughts and words in a new way, and with the new frame, come to conclusions in their own time about how and what and how much they seek to change in their behavior.

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The HCH model of care takes into account that homelessness is a traumatic event, and often times, other traumas such as domestic violence, environmental disasters such as earthquakes or floods, or long-term chronic and expensive mental and physical illnesses are the reasons for a patient's homeless status. Stresses associated with homelessness also reduce resistance to disease, account for the emergence of some mental illnesses, and enhance the false promises of relief offered by alcohol and drugs. Homeless people experience illness at three to six times the rates experienced by housed people.

Motivational Interviewing techniques focus on a patient's strengths and abilities. By establishing rapport with the patient, the provider is able to help her identify those strengths.

An approach that is client-centered means that the provider listens to the patient well, and then is able to begin with what the patient identifies as his most pressing issues. Rather than strive to fix the problem ***for*** the patient, the provider works to create an environment of self-discovery, so that the patient is empowered to guide his recovery.

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Becoming proficient in MI takes time and practice, and like any new skill set, it is wise to take a long view. It's helpful to have feedback from clients or patients, colleagues, and supervisors. Being able to discuss technique through case discussion increases the practitioner's proficiency, and therefore makes the patient's experience more successful.

As the practitioner becomes more comfortable and skilled in MI technique, it becomes easier for the client to follow the guides of the clinician and

increases her desire to make positive changes. Skilled in MI techniques, the practitioner can best assist in creating plans for client change.

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Typically, there are three styles of communication used in patient encounters: Following, Directing, and Guiding. All can be effective, but one is best suited to Motivational Interviewing.

The Following Style, aligned with Carl Rogers, or a "Rogerian Approach," focuses mainly on listening while allowing clients to talk their way through, which eventually produces change. This style, which is a passive approach to listening, is often used by HCH providers. The provider thinks about things they 'need' to say to the client, but lets the client lead the way and do whatever he or she wants to do, moving toward his or her own goals.

Another word for the Directing Style is authoritarian. In the directing style, the provider listens briefly to the client, and then directs the client on the next steps to take. This approach is very prescriptive and even parental, and is often a good approach for managing acute crises, but it is the least helpful approach for facilitating individual change.

The guiding style is the style most aligned with the motivational interviewing approach. While this style is a more time consuming style of communication, it is the best one for providers to use to assist a patient in facilitating his own changes. The practitioner uses acceptance, empathy, egalitarianism, and genuineness to help the patient process through the Six Stages of Change.

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There are Six Stages of Change:

The Pre-contemplation Stage

The Contemplation Stage

The Preparation Stage

The Action Stage

The Maintenance Stage

The Relapse/Recycle Stage

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In the 1980's experts believed a person had to be ready to change before she could be helped. Today, we know that we can help clients and patients *before* they are ready to change.

Patients in the Pre-contemplation Stage often do not recognize their behavior as problematic. This might not be as prevalent in the HCH setting. Homeless healthcare practitioner, Dr. Deborah Borne, states, “Most people who are homeless have some clarity or believe that problematic behavior contributed to their situation. What this means for our population is that you don’t spend a lot of time in this stage. The more skilled you are, the less you have to worry about pre-contemplation in homeless health care.”

A person who is in the pre-contemplation stage may say something like, “I love alcohol. If I could spend all day drinking, I would be happy.” He may not be at all interested in quitting drinking, but he may be very interested, instead, in staying healthy around his drinking.

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Relationship building is key in this interpersonal style of assisting. The practitioner seeks to understand the patient’s frame of reference, often through reflective listening. The tone is conversational, not controversial, and the practitioner seeks to create a safe environment where the patient feels accepted, even if the practitioner does not approve of the patient’s behavior.

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During the contemplation stage, patients will express ambivalence about making a change. While she may understand what is to be gained by changing her behavior, a patient will often experience a sense of loss at giving up that behavior. A patient may make statements like, "I know I should stop drinking. It's just so hard to give it up."

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The practitioner's focus in the Contemplation Stage should be on the exploration of the patient's ambivalence. This process can be lengthy, and relies upon the rapport built in the initial, pre-contemplation stage to be effective. The practitioner strives to elicit change talk, which is how the patient discusses desire, ability, reason, need, and commitment to change. The patient is guided through these conversations in a manner which builds her self-confidence, and assists her in coming to her own conclusion that the positive change is a good idea.

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During the preparation stage, the patient begins to set himself up for taking future action. For example, the patient who is considering giving up drinking may consider the times when he drinks the most, and may experiment a bit by giving up one of those times. He may begin to use what is called "commitment language," which are client statements that indicate resolution of ambivalence. The strength of the commitment language is directly related to the level of subsequent change.

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The practitioner uses open-ended questioning and reflective listening skills to assist the patient in brainstorming ideas for making changes, problem solving, the logistics involved, and experimentation of the new behavior. Support is imperative in this stage, as often logistics involve the patient changing relationships with people who have previously encouraged or participated in the negative behaviors the patient is working to change.

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In the Action Stage, the patient works directly toward achieving positive changes. This is often the most enjoyable stage, as the patient demonstrates her commitment to improving her life, and brings the preparation to fruition.

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It is helpful for clinicians to encourage the patient in the Action Stage to work toward small, attainable goals. A series of small successes will build upon one another, and provide the patient with a continued sense of self-confidence. The practitioner continues to use reflective listening and open-ended questions in the therapeutic setting, and also utilizes affirmations to assist the patient in recognizing his positive changes and the effects they are having in his life.

It is important in this stage that the practitioner assist the patient in exploring realistic expectations, as well as those situations when the patient does not do as he stated he was going to do.

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In the Maintenance Stage, it is clear to both the patient and the practitioner that the desired positive change has been achieved. The patient recognizes the benefits to having changed her behavior, and seeks to maintain them in her daily life.

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Maintenance involves incorporating the new behavior "over the long haul." Practitioners should be aware that sometimes patients will sabotage their own good work when they experience self-doubt or are reminded of the times when they behaved differently. It is important that the practitioner offers sincere affirmation about the positive change, and offers relapse prevention counseling. The provider should assist the patient in establishing support systems outside of the therapeutic or clinical setting, and if termination of the therapeutic relationship is on the horizon, the process should be developed with the patient's input.

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Most clients will experience setbacks, or Relapses, before the positive change is firmly established. It is quite common for a patient to have to Recycle through the stages of change several times. While this is sometimes discouraging, the patient should be reassured that it is common and something that can be overcome. HCH provider Dr. Nicholas Apostoleris puts it this way, "When working through relapse issues with patients, I like to talk about the 'slope of recovery' – that the general trend has been positive over the past weeks/months/years."

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During this stage, the practitioner may be surprised to hear resistance talk, something that hadn't been heard since the first of the six stages. It is beneficial to the patient if the provider can offer positive affirmations – those the patient can use herself, reflections on the work accomplished in the previous stages, and summaries of the patient's story with her. A positive reframe and a normalizing of the relapse phenomenon often are enough to assist the patient to get back in the game.

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OARS is an acronym to describe the introductory MI methodology. The four techniques in OARS are: Open-ended questions; Affirmations; Reflections; and Summaries.

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When a practitioner uses closed-ended questions, such as, "Did you take your medicines today?," the patient is invited to respond with a brief, often one-word answer, like, "Yes," or "No." An open ended question invites the patient to tell his story, to perhaps talk around the issue until he talks himself into telling you what the issue really is. Open-ended questions are ideal for establishing rapport with a patient, and creating the environment needed to help the patient elicit change.

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These examples of open-ended questions demonstrate a sense of "wondering." The provider "wonders" with the patient about what's going on, and what the patient would like to see change.

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Affirmations are confidence builders. It's helpful to the patient if the provider can point out the patient's strengths, as often he will be more focused on his problems or his perceived deficiencies. Affirmations are tools to help the patient hit the stop button on his internal, looped messages of failure and shame.

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It's important for the provider to be authentic in offering affirmations. It requires really knowing the patient to be able to make an affirming statement that makes sense in the setting and relates to the patient's story. Affirmations are prime examples of client-centered, or patient-centered care, because they reinforce dignity and non-judgment.

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Reflections are the provider repeating back to the patient what she heard the patient say. This offers an opportunity for the patient to know that he's being heard and being understood, or allows for the patient to edit his story or make corrections in what was said.

Homeless health care expert, Jan Caughlan, says, "Reflecting isn't just what you do with your ears and voice; it's also what you do with your mind. Thinking reflectively produces the best reflections." The most effective provider is one who is engaged in the conversation with the patient, and is able to repeat back what she heard.

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Remember when forming reflective statements that they are STATEMENTS, not questions. The practitioner's voice should turn down at the end. Commonly, these statements use the word "you." Look at the examples, and consider how you might complete the reflective statements that have been started.

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When summarizing, the provider tells the patient's story back to him. The main details are repeated, and the patient is given an opportunity to hear all about his journey, how he started, and how he acted, and how he changed or hopes to change.

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MI is a client-centered, trauma-informed approach to helping people recognize the need for change, talk themselves into working to make the change, taking action, realizing the desired behavior, maintaining the new balance, and recovering when or if there is relapse.

MI is a technique that requires commitment and practice on the part of the clinician, but is highly effective and rewarding when used well.