# *Motivational Interviewing*

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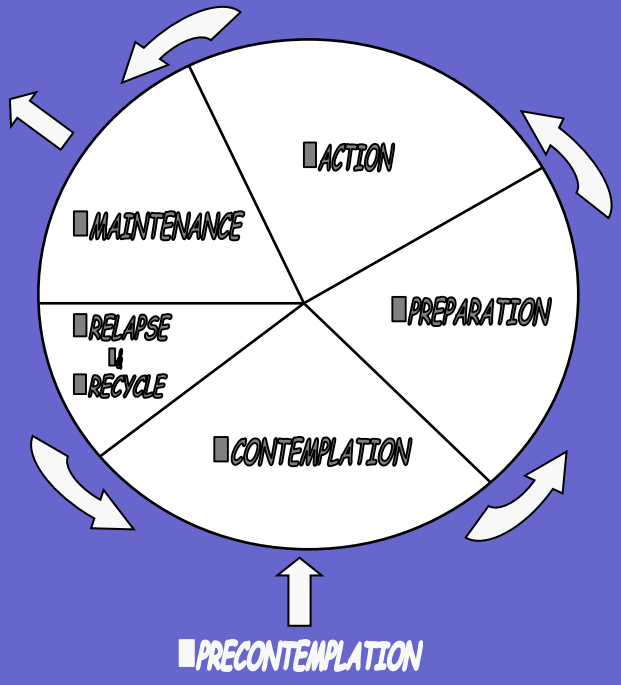
## Stages of Change




THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER AT HOUSTON
MEDICAL SCHOOL


# Health Behavior Research and Training Institute

# Transtheoretical Model

- Offers an integrative framework for understanding, measuring, and intervening with problem behaviors

- Clinicians assess clients' readiness to change and enhance motivation through a series of techniques, depending on patients' stage of readiness

# Why Motivational Interviewing?

- Evidence-based  >200 clinical trials
- Relatively brief
- Specifiable
- Grounded in testable theory
- With specifiable mechanisms of action
- Generalizable across problem areas
- Complementary to other treatment methods
- Verifiable – Is it being delivered properly?

# Building the Evidence Base


WAY TOO GENERAL PRACTITIONER

# Research Examples

***Settings***

- ***Jails***
- ***Substance Abuse Treatment Centers***
- ***Community Health Clinics***
- ***Hospital Trauma Unit***

# Recently Completed Studies

- **Screening and Brief Intervention in Primary Care (NIAAA)**
- **Project CHOICES Efficacy Study: A Fetal Alcohol Spectrum Disorder (FASD) Trial (CDC)**
- **Preventing Alcohol Exposed Pregnancy After a Jail Term (NIAAA)**
- **STI Screening in Young Women: A Stage-Based Intervention (NIAID)**
- **HIV Risk Reduction in Alcohol-Abusing MSM (NIAAA)**
- **A Transtheoretical Model Group Therapy for Cocaine (NIDA)**
- **Alcohol Screening, Brief Intervention and Referral to Treatment (SBIRT; CSAT)**
- **Efficacy of Motivational Enhancement and Physiologic Feedback for Prenatal Smoking (RWJ)**
- **How Does Motivational Interviewing Work? Mechanisms of Action in Project CHOICES (NIAAA)**

# Project CHOICES Efficacy Study: A Fetal Alcohol Spectrum Disorder (FASD) Trial

A multi-site collaborative RCT to evaluate the efficacy of a motivational intervention for reducing alcohol-exposed pregnancies in high-risk women. Women are recruited from six special community-based settings found to have high concentrations of women at high-risk of having an alcohol-exposed pregnancy.


Velasquez, M. M., Ingersoll, K. S., Sobell, M. B., Floyd, R. L., Sobell, L. D., & von Sternberg, K. (2010). A dual-focus motivational intervention to reduce the risk of alcohol-exposed pregnancy. *Cognitive and Behavioral Practice 17* (2), 203-212

Floyd, L., Sobell, M., Velasquez, M.M., Nettleman, M., Sobell, L., Dolan Mullen, P., von Sternberg, K., Skarpness, B & Nagaranja, J., and the Project Choices Efficacy Study Group (2007). Preventing Alcohol Exposed Pregnancies: A randomized controlled trial. *American Journal of Preventive Medicine*, 32(1), 1-10.

# Project CHOICES

## Epidemiologic Study

- Characterized the population including level of risk for AEP
- Identified variables correlated with risk
- Identified independent predictors of risk

Project CHOICES Research Group (2002). Alcohol-exposed pregnancy: characteristics associated with risk. *American Journal of Preventive Medicine. 23(3):*166-173.

## Feasibility Study

- Developed the CHOICES intervention to prevent AEP
- Tested the feasibility and promise of the CHOICES intervention

The Project Choices Intervention Research Group (2003). Velasquez, M. (chair of writing group and primary investigator.) Alcohol-exposed pregnancies: a study of motivational counseling in community settings. *Pediatrics, 111 (5),* 1131-1141.

# Participant Behaviors at 9 Months

- 69.1% of the intervention women reduced risk for an AEP at 9-months.
- 15% more women in the intervention group reduced risk for AEP than in the control group ($p<.05$)
- Of the intervention women who reduced their risk for AEP
  - 32.8% used effective contraception only
  - 19.9% reduced risk-drinking only
  - 47.3% used both effective contraception and reduced risk drinking

# Research to Practice

- Translation into Community Settings

(prenatal care clinics, substance abuse treatment settings, primary care, STI clinics)

Can Project CHOICES be modified so there is only one or two sessions? (“Choices Light)

Identify the “mechanisms of action”

# CHOICES *Plus*: Preventing Alcohol- and Tobacco-Exposed Pregnancies

This four-year randomized clinical trial is testing a modified version of CHOICES designed for medical settings to address alcohol- and tobacco-exposed pregnancies.

# Traumatic Injury Prevention: TIP Project (NIDA)

NIDA funded research (5RO1DA026088) to conduct a randomized clinical trial of screening and brief motivational intervention (SBMI) targeting drug use in a Level I trauma center.

Primary Aim:

Compare the effect of a Brief Motivational Intervention (BMI), a Brief Motivational Intervention plus a booster session (BMI+B), and Brief Advice (BA) on reducing drug use as measured by length of abstinence and percent days abstinent from drug use.

# University Medical Center at Brackenridge

Level One Trauma Center

Provides trauma care for Austin and 11 surrounding counties

Admits 3,000 adult trauma patients per year

# University of Texas at Austin
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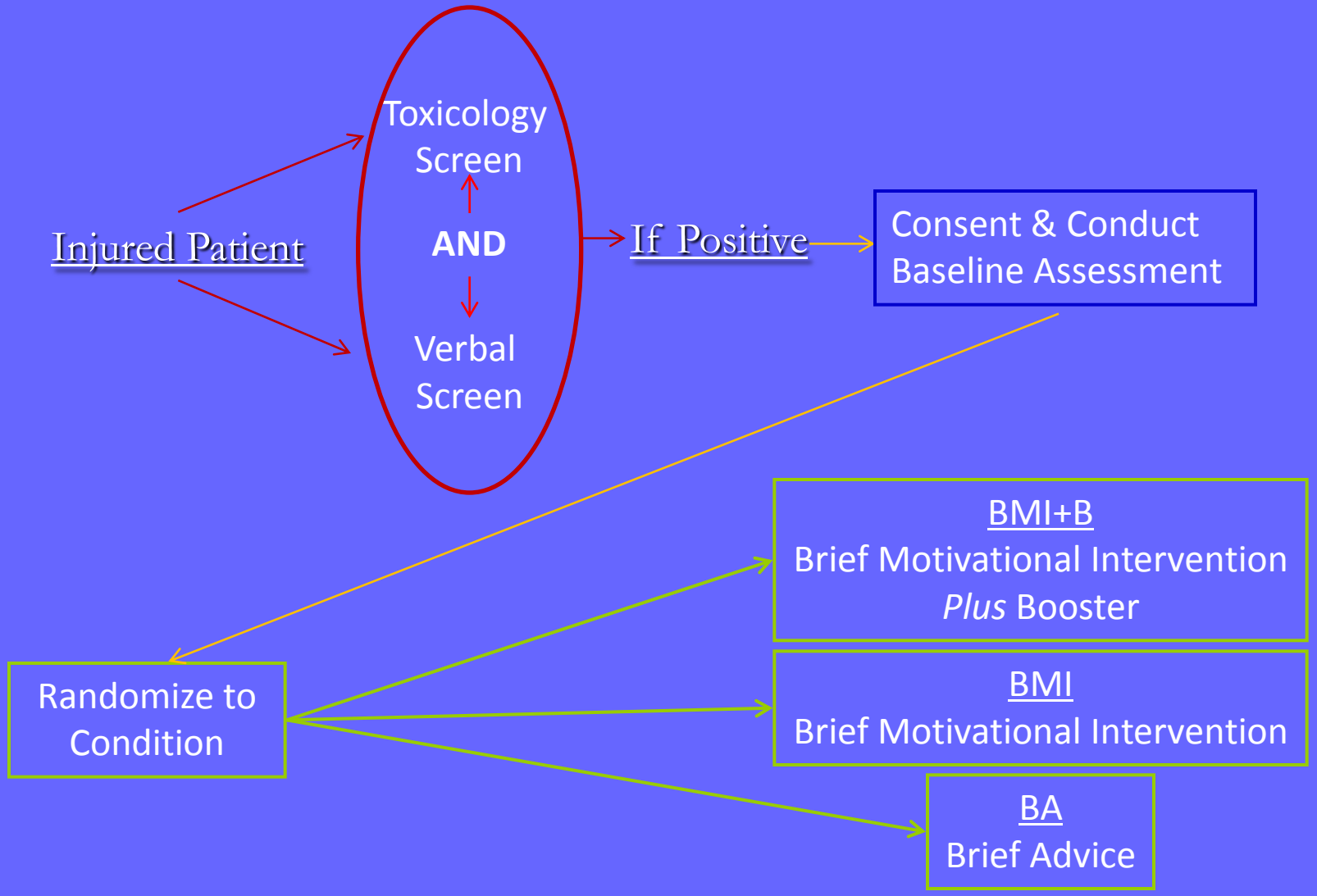
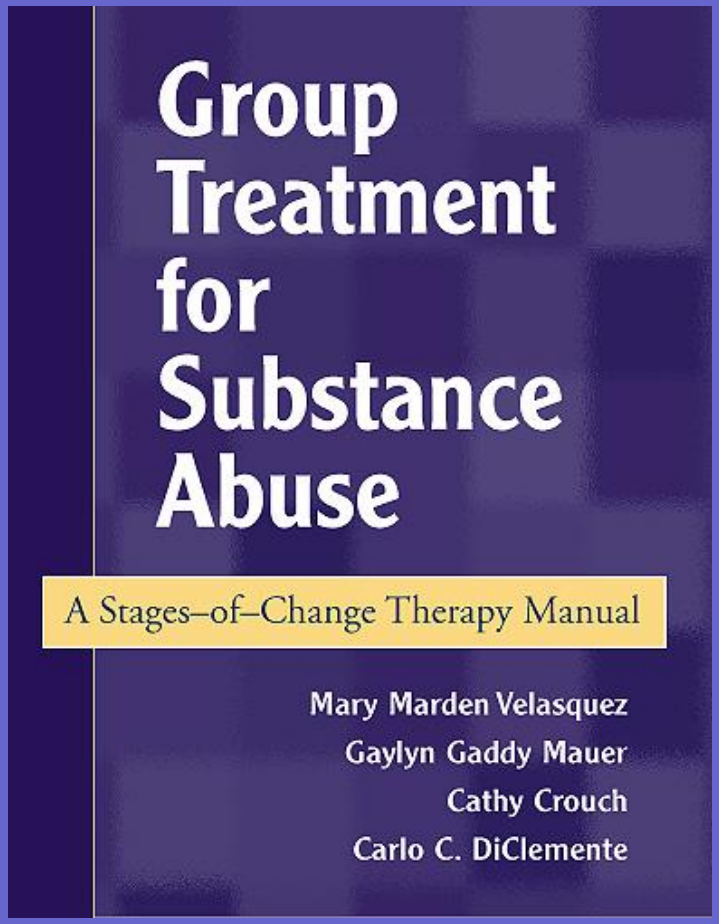
# Screening, Recruitment, and Randomization



# A TTM Group Therapy for Cocaine Abusers




*Funded by the National Institute on Drug Abuse RO1 DAO15453*

# What do we know?

MI triggers reliable change across a range of target problems, settings, and providers

The effects of MI are highly variable by site, study and counselor

# Effectiveness of Brief Interventions

**Three major factors contribute to a patient's long-term compliance with treatment:**

1. **The patient feels that behavior change is a personal choice**
2. **The encounter between the patient and the provider is positive**
3. **The patient has adequate self-confidence about his or her ability to make recommended behavior changes.**

# *Speaker*

Role play a patient presenting for treatment, where there is a clear behavior change goal. You are ambivalent and somewhat resistant to change.

# *Speaker*

- Something about yourself that you

  - want to change

  - need to change

  - should change

  - have been thinking about changing

but you haven't changed yet

(i.e. – something you are ambivalent about)

# *Clinician #1*

- Explain why the patient should make this change
- Give at least three specific benefits that would result from making the change.
- Tell the patient how to change.
- Emphasize how important it is for the patient to change, and the best way to do it.

*(Note:  This is NOT Motivational Interviewing)*

# Motivational Interviewing Assumptions-II

- People struggling with behavioral problems often have fluctuating and conflicting motivations for change, also known as ambivalence. Ambivalence is a normal part of considering and making change and is NOT pathological

- Each person has powerful potential for change. The task of the counselor is to release that potential and facilitate the natural change process that is already inherent in the individual.

# Motivational Interviewing Assumptions - I

- Motivation is a state of readiness to change, which may fluctuate from one time or situation to another. This state can be influenced.
- Motivation for change does not reside solely within the client.
- The counselor's style is a powerful determinant of client resistance and change. An empathic style is more likely to bring out self motivational responses and less resistance from the client.

# *Change Talk*

- Change talk is any client speech that favors movement in the direction of change
- Change talk is by definition linked to a particular behavior change target

# Eliciting Change Talk

D = Desire for change

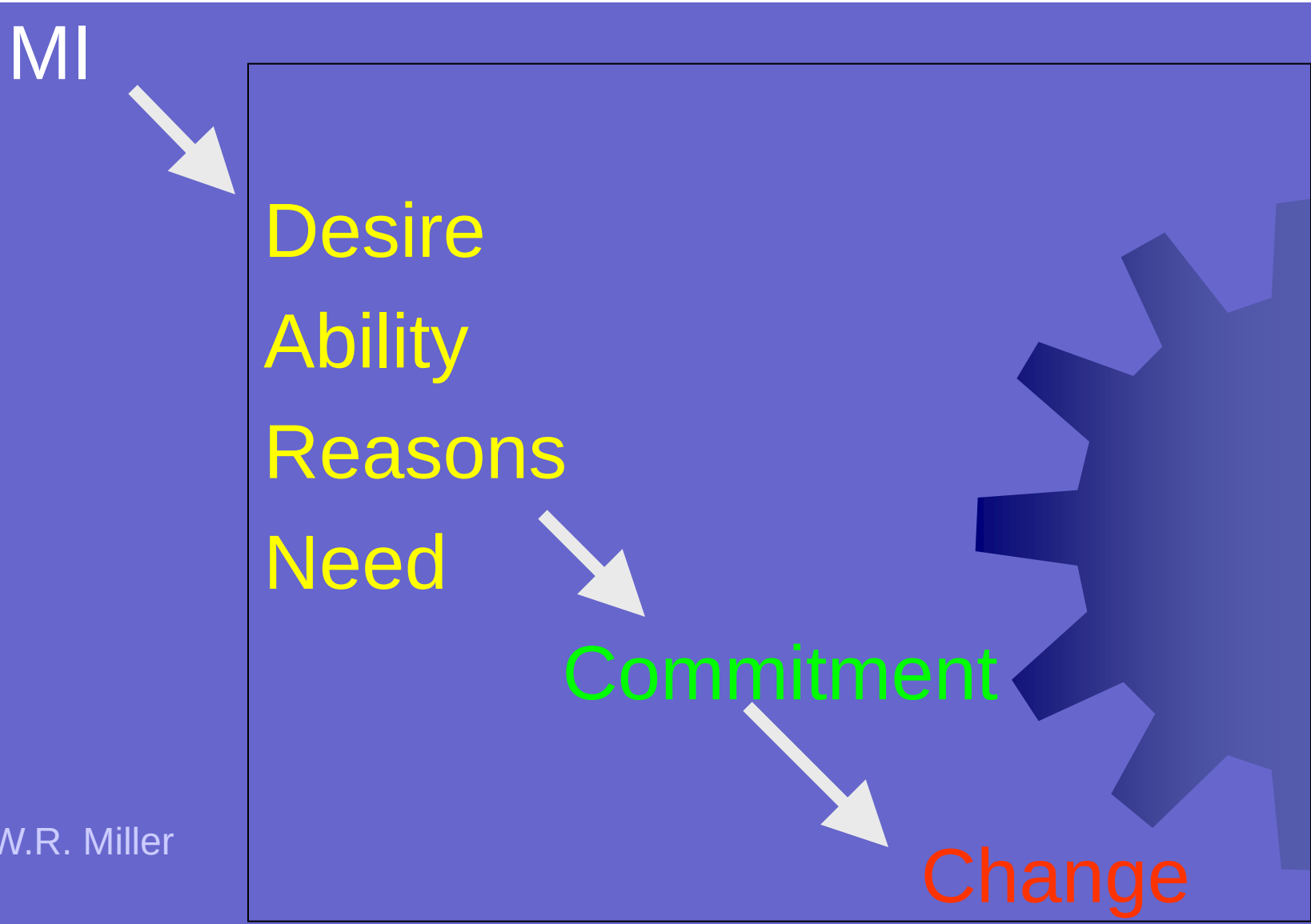
A = Ability to change

R = Reasons for change

N = Need for Change

C = Commitment to Change

# The Flow of Change Talk




W.R. Miller

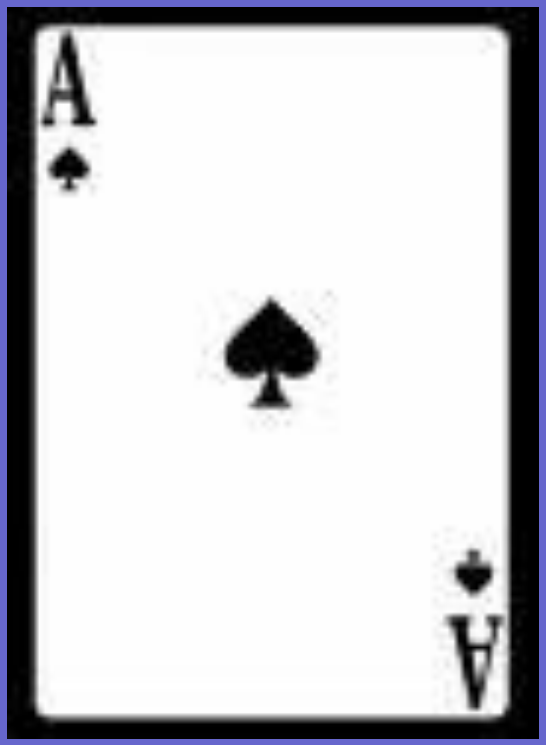
# *Awareness Test*

# Components of MI Spirit

***A*** = Autonomy

***C*** = Collaboration

***E*** = Evocation



# *Underlying the Spirit of Motivational Interviewing is:*

- Autonomy – Responsibility for change is left with the client, hence there is respect for the individual's autonomy. The clients are always free to take our advice or not. When motivational interviewing is done properly, it is the client rather than the counselor who presents the arguments for change.

# *Underlying the Spirit of Motivational Interviewing is:*

- Collaboration - In motivational interviewing, the counselor does not assume an authoritarian role. The counselor seeks to create a positive atmosphere that is conducive to change.

- Evocation - Consistent with a collaborative role, the counselor's tone is not one of imparting things, such as wisdom or insight, but rather *eliciting* – finding these things within and drawing them out from the person.

# *Motivational Interviewing Skills*

# *Exercise*

- Work in groups of 3
- One speaker and two counselors
- Counselor #1 will go first
- Counselor #2 – listen carefully but don’t speak yet

# *Speaker's topic*

Something about yourself that you

- want to change
- need to change
- should change
- have been thinking about changing

but you haven't changed yet.

(i.e. – something you are ambivalent about)

# *Counselor #2*

- Listen carefully with the goal of understanding the dilemma
- Give no advice
- Ask these five open questions:

# *5 Questions*

- Why would you want to make this change?
- How might you go about it, in order to succeed?
- What are the three best reasons to do it?
- On a scale from 0 to 10, how important would you say it is to make this change?
- And why are you at ___ and not zero?

# *Counselor #2*

- Give a short summary/reflection of the speaker's motivations for change

  - Desire for change

  - Ability to change

  - Reasons for change

  - Need for change

- Then ask: "So what do you think you will do?" and just listen with interest.

# *OARS*

- Five skills are important to use right from the start, and when woven together they form the fabric of MI

- The first four skills form the acronym **OARS** (Open Questions, Affirming, Reflecting and Summarizing)

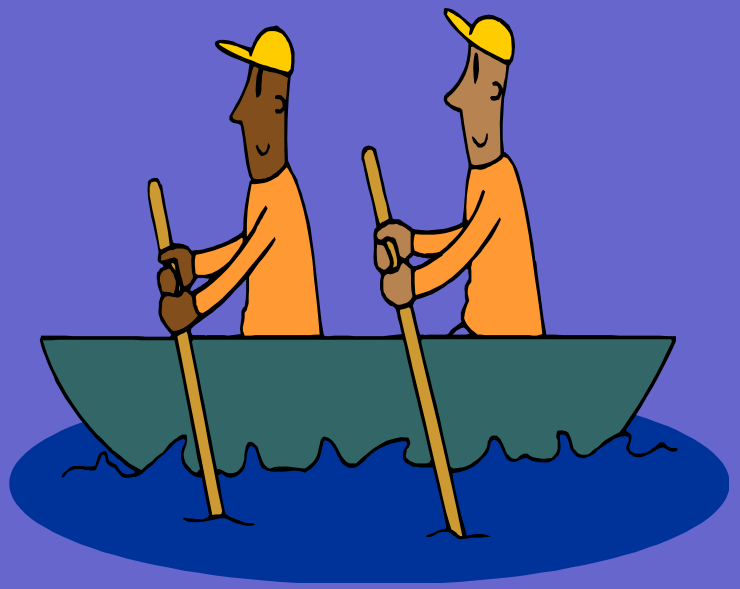
# *Basic Interaction Strategies*

**O** = Open-ended Questions

**A** = Affirmations

**R** = Reflections

**S** = Summary



# *Using OARS Micro-skills*

## Ask Open Questions

During the early phases of MI, it is important to establish an atmosphere of acceptance and trust in which clients explore their concerns. This means the client should be doing most of the talking. One key for encouraging this is to ask questions that do not invite brief answers.

# *Using OARS Micro-skills*

## Affirming the Client

Directly affirming and supporting the client is another way of building rapport and reinforcing open exploration. This can be done in the form of compliments or statements of appreciation and understanding. The key is to notice and appropriately affirm the client's strengths and efforts.

# *Using OARS Micro-skills*

## Reflection

- It is a fundamental foundational skill without which motivational interviewing cannot be practiced.

- True reflective listening requires continuous alert tracking of the client's verbal and nonverbal responses and their possible meanings, formulation of reflections at the appropriate level of complexity, and ongoing adjustment of hypotheses.

# *Using OARS Micro-skills*

Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning, in favor of continued exploration of the client's own processes

Techniques are:

- Listen attentively
- Give voice to a guess about the meaning of a person’s communication in the form of a statement
- Reflective listening is a means of checking, rather than assuming you know what is meant.

# *Using OARS Micro-skills*

## Summarize

Summary statements can be used to link together and reinforce material that has been discussed. Summaries should continue rather than interrupt the person's momentum. It is useful to end with "What else?" or some other invitation to continue

# Change Talk

- Represents statements about change (DARN)
- These statements are linked to a specific behavior or set of behaviors
- Typically comes from the client
- Is typically phrased in present tense

# *Strategies for Eliciting Change Talk*

- Ask Evocative Questions

  Ask open questions, the answer to which is change talk.

- Explore Decisional Balance

  Ask first for the good things about status quo, and then ask for the not-so-good things.

- Ask for Elaboration

  When a change talk theme emerges, ask for more detail. In what ways?

- Ask for Examples

  When a change talk theme emerges, ask for specific examples. When was the last time that happened? Give me an example. What else?

- Look Back

  Ask about a time before the current concern emerged. How were things better/different?

# *Strategies for Eliciting Change Talk*

- **Look forward**

  Ask what may happen if things continue as they are (status quo). Try the miracle question: If you were 100% successful in making the changes you want, what should be different? How would you like your life to be five years from now?

- **Query Extremes**

  What are the worst things that might happen if you don't make this change? What are the best things that might happen if you do make this change?

- **Explore Goals and Values**

  Ask what the person's guiding values are. What do they want in life? Using a values card sort can be helpful here. If there is a "problem" behavior, ask how that behavior fits in with the person's goals or values. Does it help realize a goal or value, interfere with it, or is it irrelevant?

# Some Possible Open Questions

- What is your concern about ____?
- What might you like to do or change about your ____?
- What is the one thing you might do for your health in this area?
- How might you go about ____?

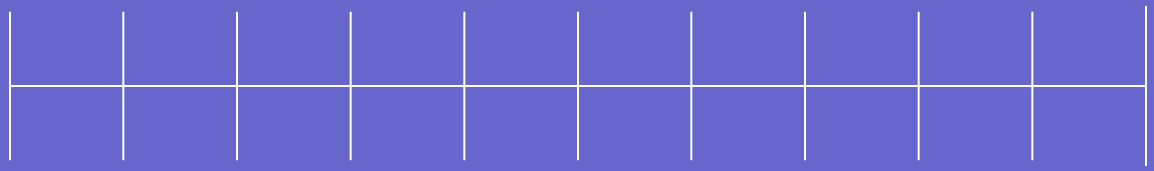
# *Strategies for Eliciting Change Talk*

- Scaling Rulers
- Typical Day
- Agenda Setting

# *Importance Ruler*

How important is it to you to quit smoking?

If 0 was “not important,” and 10 was “very important,” what number would you give yourself?



0 10


LOW IMPORTANCE
LOW CONFIDENCE
LOW IMPORTANCE
HIGH CONFIDENCE
0
Does not see change as important or believe they could succeed if they tried.
Could make the change if they thought it was important enough, but are not persuaded of the need to change.
0
10
HIGH IMPORTANCE
LOW CONFIDENCE
HIGH IMPORTANCE
HIGH CONFIDENCE
The problem is not in willingness to change, but low confidence in their ability to succeed.
See importance to change and believe they could succeed.
10
IMPORTANCE
CONFIDENCE

# *Exploring Importance*

- Why are you at x and not y? Or, how did you get from x to y? (always start with the higher number)
- What concerns do you have about your tobacco use?
- What would have to happen for it to become much more important for you to change?

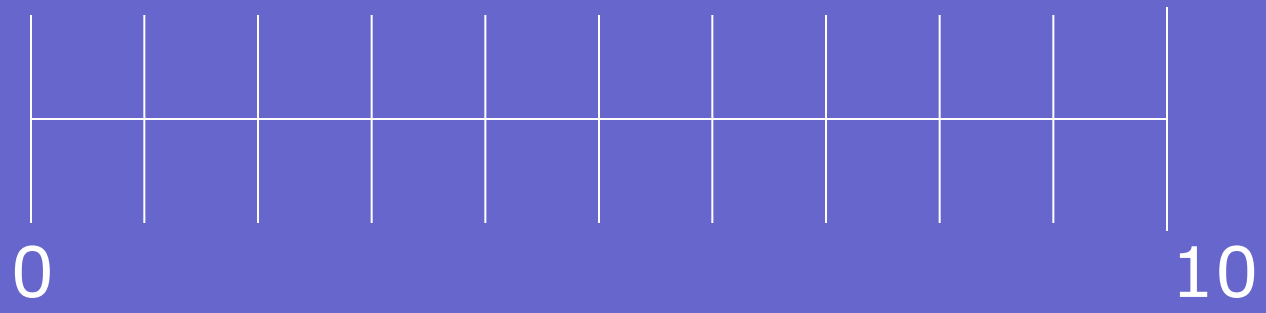
# *Exploring Importance*

- What are the good things about your tobacco use?
- What are some of the less good things?
- What concerns do you have about your tobacco use?
- If you were to change, what would it be like?
- Where does this leave you now?
  - Use this when you want to ask about change in a neutral way)

# *Confidence Ruler*

If you decided right now to quit smoking, how confident do you feel about succeeding with this?

If 0 was ‘not confident’ and 10 was ‘very confident’, what number would you give yourself?

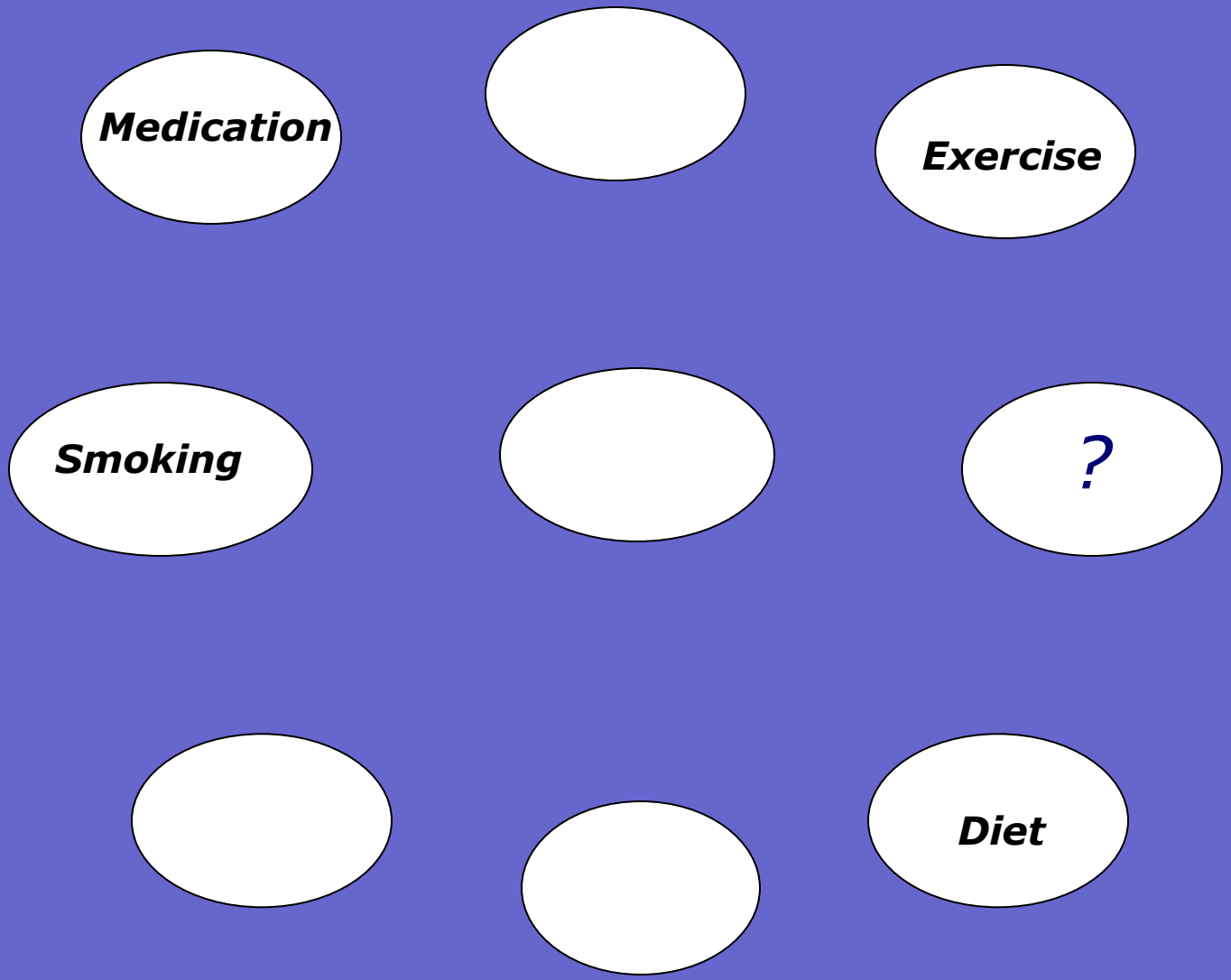


# *Building Confidence*

- What would make you more confident about making these changes?
- Why have you given yourself such a high score on confidence?
- How could you move up higher, so that your score goes from x to y?
- What have you found helpful in previous attempts to change?

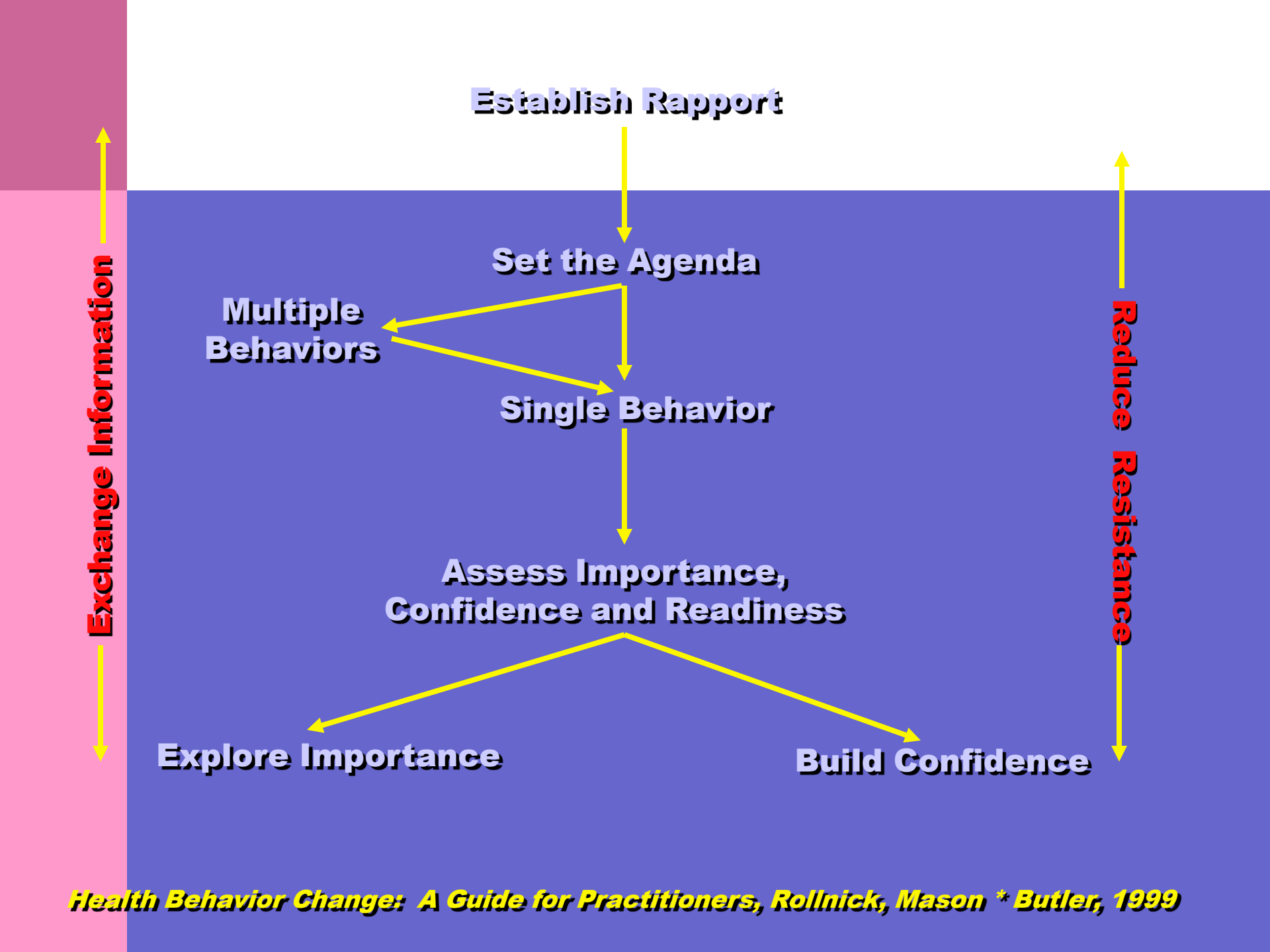

Extreme Confidence

# *Agenda Setting*



# Agenda Setting

- Here are some topics we might talk about for a few minutes
- They are all things that can be related to your health
- I wonder if there is one of these you might like to talk about in an area where you are concerned or could improve your health




*Health Behavior Change: A Guide for Practitioners, Rollnick, Mason * Butler, 1999*

# What's new in MI?

- Four fundamental processes:
- Engaging- The relational foundation
- Guiding- The strategic focus
- Evoking- the transition
- Planning-The bridge to change

# MI in Groups

Group OARS

# Group OARS

- The goal is to enhance group members' own change processes rather than imparting the facilitator's wisdom, solutions, advice
- Group members talk themselves into making changes, rather than a facilitator's convincing, persuading, directing them to change
- Group members often become co-facilitators for other group members' changes

# O.P.E.N.

Open with group purpose: to learn more about members' thoughts, concerns, and choices

Personal choice is emphasized

Environment is one of respect and encouragement for all members

Non-confrontational nature of the group

# Use Selective Reflective Listening to Build Motivation and Reinforce Change Talk

Judicious reflections:

-- are the heart of MI

-- are useful for building rapport, decreasing resistance, expressing empathy

-- select member responses most relevant to support autonomy, build self-efficacy and promote change talk

- When negative comments arise, reframe them in a friendlier, more cooperative style, affirming the objector and perhaps adding a "twist" to the comment
- Ask quieter members or those who are more experienced for their reactions to permit an alternate viewpoint
- Use "time outs" strategically. This is simply ignoring argumentative comments. Again, use "differential reinforcement" to attend to positive, nonargumentative, or change talk.
- Selective reflection allows individuals to be reinforced and heard within the context of increasingly constructive comments.

# Group Summaries

**Strategically use summaries to:**

- Review and highlight relevant information provided by the group
- Reinforce change talk
- Relate a response by one member to an earlier comment from another member
- Transition the group discussion to another area of focus

# MITI Coding

- Randomly selected 20 minute segments
- Data based on scores averaged across all TTM or Ed/Ad groups

| MITI Scale | TTM | Ed-Advice |
|---|---|---|
| Evocation | 4.4 | 2.4 |
| Collaboration | 4.4 | 2.6 |
| Autonomy/Support | 4.7 | 2.6 |
| Direction | 4.8 | 4.2 |
| Empathy | 4.8 | 2.2 |

# MITI Coding

| MITI Scale | TTM | Ed-Advice |
|---|---|---|
| MI-Adherent | 14.8 | 5.2 |
| MI-Non Adherent | 0.4 | 5.8 |
| Closed Questions | 4.4 | 8.8 |
| Open Questions | 6.2 | 2.4 |
| Simple Reflections | 8.4 | 2.6 |
| Complex Reflections | 13.5 | 2.6 |
| Information | 3.5 | 10.6 |

# MITI Coding

**Questions / Reflections**

- **TTM 10.6 / 21.9** ***twice as many reflections as questions***
- **Ed/Ad 11.2 / 5.2** ***twice as many questions as reflections***

**Percent of Complex Reflections to All Reflections**

- **TTM 13.5 / 21.9 = 61.6%**
- **Ed/Ad 2.5 / 5.2 = 48.1%**

**Percent of Open Questions to All Questions**

- **TM 6.2 / 10.6 = 58.5%**
- **Ed/Ad 2.4 / 11.2 = 21.4%**

# MI in Groups

Velasquez, M. M., Stephens, N. & Ingersoll, K. (2006). Motivational Interviewing in groups. *Journal of Groups in Addiction and Recovery, 1* (1), 27-50.

Velasquez, M. M., Stephens, N. & Drenner, K. (In press). The Transtheoretical Model and Motivational Interviewing: Experiences with a Cocaine Treatment Group. In C. Wagner & K. Ingersoll (Eds). *Motivational Interviewing in Groups*. The Guilford Press.

Sampson, M., Stephens, N. S. and Velasquez, M. M. (2009). Motivational Interviewing. In *The Clinician's Guide to Evidence-Based Practice* (Eds. Rubin, A., & Springer, D.). John Wiley and Sons.

# *Organizational Readiness to Change*

- Organizations are made up of individuals and each key person will be at a different state of readiness to change.
- The task is to elicit these feelings about change and facilitate movement through the stages-both at the individual and organizational level.

# *Organizational Stages of Change*

Precontemplation –

Not considering the possibility of change.

May be surprised or defensive about the discussion of the problem.

May be many reasons for being in this stage. Some will be 'reluctant' because they're not sure that their agency has all the tools it needs or 'resigned' because they have attempted organizational change before and things haven't worked out the way they hoped.

# *Stages of Change*

Four different types of precontemplators.

- Reluctant
- Rationalizing
- Resigned
- Rebellious

# *Stages of Change*

## Contemplation -

May have ambivalent thoughts or feelings.

Both considers change and rejects it. Our task at this stage is to help tip this balance in favor of change.

# *Organizational Stages of Change*

Working with ambivalence is working with the heart of the problem…

…helping people get "unstuck" from their uncertainty - to make a decision and move on toward change.

# *Organizational Stages of Change*

Preparation –

- Getting ready to make a change, but they are not yet ready to act.
- This stage is like a window of opportunity, which opens for a period of time…if the change process does not continue, the person slips back into contemplation.
- The task is not one of motivating so much as matching; helping them find a change strategy that is acceptable, accessible, appropriate, and effective

# *Organizational Stages of Change*

Action -

Here people and organizations engage in a particular action(s) intended to bring about change.

Our task in this stage can be to provide positive reinforcement about changes being made and seek out statements of confidence on use of new practice.

# *Organizational Stages of Change*

Maintenance -

Already made a change and working to maintain the new behavior.

The challenge is to sustain the change accomplished by previous action, and to prevent a return to former behaviors.

# *Organizational Readiness to Change*

The National Addiction Technology Transfer Network has created a guide - The Change Book - to help organizations bring new practices into use.

*At what stage of change is my organization?*

*What are the barriers to change?*

*What can we do to overcome those barriers?*

# *The Ineffective Physician*

# *The Effective Physician*