Practice Development Workshop

Motivational Interviewing: Introduction & Integration

Sofia Gardens, Cardiff, Wales

16-17 November 2005

Trainers: Steve Rollnick & Jeff Allison

These slides are simplified versions of some of the materials used at this workshop, but without the pictures. The motion and colour sequencing within slides is not active.

To start us off ...

In clusters of 5/6, with the people around you, for 10 minutes. Please discuss these questions:

1. What are the common daily challenges you face in attempting to promote behaviour change in your patients?

2. Specifically, what do you do with your patients that you regard as 'motivational'?

3. At work, what gives you greatest pleasure?

The Righting or Correcting Reflex

We often think we know what's best for other people – especially when it's our job!

The Righting Reflex

"Human beings seem to have a built-in desire to set things right ... it is common when we see something awry, to want to fix it. See someone going astray ... and the reflex kicks in to set them back on the right path."

Miller & Rollnick 2002

Common practitioner beliefs explaining lack of readiness to change

Our beliefs and aspirations for patients often determine our 'way of being' with patients.

Common practitioner beliefs explaining lack of readiness to change

- Patients don't see the problem.
- Patients don't understand the problem.
- Patients don't know how to change.
- Patients just don't care.

Common Practitioner Responses

Common Practitioner Responses. № 1.

Problem: "My patients don't see the problem. If I can just make patients see, then they will change."

Solution: "I must give them insight. That'll put them right!

Common Practitioner Responses. № 2.

Problem: "My patients don't understand the problem. If patients knew enough, then they would change."

Solution: "I must give them knowledge. That'll put them right!

Common Practitioner Responses. № 3.

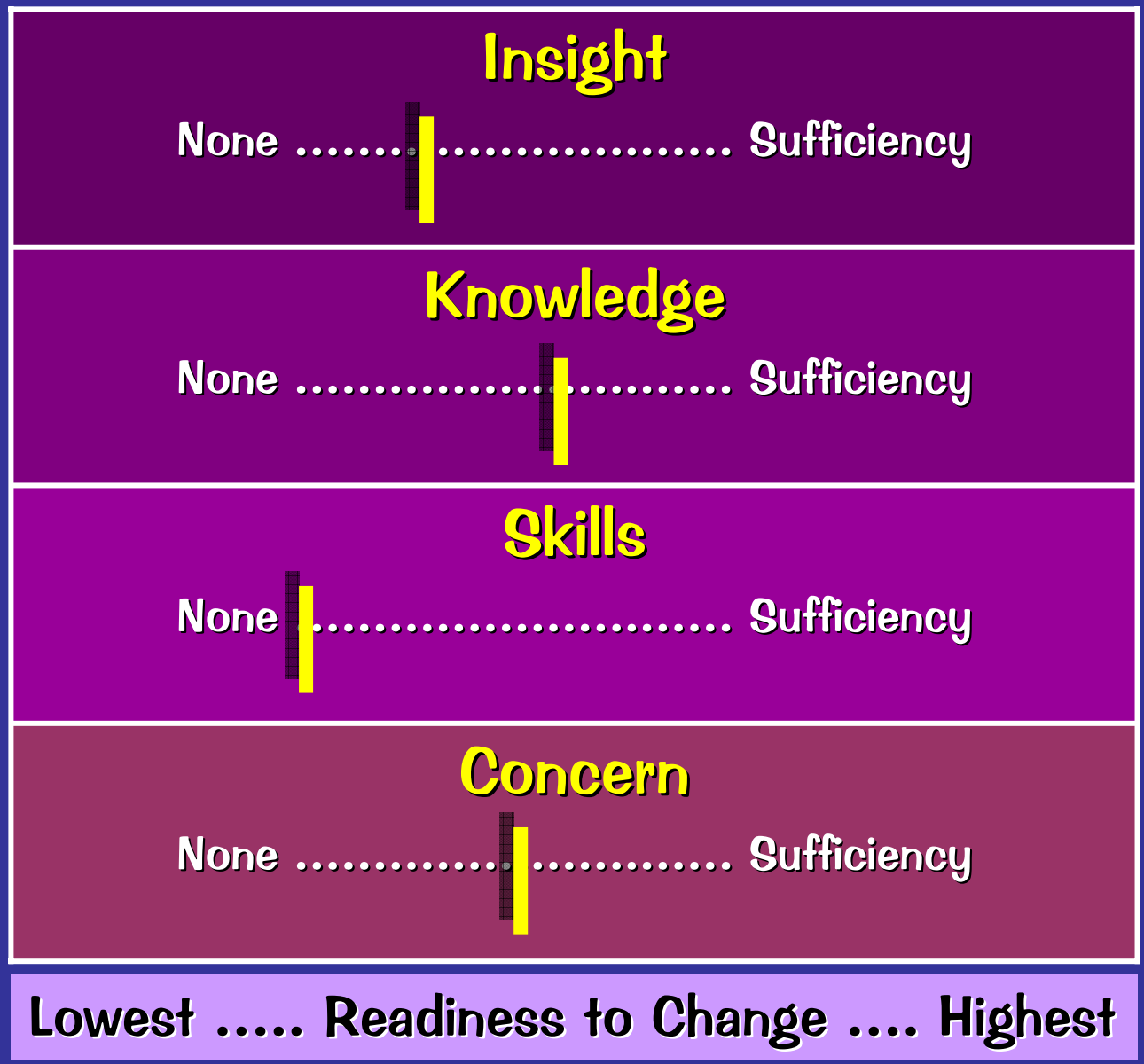
Problem: "My patients don't know how to change. If I can teach them how, then they will do it."

Solution: "I must give them skills. That'll put them right!"

Common Practitioner Responses. № 4.

Problem: "My patients just don't care. If I can make patients feel bad or afraid enough, then they will change."

Solution: "I must give them Hell. That'll put them right!"



Assumption: patients need to be full enough of this stuff before they will change.

But what currently sustains their 'way of being' may not merely be an insufficiency of insight, knowledge, skills or concern.

Is there something missing?

- Do we know what makes patients behave as they do?
- Do we know what beliefs and values influence their current behaviour?

Is there something missing?

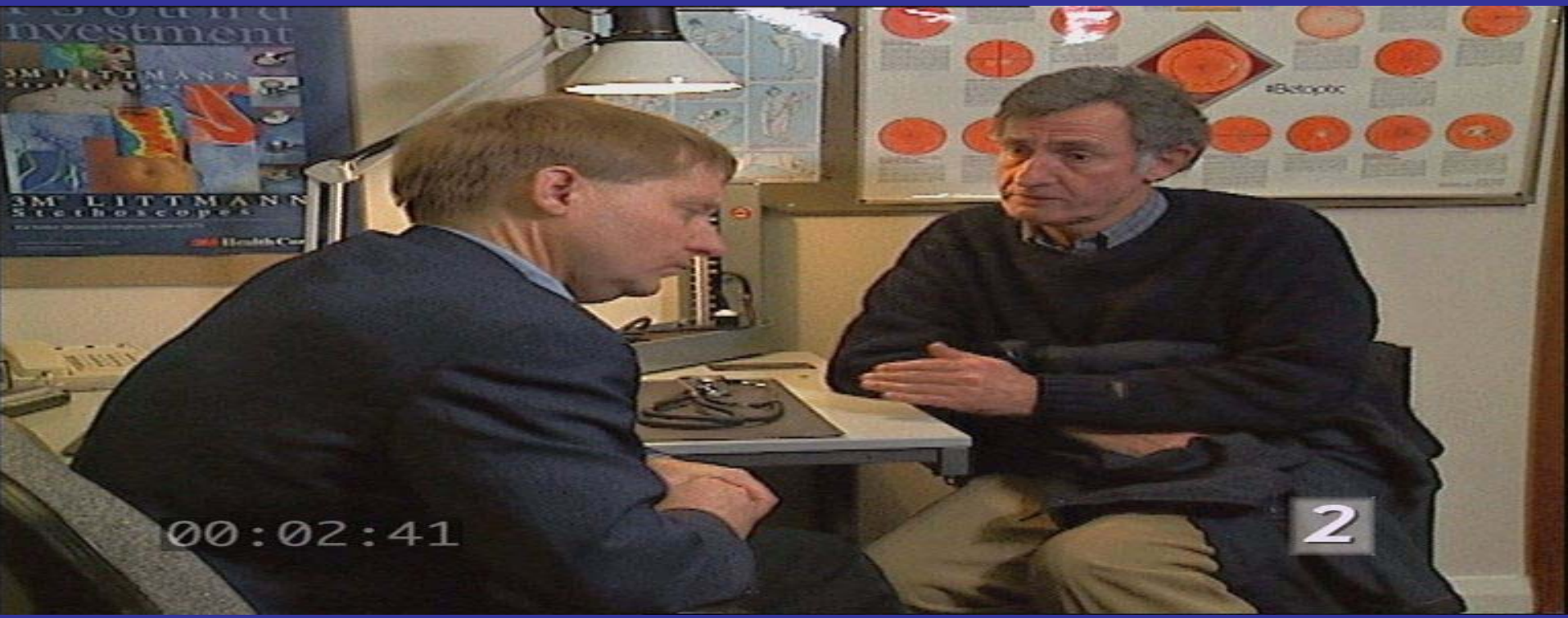
- Are we aware of what beliefs and values influence *our* practice behaviour?

The challenge

How can we use our technical knowledge, skills and experience to best guide the patient to a helpful conclusion – but without merely making the case for change in an overtly persuasive manner?

Our good intentions, alone, are rarely sufficient.

Video Simulation. 4.5 minutes



An Example of a Less Helpful Consultation: The Righting Reflex in Action!

www.jeffallison.co.uk

In this demonstration the GP:

... assumes that because he's had a heart attack, the patient is highly motivated to change his smoking, drinking and diet.

... attempts to overtly persuade the patient using his 'expert logic'.

... suggests immediate action, albeit prompted by his genuine concern.

... shows his frustration and disappointment.

... doesn't appreciate the incremental changes already made.

In this demonstration the patient:

... becomes defensive and resistant to change.

... feels the practitioner doesn't understand his struggle.

... leaves less motivated to change than when he went in – the worst possible outcome!

Question: Why has this consultation gone so wrong?

Answer: The case for change is heard coming out the wrong mouth!

Practitioner's Posture of Concerned Confrontation

Patient's Posture of Defence

Advantages of change

Disadvantages of change

Disadvantages of no change

Advantages of no change

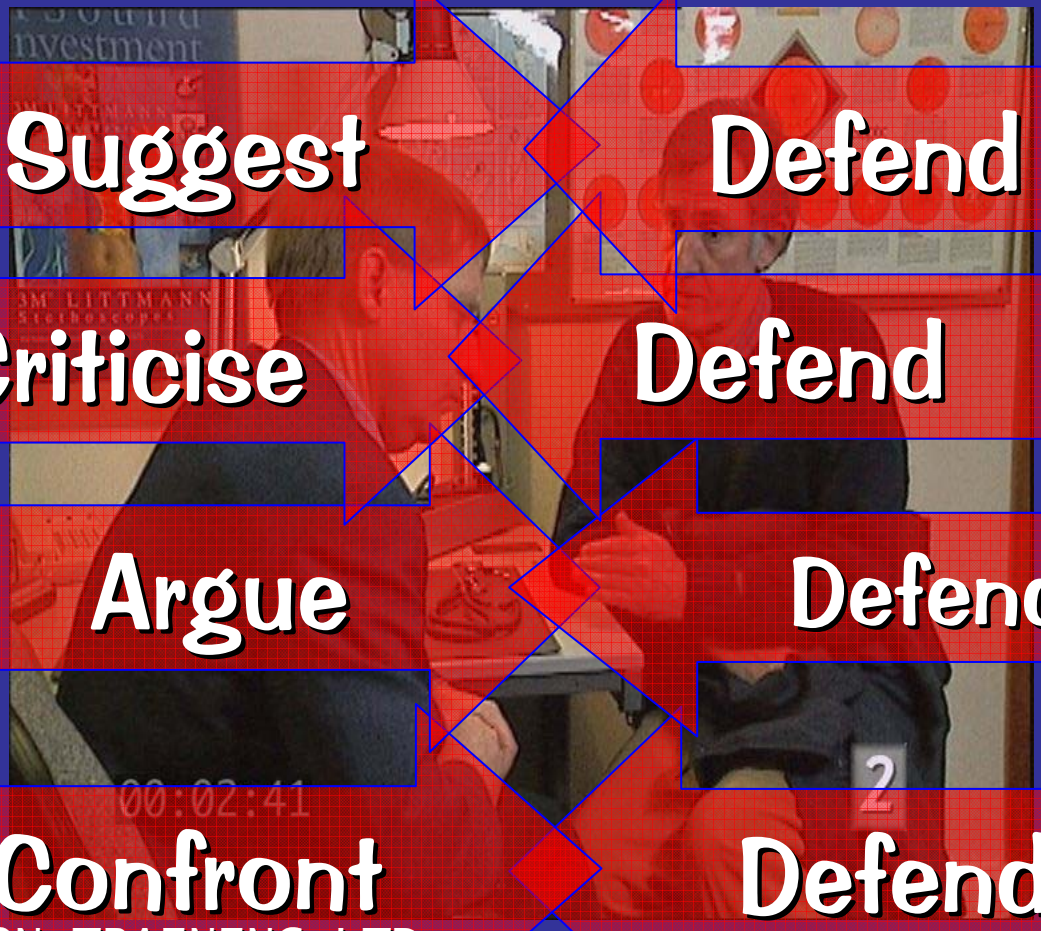
Postural Confrontation

I do know what's best for you, so you should do as I say.

You don't seem to understand. I'll do as I choose.

We're really getting nowhere fast but it's not my fault.

The 'battleground' of behaviour change consultations



Two Important Issues:

1. Reactance

As a consequence, what did the patient feel and what did he do?

Brehm, S. S., & Brehm, J. W., (1981) Psychological Reactance: a theory of freedom and control. New York: Academic Press.

Two Important Issues:

2. Self-perception

What did the patient hear himself say and what effect might that have?

Bem, D. J., (1972) Self-perception theory. In L. Berkowitz (Ed.) Advances in Experimental Social Psychology (Vol. 6, pp.1-62). New York: Academic Press.

The Definition of MI

"We define motivational interviewing as a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence."

Miller & Rollnick (2002)

Can you imagine yourself saying or thinking this?

"Perhaps I should do something about this. I'm a little concerned but I don't think I'll do anything about it yet. Besides, it's not that bad. I'm happy enough for the moment – one day, maybe!"

Ambivalence is a normal and defining state of human experience.

Dissonance & Resistance

What are they?

Dissonance

An ambience of distrust, conflict, discord, friction, fear, anger or non-cooperation.

It's the quality of the relationship that counts!

Resistance

Opposition in thought, feeling, speech and behaviour – toward the practitioner.

Resistance

Typical behaviours:

- Arguing with you
- Interrupting you
- Insincere agreement
- Ignoring you
- Missing appointments

The relationship fluctuates along this continuum

Dissonance
'wrestling'

Consonance
'dancing'

The relationship fluctuates along this continuum

strongest — Resistance — weakest — absent

Dissonance *'wrestling'*

Consonance *'dancing'*

The relationship fluctuates along this continuum

'Natural' tendency
← is toward dissonance

Dissonance & Resistance

What are the causes?

Practitioner 'Advocacy'

Five types of practitioner behaviour that may cause dissonance, and lead to resistance.

The practitioner as campaigner

Arguing for change: trying hard to convince

Directly taking up the pro-change side of ambivalence on a particular issue. Seeking to persuade the patient to change.

The practitioner as campaigner

Assuming the expert role: I know what's best for you

Structuring the conversation in a way that communicates that the practitioner has the 'answers' the patient needs.

The practitioner as campaigner

Criticising, shocking or blaming: shaking complacency

Trying to shock the patient into changing by instilling negative emotions about the status quo.

The practitioner as campaigner

Labelling: mechanistic problem/solution reasoning

Demanding the acceptance of a specific label or diagnosis to characterise and explain the patient's behaviour.

The practitioner as campaigner

Being in a hurry: don't talk, listen!

With limited time, believing that clear, forceful tactics are required in order to *'get through'* to the patient. Getting ahead of the patient's state of readiness.

The practitioner's behaviour may cause dissonance in the relationship and elicit resistance from the patient.

It's <u>our</u> responsibility to get on with patients; not the other way around.

Speech Evoked from Patient

Sustain Talk ..... Change Talk

Behaviour Elicited from Patient

Resistant ..... Collaborative

Relationship's Ambience

Dissonance ..... Consonance

Practitioner's Behaviour

MI Inconsistent ..... MI Consistent

Exercise: The Advocating Practitioner: campaigning for change

In triads - 3 roles. 10 minutes of conversation, followed by 5 minutes of discussion.

- One person to discuss a dilemma in their own lives. Pick something you feel comfortable discussing.
- One person with whom to discuss the issue, who will 'campaign for change' using the advocacy tactics.
- One person to act as observer and commentator.

Key Questions for Discussion:

1. What thoughts and feelings were evoked in the speaker?
2. Did the conversation affect readiness?
3. Did the conversation resonate with actual practice?

What is Motivational Interviewing?

It's dancing, not wrestling!

Motivational Interviewing:

a few simple messages

The Principal Text

Miller, W. R., & Rollnick, S., (2002) Motivational Interviewing: Preparing People for Change (2nd Edition) Guilford Press: New York

New MI text to be published in early 2006

Why is it called MI?

Because as a consequence of the interview – however short - the patient's motivation to change is enhanced.

Prosaic and yet mysterious.

How is that achieved?

- Less wrestling, more dancing!
- Listening more accurately
- Exercising restraint
- Working collaboratively
- Acting more like a guide than an interrogator.

Motto!

All helpfulness starts with humility and in ignorance.

What does this suggest to you?

The Definition of MI

"We define motivational interviewing as a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence."

Miller & Rollnick (2002)

Ambivalence: the conceptual 'anchor'

The coexistence in one person of contradictory and incompatible emotions or attitudes, and the tension arising as a consequence.

"I need to but I don't want to."

Ambivalence

Complex forces are often represented in simple speech.

"Smoking helps me concentrate and calm down but I'd really like to stop it because I'm always coughing."

MI is the practice of disentangling competing and often obscured motives.

Basic Premises

Patients talk themselves into changing.

Patients don't change just because we want them to change.

Patients rarely change just because we tell them to change.

This process of changing may be accelerated by practitioners - but it might also be inhibited.

Basic Premises

Practitioners who understand the effects of ambivalence within the patient are more likely to influence behaviour.

It's the patient that has to do the changing – and that's often hard work.

What we do – and how we do it – makes all the difference.

The Definition of MI

"We emphasise that MI is a method of communication rather than a set of techniques. It is not a bag of tricks for getting people to do what they don't want to do. It is not something that one does to people; rather, it is a fundamental way of being with and for people - a facilitative approach to communication that evokes natural change."

Miller & Rollnick (2002)

The Method's Essence

A partnership within which one's style is quiet, accepting, attentive, respectfully curious, and directive rather than overtly persuasive.

Motivation to change is found within the person: you can't pump it in like petrol in a car!

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The practitioner becomes the "quiet centre" of the conversation.

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The Method's Essence

"... and directive rather than overtly persuasive."

- Guiding the direction of the conversation.
- Guiding understanding.
- Guiding decision-making.

The Method's Essence

- Collaborative
- Evocative
- Autonomous
- Guiding

The Method's Essence

Collaborative

MI requires a partnership that respects the person's expertise and perspectives. The practitioner provides an atmosphere that is conducive rather than coercive to change. *The patient is seen as a "co-therapist".*

The Method's Essence

Collaborative

MI requires a partnership that respects the person's expertise and perspectives. The practitioner provides an atmosphere that is conducive rather than coercive to change. *The patient is seen as a "co-therapist".*

A posture of respectful curiosity is adopted.

The Method's Essence

Evocative

The resources and motivation for change are presumed to reside within the person. Intrinsic motivation for change is enhanced by drawing on the person's own perceptions, goals and values.

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Evocative

The resources and motivation for change are presumed to reside within the person. Intrinsic motivation for change is enhanced by drawing on the person's own perceptions, goals and values.

The practitioner works to understand the countervalent forces influencing the person's behaviour.

The Method's Essence

Autonomous

The practitioner acknowledges and endorses the person's right and capacity for self-direction and facilitates informed choice.

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Autonomous

The practitioner acknowledges and endorses the person's right and capacity for self-direction and facilitates informed choice.

The practitioner communicates acceptance, and adopts a posture of apparent impartiality as to the outcome.

The Method's Essence

Guiding

The practitioner leads and shows the way ahead, influences the patient's decision-making as to what to do, and how to do it.

The Method's Essence

Guiding

The practitioner leads and shows the way ahead, influences the patient's decision-making as to what to do, and how to do it.

The practitioner is a source of 'wise counsel' - not a sergeant leading a route march!

The Goal of MI -

talking yourself into changing.

"People are generally better persuaded by the reasons which they themselves discovered, than by those which have come into the minds of others."

Blaise Pascal (C17th French Mathematician/Philosopher)

The Various Components of Motivational Interviewing

Everything is there for a reason

Tactics: for Eliciting Change Talk

Tactics: for Responding to Dissonance

Core Skills: Asking Open Questions, Listening Reflectively, Affirming, Summarising.

Principles: Expressing Empathy, Developing Discrepancy, Rolling with Resistance & Supporting Self-efficacy.

Spirit: a partnership within which one's style is quiet, accepting, attentive, respectfully curious, and directive rather than overtly persuasive. Motivation to change is elicited.

Principles

Expressing Empathy - Demonstrating warmth, accurate understanding and positive regard.

Developing Discrepancy - Promoting discomfiture within the other person.

Supporting Self-efficacy - Imparting a belief in the possibility of change.

Rolling with Resistance - Inviting new perceptions, but not imposing or arguing for them.

Principles

Empathy

- Understanding the perspective of the patient

Discrepancy

- Exploring inconsistencies with goals and values

Self-efficacy

- Being optimistic, positive and hopeful

Resistance

- Refusing to argue or be 'pushy'

The Definition of MI

"Motivational Interviewing … can be viewed as a refined form of the guiding style.

"The guiding style is more suited to consultations about changing behaviour because it harnesses the internal motivations of the patient."

Rollnick et.al. BMJ October 2005

It's Dancing, not Wrestling!

This is Motivational Interviewing

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MI: Learning the Core Skills

This section contains the didactic components, not the exercises.

Learning Empathic Reflection

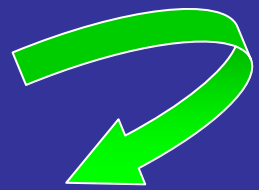
the demonstration of accurate understanding

What is a reflective listening statement?

Question: *"Do you think your partner understands how depressed you've been feeling lately?"*

A question requires an answer.
An incomplete component.

Statement: *"It seems that your partner doesn't appreciate how depressed you've been feeling lately."*



A statement invites a response.
A complete component.

It's active listening, that demonstrates accurate understanding.

Reflective Listening Statements: An example dialogue

1. "One thing about myself I would like to change is my moodiness."
2. "You never know if you're going to be up or down."
3. "No, it's not that. I can tell how I'm going to feel. It's just that I overreact to things."
4. "Even little things can upset you."
5. "Sometimes, yes. I think I worry too much."
6. "You sit and fret about things too much."
7. "Yeah. Often there's nothing I can do about it, but still I go over and over it in my mind."
8. "And that gets you moody."
9. "Absolutely! I get myself worked up and I can't sleep."
10. "Even at night you're worrying."
11. "Yes, that's right. That's what I want to change."

The speaker is identifying the problem; not the listener.

1. So, tell me some more about this argument with John.

2. Oh, you know, it was the same old thing. [Ah ha. He says my smoking in the house all day long is a bad example to our daughter. But I told him coming home drunk is just as bad ... and our son is going to grow up a bloody alcoholic like his father, and then, you know, he storms out sorta thing.

3. It seems like both of you are concerned that your smoking and drinking might influence the children; [Of course we are. it's just that this concern comes out, I suppose, as criticism of each other.

4. Well, yeah, I suppose so, but everyone smokes but not everyone drinks like my husband. He's a lot worse than me.

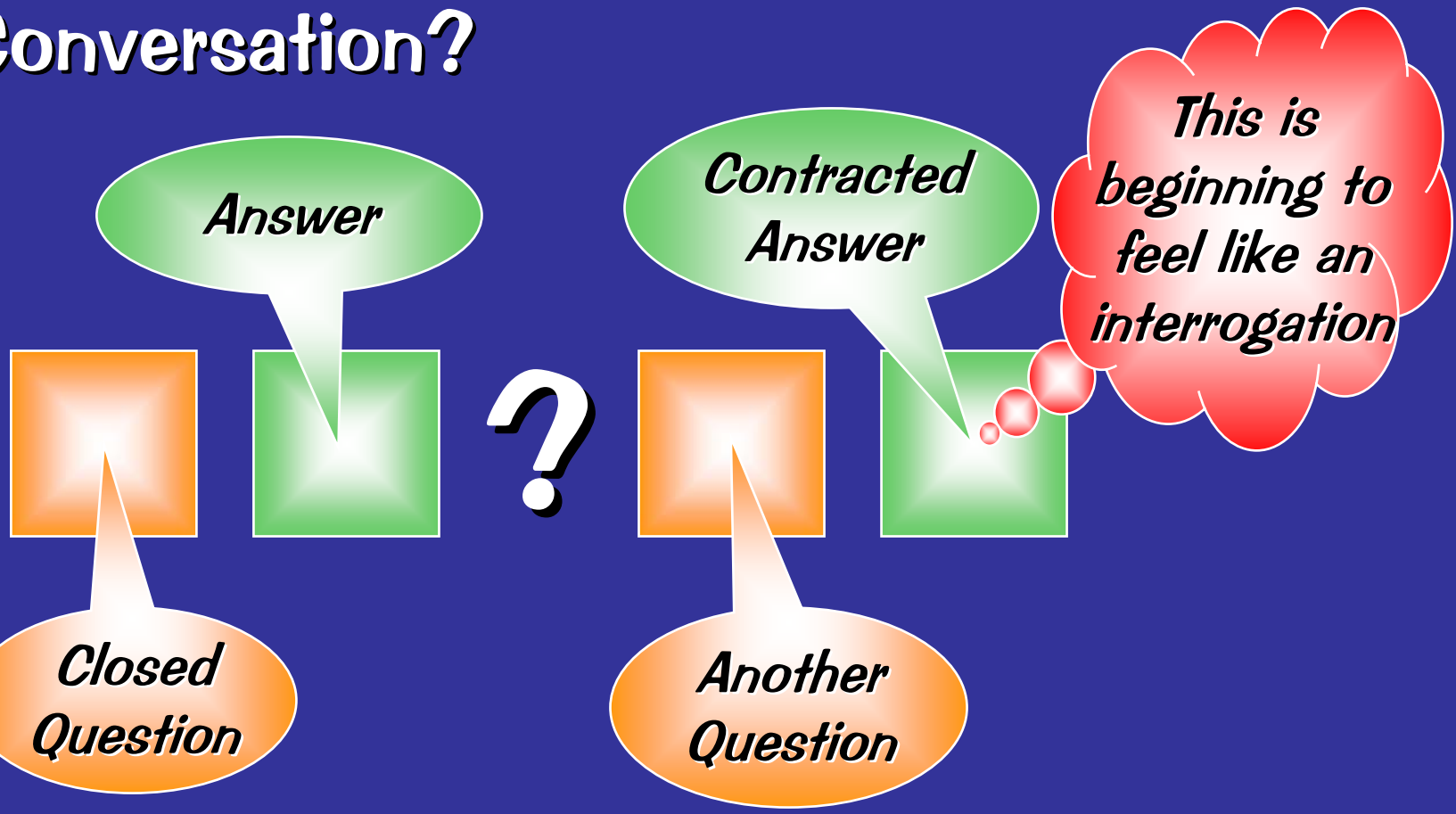
5. So, the effect on your son is much greater than on your daughter. [Probably. You think she's not going to be influenced by your smoking at all.

6. She makes remarks, but it's not easy [No. I've smoked since I was her age, you know. I couldn't just give it up. [It's difficult for you. But if she started smoking, I would feel guilty, obviously I would.

7. You see a link. [Yes. A link, perhaps, between your own smoking and the likelihood of your daughter starting, and the prospect of stopping is a little, I guess, frightening, and yet it's something that you've considered.

8. *(Long pause)* My mum smoked like a chimney. She never said a word to me when I started. I don't think she cared much at all what I did.

Contrasting Styles of Conversation?



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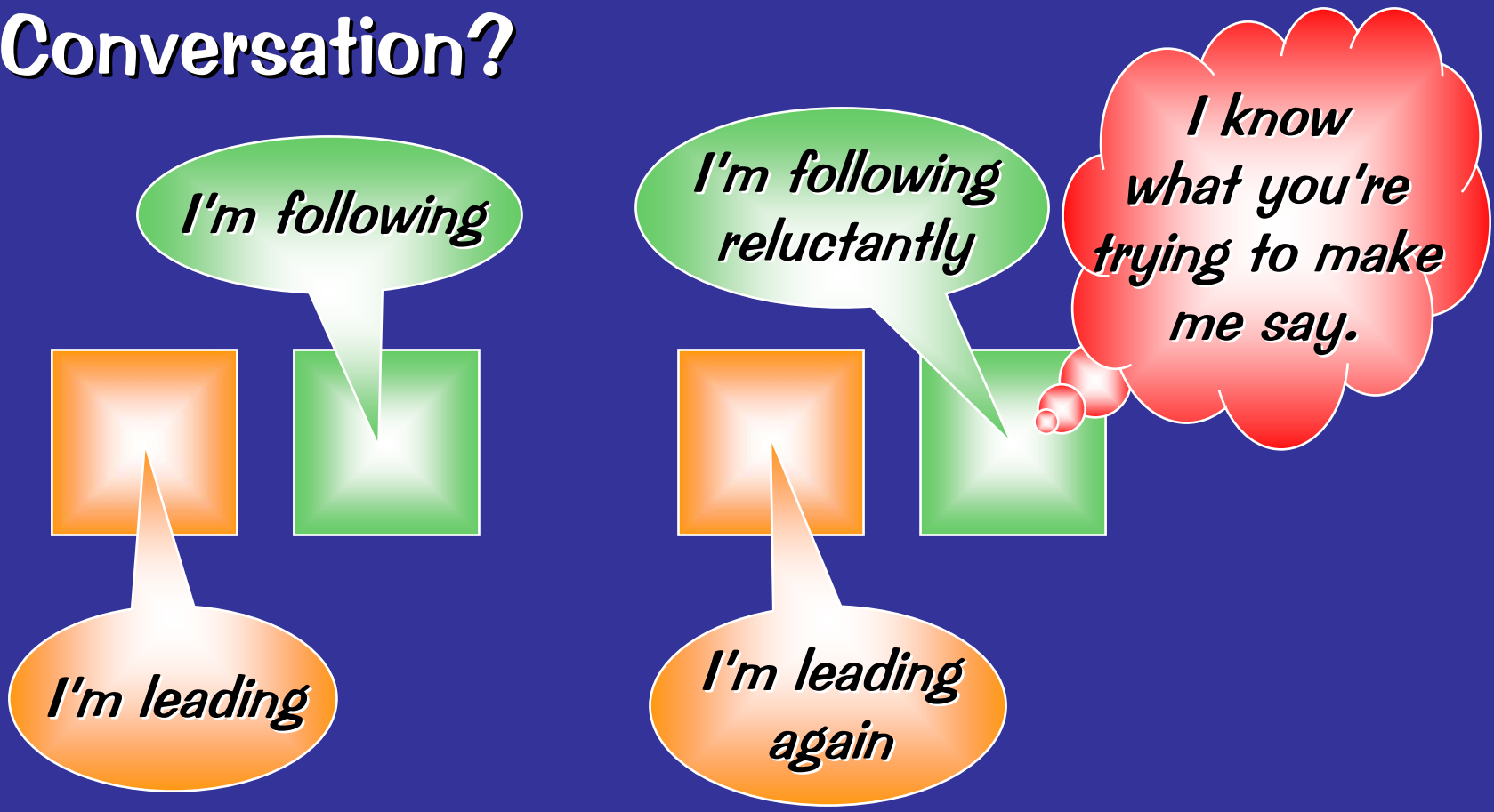

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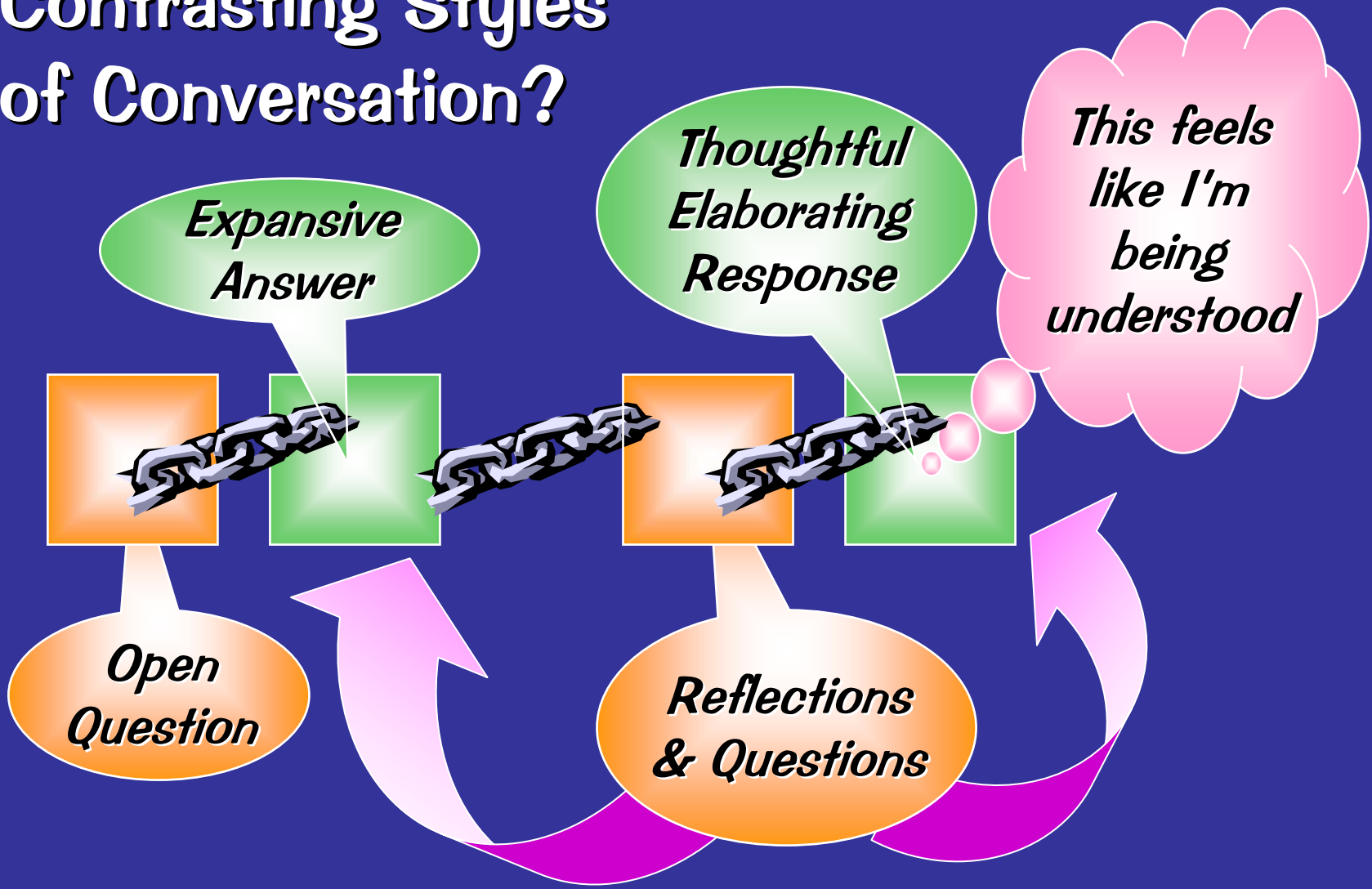

Forming Reflections:

Some useful statement openers

"So, you feel ..."

"It sounds like you ..."

"You're wondering if ..."

"It seems like you ..."

"You're thinking, perhaps, that ..."

Empathic Reflection .... *It's the curious and sensitive exploration of meaning.*

How would you respond to this client statement?

"There's no way I'm ever going to be able to stop drinking. Every time I say I'll try I just let myself down. I can't cope with anything unless I've had a drink. I wish I wasn't like this."

Please write down an empathic reflective response.

To which clause did you choose to respond – and why?

1. There's no way I'm ever going to be able to stop drinking.
2. Every time I say I'll try I just let myself down.
3. I can't cope with anything unless I've had a drink.
4. I wish I wasn't like this.

Some General Suggestions:

- ✓ Be curious rather than intrusive.
- ✓ Try to be impartial as to the outcome.
- ✓ Demonstrate accurate understanding through reflection & summary.
- ✓ Use open questions that encourage elaboration.
- ✓ Seek permission to ask questions and give advice.
- ✓ Maintain focus & direction.
- ✓ Find the potential for change through understanding ambivalence.

Some questions to ask yourself when in conversation ...

- What am I doing?
- Where are we going, and who's deciding?
- Am I 'guiding' or 'drilling'?
- Am I actively listening?
- Are we dancing or wrestling?

Quality, not quantity!

The Delicate Endeavour of Promoting Change: at the Heart of MI

An audio recording and transcription

(The recording used will be available for purchase on interactive CD-R early in 2006)

www.jeffallison.co.uk

The Definition of MI

"We define motivational interviewing as a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence."

Miller & Rollnick (2002)

"Motivational Interviewing is a narrative process for evoking from the client reasons for (change) and commitment to change."

Miller (1996)

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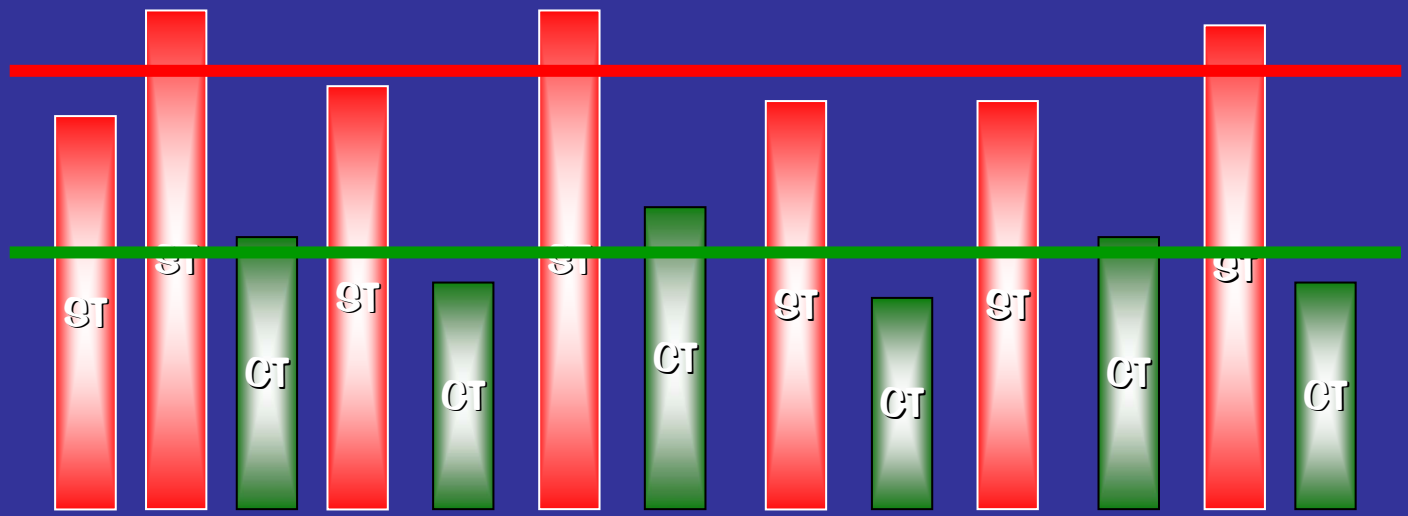
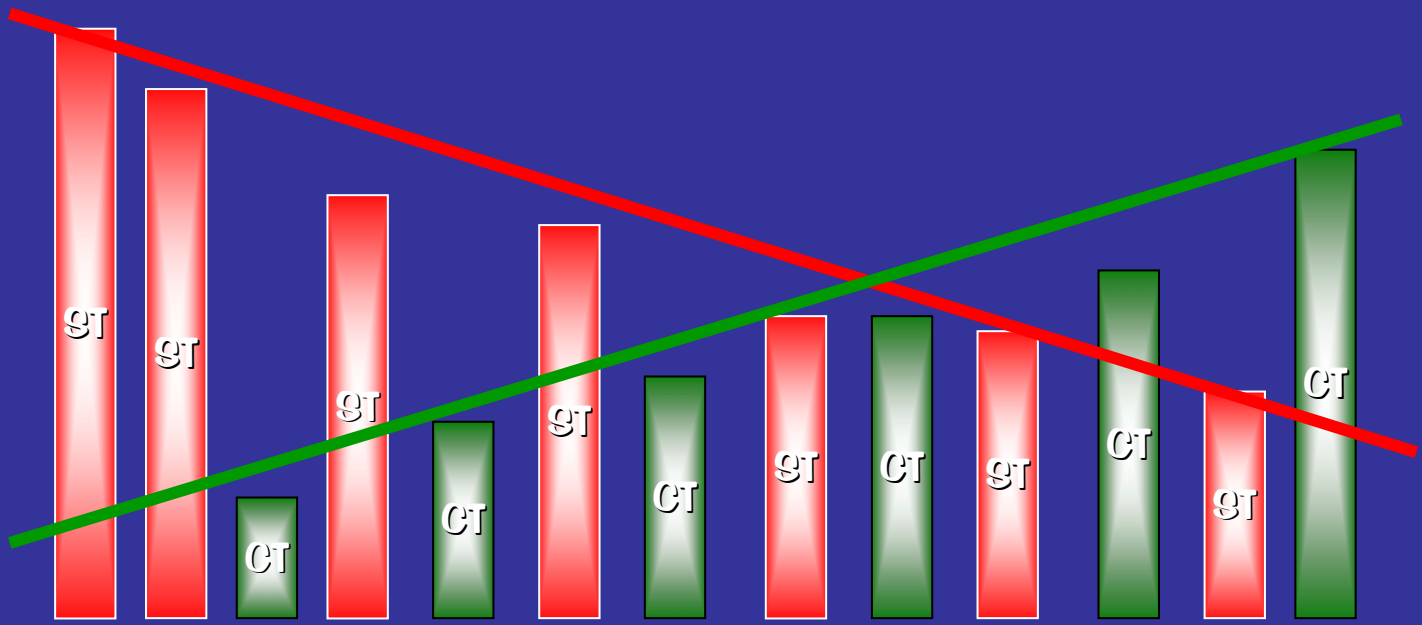
The incidence of client utterances in a less effective interview



Start.....Interview.....Finish

Low ..... Readiness ..... Low

The incidence of client utterances in a more effective interview



Start ..... Interview ..... Finish

Lower ..... Readiness ..... higher

An interesting phenomenon

weaker.....stronger.....weaker

1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Readiness

MI in a Nutshell!

The key to more effective practice:

the curious, empathetic and guided exploration of behaviour, its meanings and consequences.

MI, psycholinguistics and the promise of more constructive practice

2003

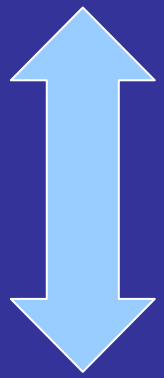
Amrhein, P. C., Miller, W. R., Yahne, C. E., Palmer, M., & Fulcher, L.

Client commitment language during motivational interviewing predicts drug use outcomes.

Journal of Consulting and Clinical Psychology. Vol. 71(5) Oct 2003, 862-878.

In a Nutshell!

weaker .... RAPPORT ..... stronger

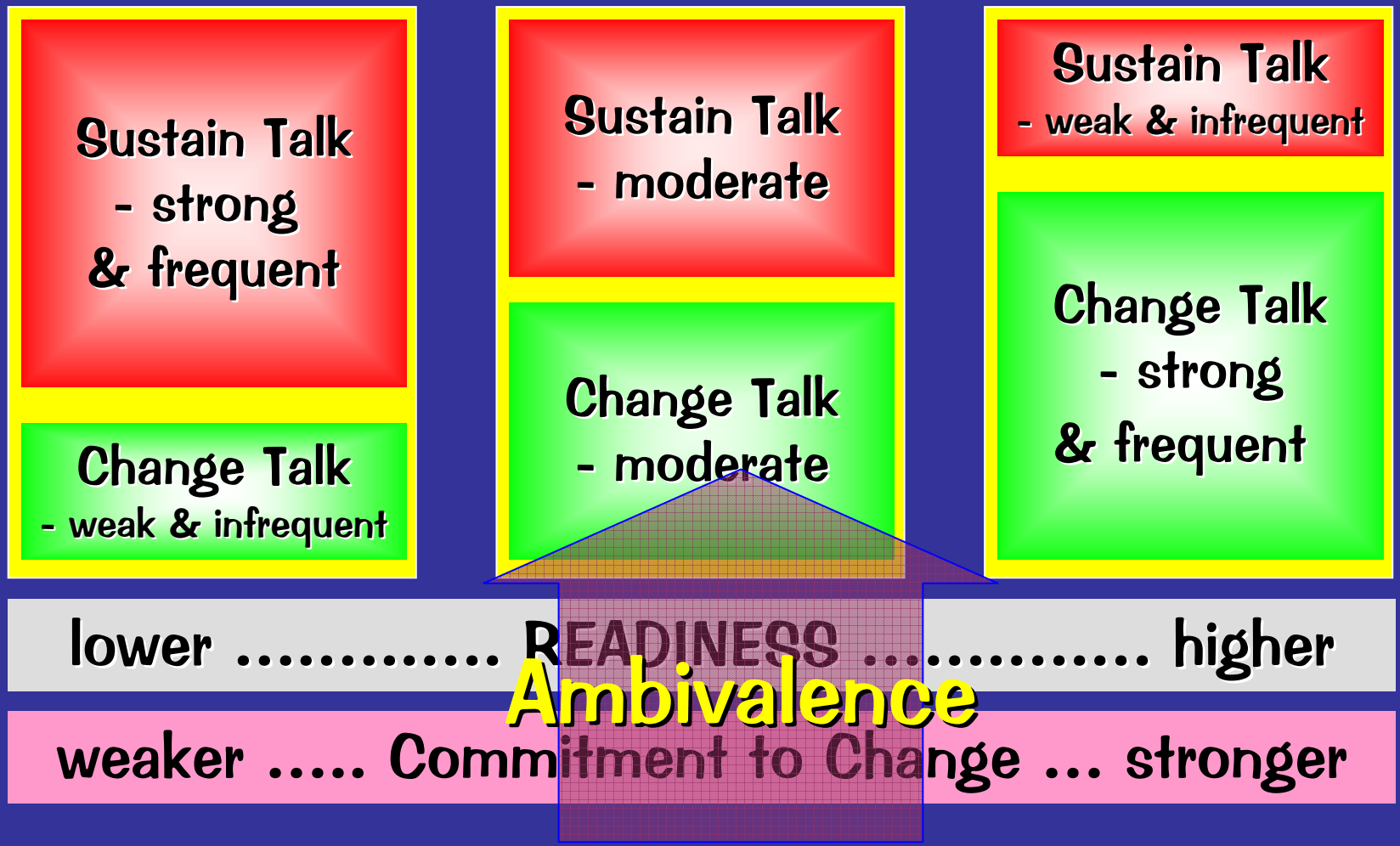


PROBABILITY

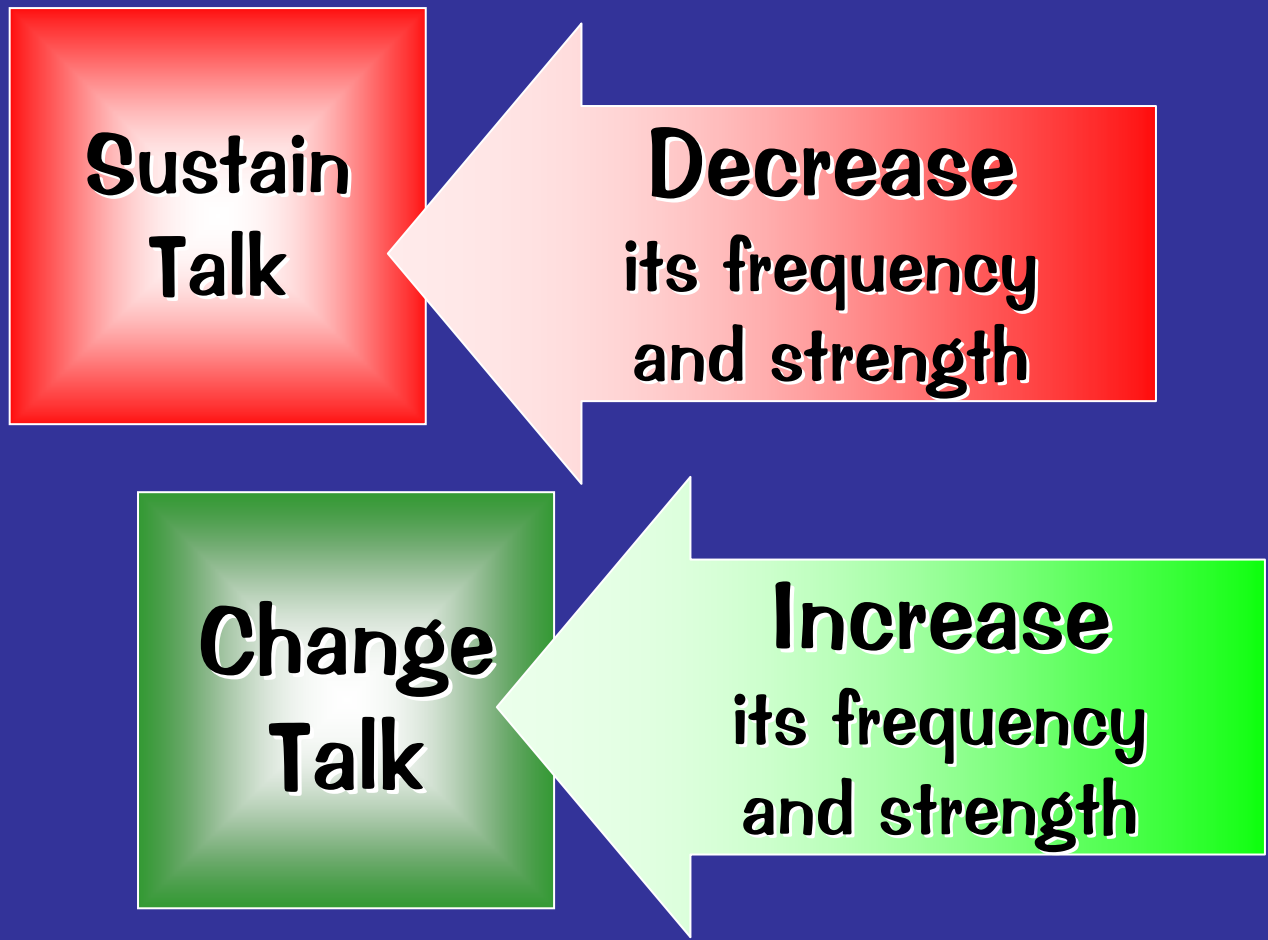
lower .... OF CHANGE .... higher

The quality of the therapeutic relationship largely determines the probability of change.

Natural expressions of readiness



The Practitioner's Challenge



Sustain Talk

All patient speech that favours a continuation of the focus behaviour

Sustain Talk

- Advantages of Status Quo
- Disadvantages of Change
- Intention Not to Change
- Pessimism about Change

The principal expressions of the motivational restraints that sustain the 'focus' behaviour.

The nature of the conversation is critical

What we say - and how we say it – largely determines what the patient says and what happens next. What we do matters.

Making sense of patients' speech

- Listening accurately
- Better understanding
- Responding differentially

MI 2002: Change Talk

- Advantages of change
- Disadvantages of status quo
- Optimism for change
- Intention to change

These were seen as more accurately representing the dimensions of commitment to change.

2003

Amrhein, P. C., Miller, W. R., Yahne, C. E., Palmer, M., & Fulcher, L.

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2003: Amrhein et.al. Change Talk

- Several research studies failed to find predicted relationship between 'change talk' and behaviour change outcomes.
- Amrhein et.al. suggest a different structure for coding client speech.

2003: Amrhein et.al. Change Talk

- Requires a specific goal proposition – the target behaviour change.

Examples:

- To stop smoking
- To cut down or quit drinking
- To take regular exercise

There needs to be a behavioural focus.

2003: Amrhein et.al. Change Talk

In relation to a specific goal proposition, the person offers certain 'motivational modifiers':

- **Desire:** "I would like to stop smoking."
- **Ability:** "I could quit smoking."
- **Reason:** "Smoking makes my asthma worse."
- **Need:** "I've got to quit smoking."
- **Commitment:** "I am going to quit smoking."

2003: Amrhein et.al. Change Talk

Reason: "Smoking makes my asthma worse."

appears to build

- Desire: "I would like to stop smoking."

and

- Need: "I've got to quit smoking."

while

- Ability: "I could quit smoking."

appears to build

- Commitment: "I am going to quit smoking."

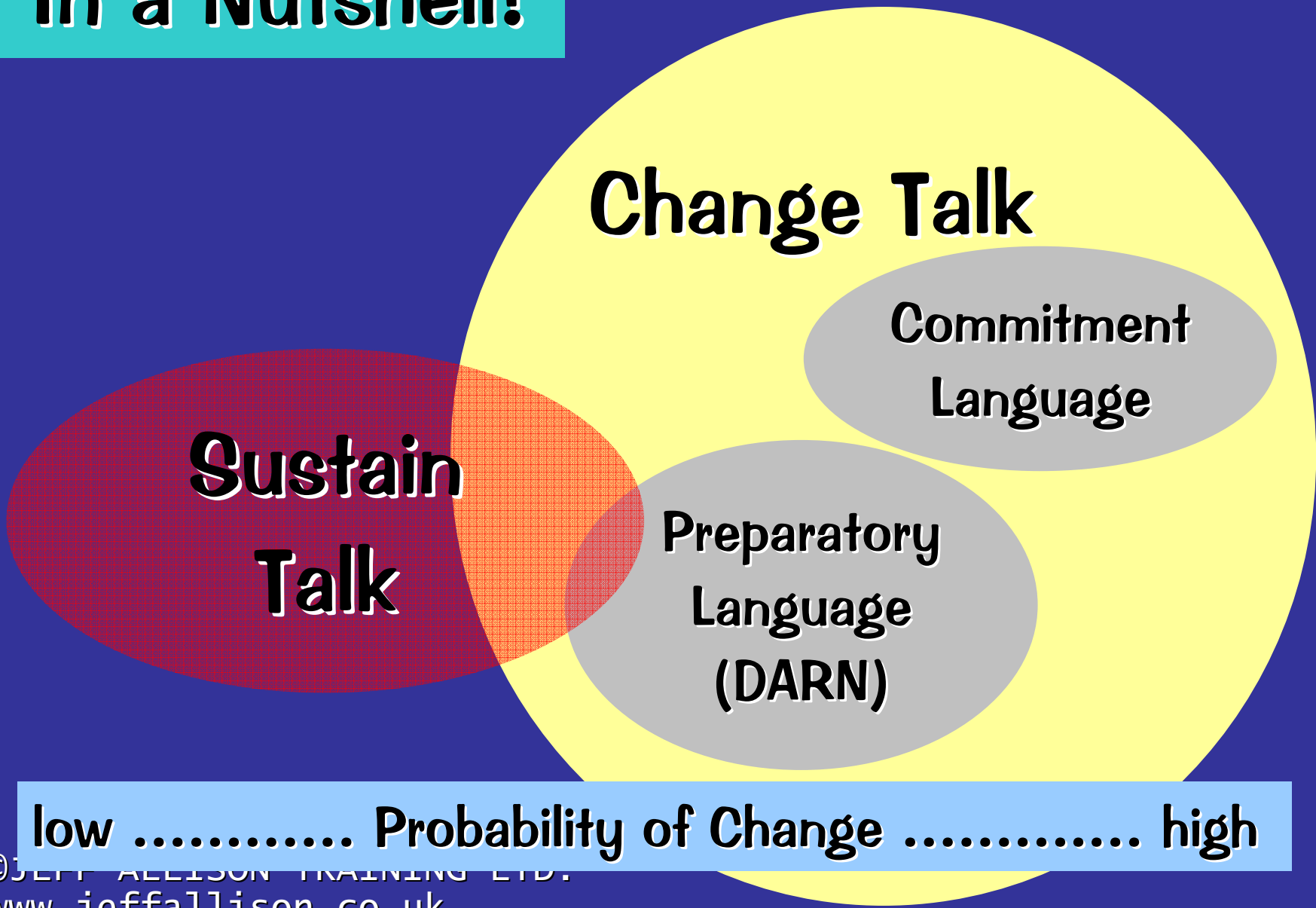
2003: Amrhein et.al. Change Talk

- Data suggested a sequential process: DARN predicts strength of client commitment to change.
- The strength of commitment language in turn predicted behaviour change.
- Important to differentiate commitment language from other kinds of change talk.

2003: Amrhein et.al. Change Talk

- Use Change Talk as a generic term to encompass all forms of speech that favour change.
- Differentiate CT into Commitment Language and Preparatory Language (including DARN) these are the non-committing antecedents of commitment.

In a Nutshell!



low ..... Probability of Change ..... high

We know CT intuitively

- Think of a typical patient. How would they be talking if they were in a heightened state of readiness?

- With your neighbours, discuss some **DARN** examples of patient speech:

Desire – Ability – Reasons – Need

Commitment

In a Nutshell!

The key to more effective practice:

the curious, empathetic and guided exploration of behaviour, its meanings and its consequences.

Sustain Talk DARN - anti-matter?

Reason: "Smoking helps me cope with stress."

appears to build

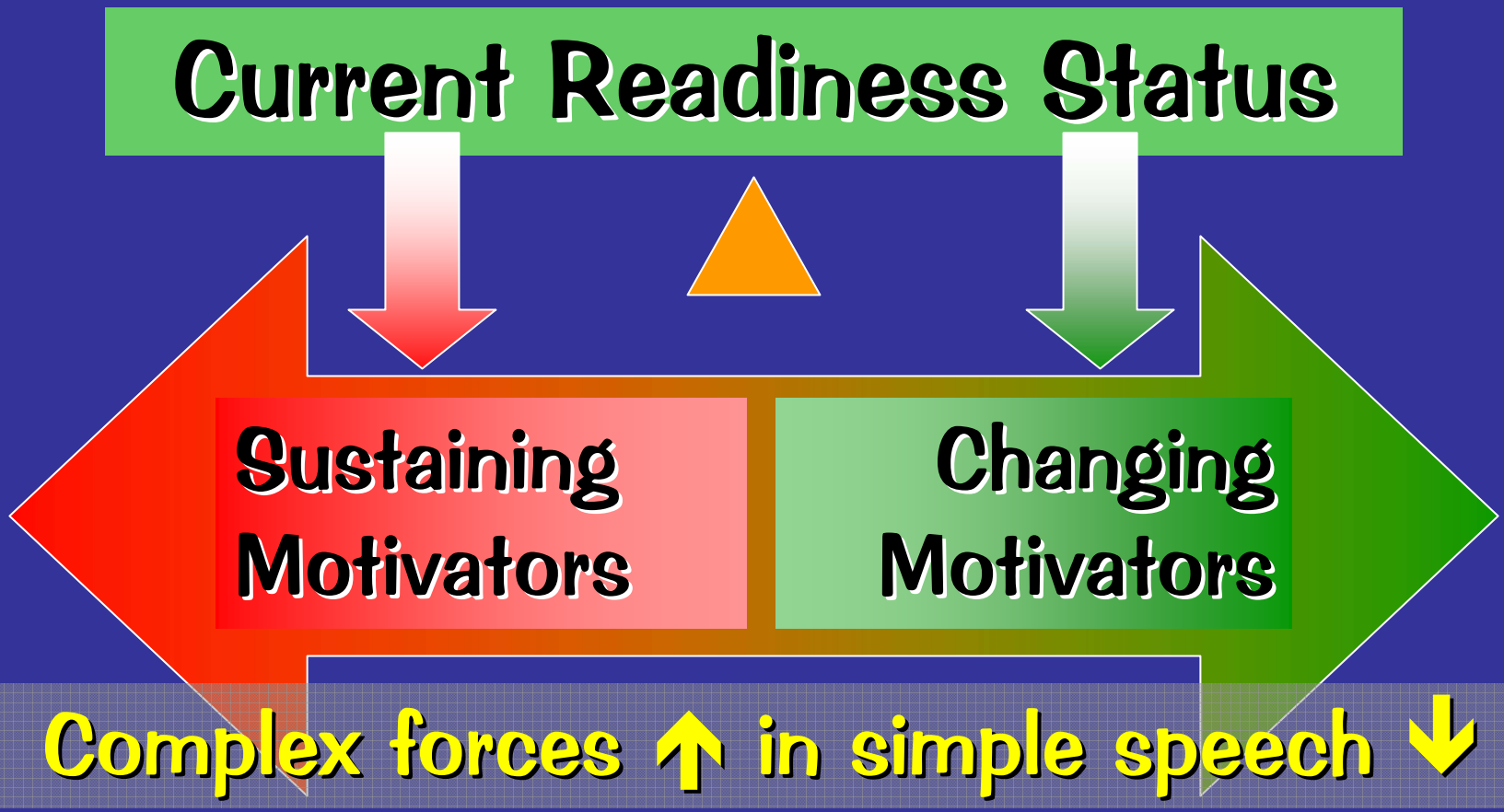
- Desire: "I want to smoke."

and

- Need: "With my busy life I have to smoke."

- Ability?: "I can afford to smoke."

- Commitment: "I am going to continue smoking."



"I don't want to, but I know I should."

"I don't want to, but I know I should."

"But if you know you should, why won't you?"

"It's not that easy."

"I know it's not easy for you, but if you don't do it your health will get worse."

"I don't think it's as bad as you say it is."

"The truth is, you just don't want to give it a go, do you?"

"I will one day, but this just isn't the right time."

Etc.

Not so helpful!

Ambivalence:

"I don't want to, but I know I should."

Sustain Talk:

"It's not that easy."

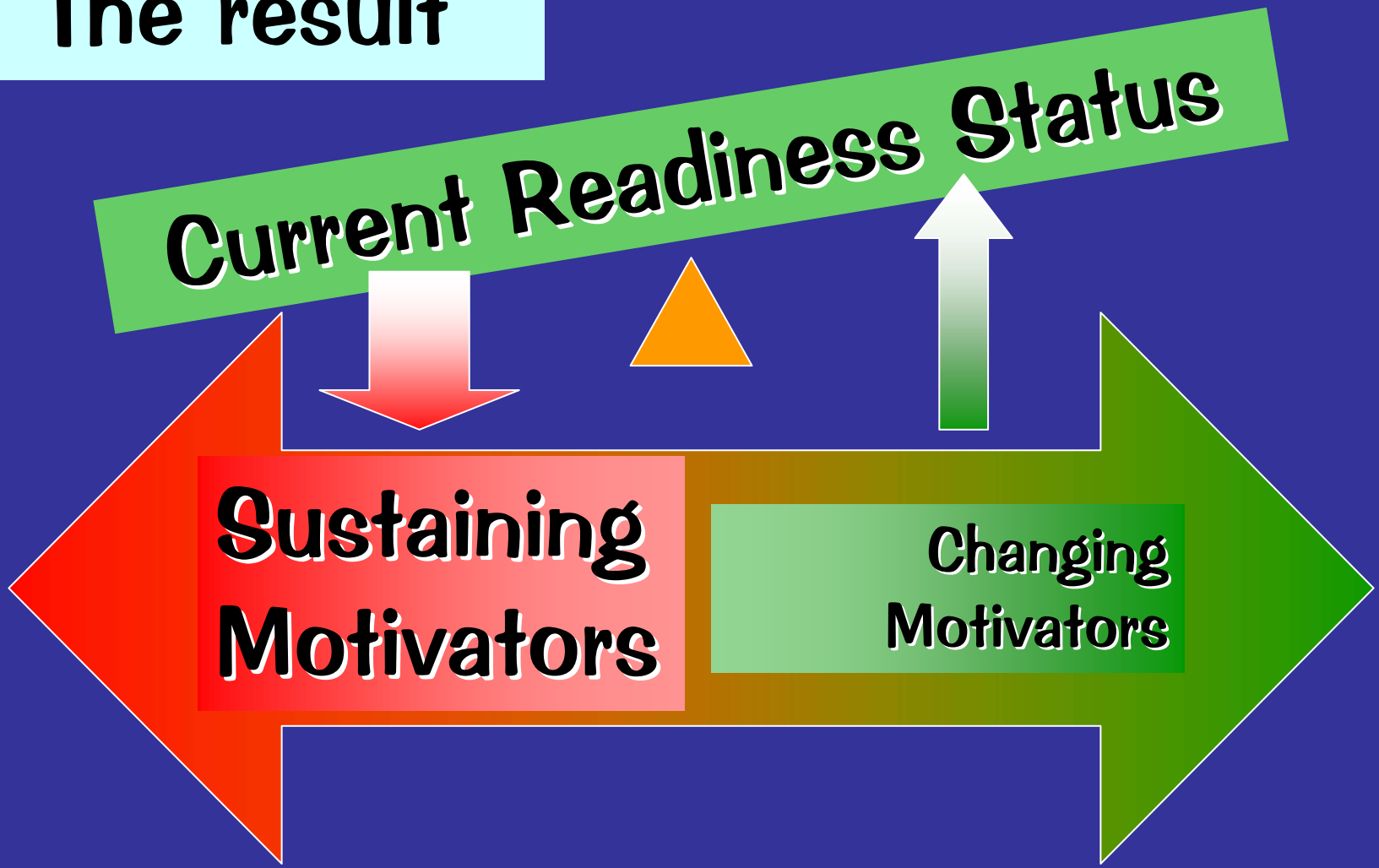
"I don't think it's as bad as you say it is."

" ...but this just isn't the right time."

Change Talk:

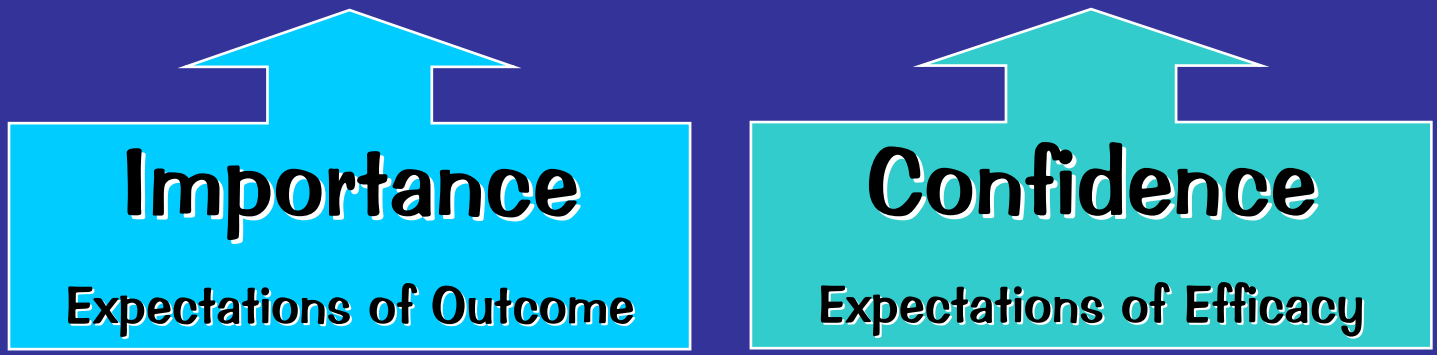
"I will one day..."

The result



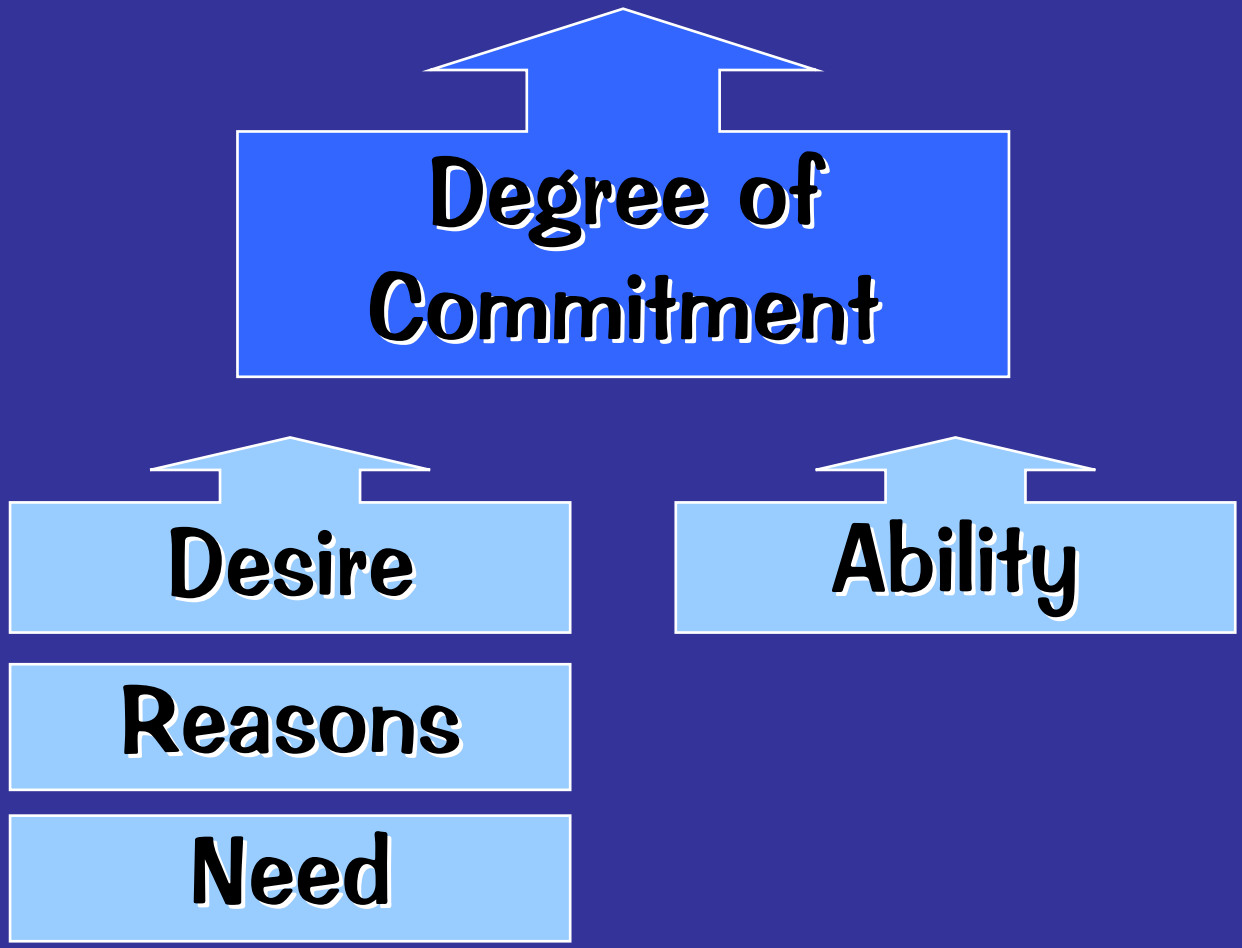
Readiness to change: what are its ingredients?

Readiness for Change - Current Status

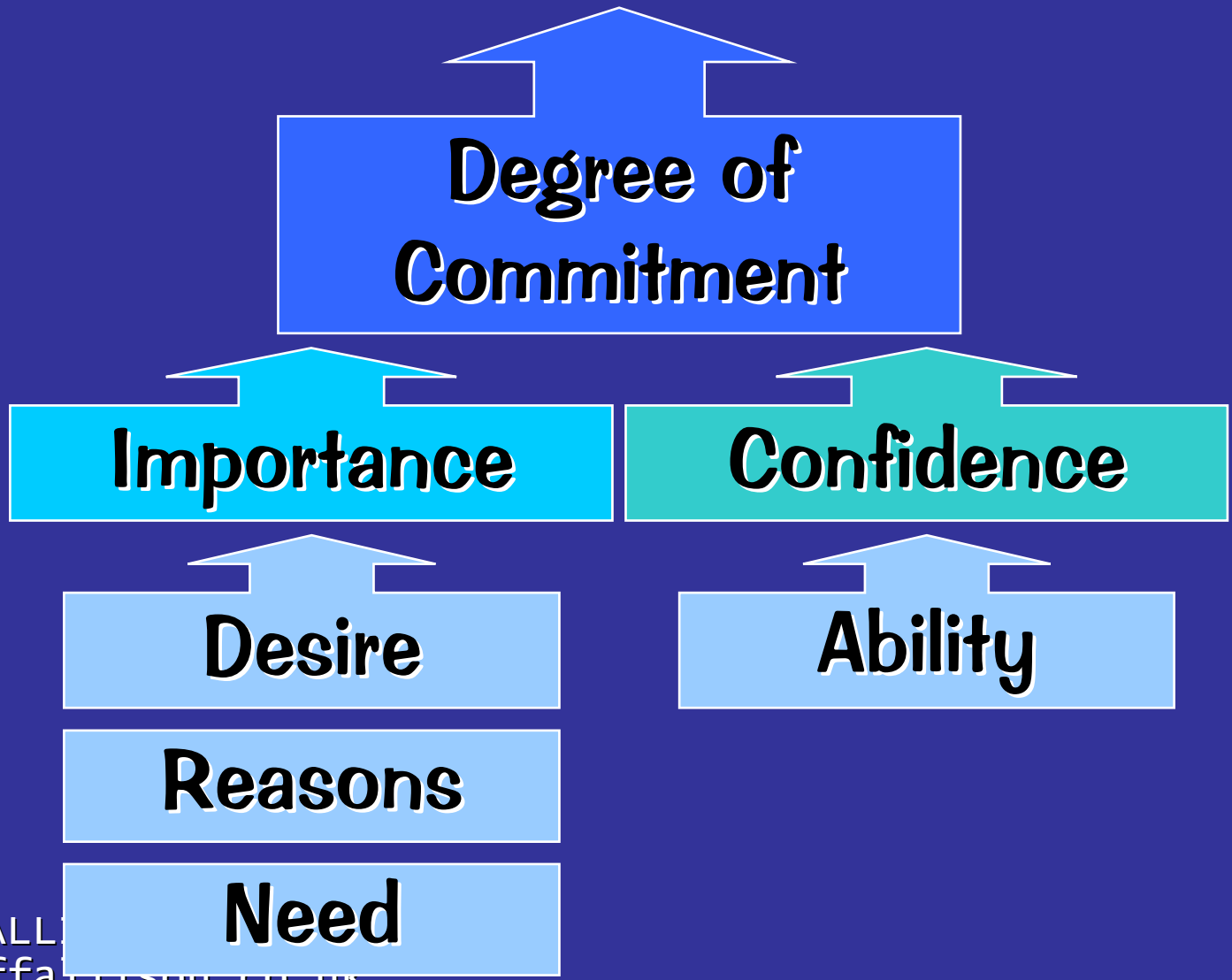


Readiness has two main components. Discussing these, rather than readiness, brings clarity and aids understanding.

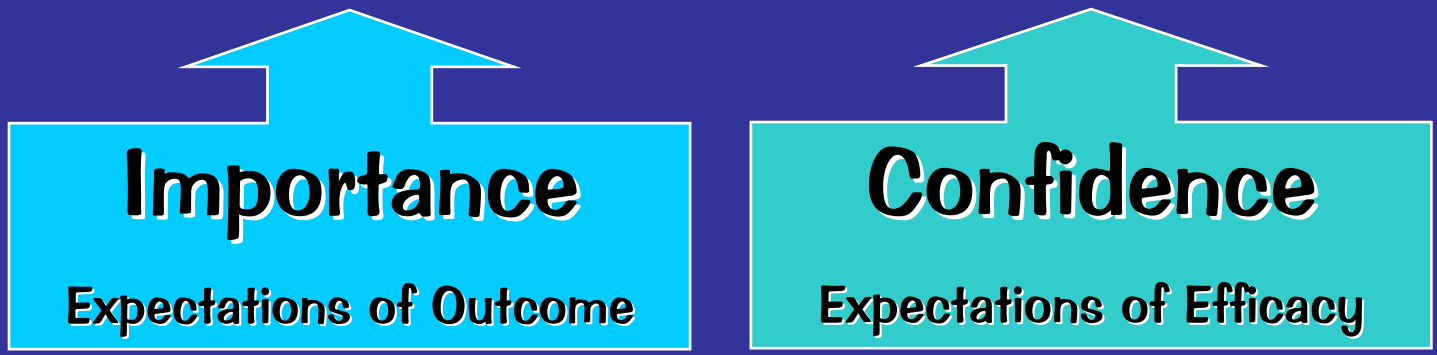
Readiness for Change - Current Status



Readiness for Change - Current Status

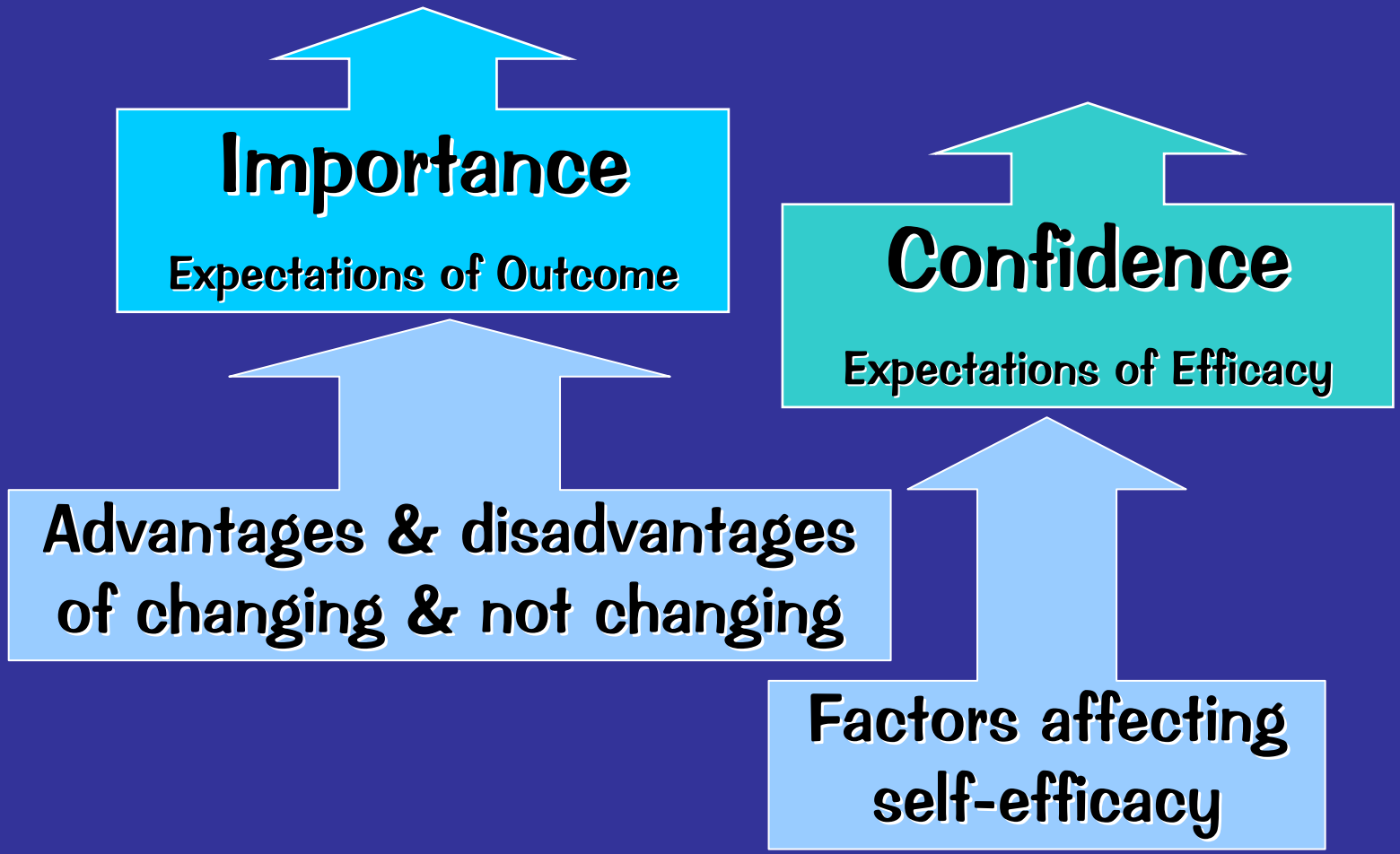


Readiness for Change - Current Status



In brief conversations, these two key words are sufficient to 'access' the motivational features, both restraining and encouraging change.

Readiness for Change - Current Status



In Summary

Off the top of your head...

Think about your own work and using MI:

1. *One way of summarising MI is ...*
2. *One thing I'm going to do less of ...*
3. *One thing I'm going to do more of ...*