

Motivational Interviewing

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Continuing Education Activity

Motivational interviewing (MI) is a process where medical professionals work together with their patients for a certain therapeutic outcome. A variety of skills and tools are utilized based on the stage of change the patient is at, working with the individual's internal motivations for behavioral change. Its ultimate goal is to solve a healthcare-related problem through patient introspection and empowerment. It combines technical aspects, such as open-ended questions and empathy, with a view toward a patient-centered approach. This activity discusses the different skills required for the successful utilization of MI on patient behavior as well as the current theories discussing how MI works to enact change.

Objectives:

- Summarize the origins of motivational interviewing.
- Identify skills required for optimal motivational interviewing.
- Describe the theories behind how motivational interviewing works on behavioral change.
- Explain how motivational interviewing between the healthcare team enhances patient outcomes.

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Introduction

Motivational Interviewing (MI) is a conversational style that facilitates collaboration between the healthcare provider and their patients. Its ultimate goal is to solve a healthcare-related problem through patient introspection and empowerment. It combines technical aspects, such as open-ended questions and empathy, with a view toward a patient-centered approach.[1]

Since the original description of MI in 1983 by William Miller, in the context of alcoholism, providers have expanded its use to a multitude of other mental and physical health conditions.[2] However, despite the wide range of potential benefits for MI, most studies are still only applied to substance abuse cases.[3] Research continues to determine which skills and tools are most beneficial in MI and the theories behind its mechanism of action in the primary care environment.

Function

Motivational Interviewing (MI) utilizes the patient's intrinsic motivations for a positive change in their health status. MI combines social and cognitive psychology to determine a patient's level of readiness to change and to work through their ambivalence to enact behavioral modifications.[4] Many of the skills used in MI have a foundation in

Carl Rogers' humanistic approach, using non-directive counseling to create a collaborative relationship between patients and healthcare professionals.[5]

The overall process behind MI is more important than the discussion between providers and patients.[6] Early research indicated that provider confrontation with a patient's behavior would cause patients to resist treatment, either directly by refusing care or indirectly with non-compliance.[7] Providers must understand the skills required for MI to implement them successfully.

Patient ambivalence can be displayed in various ways, from disinterest to reluctance to hostility, when attempting to engage them in positive behavioral modification. A tenant of MI is recognizing that patients have autonomy in making their own decisions and understanding the underlying reasons for their actions. Providers should engage their patients in discussion to learn the underlying reasons for their ambivalence and to reinforce self-motivational statements.[8]

An effective way to determine what stage a patient is at when attempting to make behavioral changes is to utilize the transtheoretical model (TTM). While the two models were developed independently of each other, MI and TTM work synergistically to determine what stage the patient is at when discussing change and to utilize the appropriate tools and skills to help the patient to the next stage.[9] The five stages are as follows:

Precontemplation: The patient is not interested in changing their behavior and may have subjective justification as to why they shouldn't change

Contemplation: The patient is considering change but may still cling to fears and reluctance to start

Preparation: The patient is actively preparing to change their behavior, potentially by considering tools and strategies to utilize, though it may require assistance with planning

Action: The patient is working through their plan and using their tools to ensure success

Maintenance: The patient has changed their behavior and is working to maintain the changes and not slip back into previous behaviors.

Issues of Concern

Despite MI's existence and extensive use over the past 40 years, researchers do not fully understand how it works to illicit changes in behavior. MI was developed using clinical experience and intuition in a bottom-up approach rather than top-down from the framework created by theory.[10]

There are three predominant hypotheses regarding how MI creates behavioral changes; the Technical Hypothesis, the Relational Hypothesis, and the conflict resolution hypothesis.[4] Additionally to these hypotheses, a central mechanism underlies all three called client motivational language. This concept organizes what the patient says into two categories: Sustain talk and Change talk. Sustain talk contains comments that resist change and tend to contain ambivalence and reasons why the patient's current behavior should remain. The more sustained talk the patient engages in is associated with fewer behavioral changes. Change talk contains comments that indicate a patient is motivated or committed and even preparing for change. These types of comments have been associated with increased levels of behavioral change.[11] Due to this underlying concept through the hypotheses, some researchers believe they are all components of one hypothesis.

The technical hypothesis is the most widely researched of the hypotheses. It predicts that the healthcare professional's proficiency in the technical skills of MI shapes the patient's behavior and allows them to talk themselves into behavioral changes.[12] This hypothesis is broken up into two paths of the same chain called the path and the b path. The a path discusses the relationship between the provider's technical skills and the patient's language, while the b path discusses the correlation between patient language and positive behavioral changes. [1]

The provider utilizes reinforcement and evocation to lead the patient towards change talk and to decrease sustain talk. Some studies estimate a 62 to 83% increased probability that the provider's questions will elicit change talk in their patients.[12] However, there are disagreements among researchers on which aspect is more important regarding the a path. Some studies suggest that increased patient change talk as a positive predictor of behavioral change is more important, while others suggest that sustain talk and its relationship with worse outcomes should take priority. Studies indicate that the sustain talk is a great predictor of a negative outcome while the level of change talk was non-significant to positive change.[11] Additionally, a significant limit to the research into these pathways is the high reliance on the correlation as the causation and does not account for potentially unmeasured factors that affect the outcome.[5]

The Relational hypothesis predicts that the relationship between the healthcare provider and the patient will lead to positive behavioral changes as they collaborate and focus on the problem. Empathy and patient-centeredness are the key skills associated with this hypothesis and allow the provider to ensure the patient retains their autonomy in making their own healthcare decisions.[12][5]

There has been significantly less research performed on this hypothesis than the technical one, likely due to the greater variability in how a provider displays empathy and the non-specific nature of the content. Additionally, early studies on the effects of relational factors on outcomes have been mixed.[13] However, there is evidence that relational strategies are essential despite studies that indicate the contrary. Some studies indicated there was no difference in outcome between a group that utilized only relational elements and empathy and one that utilized technical and relational elements.[12] The relational hypothesis has the potential to stand on its own when leading to behavioral changes, though more research is required.

The conflict resolution hypothesis prioritizes exploring and resolving patient ambivalence to change.[1] It has the potential to be very useful, especially in the beginning stages of MI when the patient is in a lower stage of change, such as pre-contemplation or contemplation. However, it is also the hypothesis with the least research performed, thus leaving the medical community with little information on how to utilize it most effectively.[12]

At least one study has been performed regarding addressing patient ambivalence and commitment to change in drinking habits. It concluded that focusing on ambivalence did not consistently predict positive outcomes, especially in those individuals who were at lower stages of change and did not resolve their internal conflicts regarding that change. Additionally, a focus on commitment to change did indicate positive results.[14] Studies that expand upon these concepts of ambivalence and commitment to change should assist in furthering the understanding of how this hypothesis works.

Clinical Significance

MI utilizes several techniques and skills to encourage patients to discontinue harmful behaviors and transition to behaviors that improve their health. The spirit of MI is essential regardless of whether the patient is pre-contemplative or maintaining change. It is important always to implement a sense of partnership and empathy between the provider and patient. When providers offer open-ended questions regarding patient motivations, it creates a sense of compassion and interest, allowing patients to open up. It was discovered early on in MI that simply giving patients the facts and information on why change is beneficial, or warnings against their current behaviors tended to have the opposite response and caused more resistance.[15] Open-ended questions can steer patients toward self-motivational statements when attempting to answer, thus reinforcing a positive mindset.[8]

Researchers determined that MI is appropriately utilized when at least 70% of questions are open-ended. Additionally, providers should practice active listening and reflection regarding their patients. Repeating the patient's words in a neutral way is the most straightforward strategy a healthcare professional can utilize to allow the patient to feel heard and can be expanded upon to allow patients to reflect on other perspectives as well as their own inconsistencies.

Evocative open-ended questions help orient patients to a goal-oriented mindset and enable them to talk themselves into change.[4]

Asking the patients their personal pros and cons to utilizing the intervention, as well as how important they think the intervention is, helps the provider to understand their internal values. Providers can then gently challenge these views by exploring the extremes if they do or do not utilize the behavioral change. Reflection can also assist the provider in shifting the focus away from barriers and reframing negative interpretations to positive ones. Throughout the process, it is important to emphasize that every patient has a personal choice and to listen to their wishes.[8] Summarizing the information the patient gives and affirming their strengths assures that all parties accurately understood what was discussed.[4]

It is then possible to use the Elicit-Share-Elicit strategy to learn what information they obtained from the discussion, share pertinent facts, and reassess their knowledge and how they will utilize it.[15] Based on which stage of change the patient is at, the provider can also assist in planning the change if the patient requires assistance, allowing the provider to monitor and participate in all potential stages.[16]

Enhancing Healthcare Team Outcomes

Motivational interviewing is a skill that can benefit all members of the interprofessional healthcare team. Despite medical providers taking the bulk of interactions with patients, the MI spirit and skills can be utilized by everyone in the medical field to assist in tackling harmful patient behaviors. Nurses trained in MI techniques can utilize their skills to educate patients on their disease and work towards positive goals.[17] [Level 2]

Pharmacists can tackle medication hesitance and non-compliance by investigating underlying reasons for these behaviors using MI skills. Even technicians and front desk staff, who tend to have the least amount of time to interact with patients, can utilize empathy and other aspects of the MI spirit to make the patient feel welcomed and able to open up while in the clinic.

By training everyone in the medical field in MI techniques, every individual can positively affect patients. Education in MI can be established during training programs for health professionals. Studies indicate that a 3-day seminar is sufficient in teaching MI skills and spirit to allied health professionals, giving them the confidence to utilize their skills effectively.[18] [Level 2] Other forms of this seminar can be created to expand the MI knowledge to every aspect of the healthcare team.

Review Questions

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