



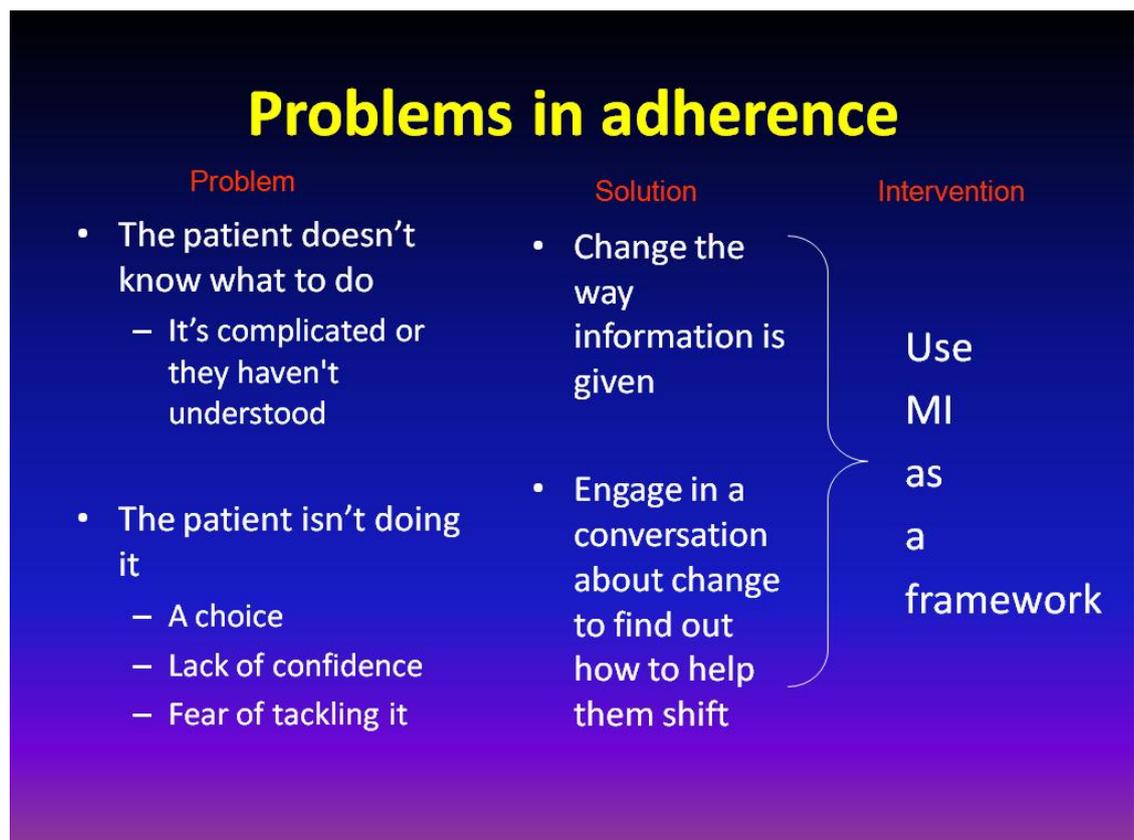
Motivational Interviewing: *the follow up workshop*

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Introduction

This handout accompanies the follow up workshop on motivational interviewing skills facilitated by Gary and Alistair. The focus is on a refresher of the main principles and skills of MI, together with some additional material on more advanced skills and plenty of time to practice. This guide will also include some materials for you to use in sessions, space for you to make your own notes, and advice on getting practice to develop your skills further.

To begin, a reminder of the nature of problems people have with adherence (see figure below). Remember, one size doesn't fit all - people have problems in adherence for many reasons. Our argument is that MI is a pretty good way of approaching a conversation with a patient about adherence whatever the reason. Even if they have some misconception that you need to help shift, using MI as a framework for this is a good starting point and helps to avoid any resistance from creeping in.



What is MI?

Time to get rid of a few misconceptions. Sometimes people feel that to do MI they have to watch everything they say, and not waist a word. Not so, MI is very forgiving. It's the spirit of your encounters that counts. Also, as long as you are practicing, your skills in MI will get better over time without you knowing. Remember, it's often a case of feeling free to use some of your many conversational skills at work. The other misconception is that MI is all about listening. Not true. In good MI you'll hear lots of reflections, good listening, some silence, and also questions and answers - at times someone using MI will give advice or information. In MI, there is a nice balance between different styles of conversation, and it is all delivered in the MI spirit - a friendly attempt to guide the patient.

Styles & skills

	Asking	Listening	Informing
Directing	Some	Little	Loads
Following	Some	Loads	Little
Guiding	Some	Some	Some

You can think of consultations with patients as tending to fall in to one of three camps - directing, following and guiding. All of these may be useful in different consultations. The problems come when the wrong one is being used in the wrong situation!

Many consultations feature directing - with the health professional giving advice to the patient or family - though sometimes a patient's history will dominate as the health professional listens to try to understand what's going on. MI is more akin to guiding, where the health professional listens, asks some questions to bring issues out into the open, and offers advice at the right time.

The MI process

Miller and Rollnick have described the process of MI in terms of two phases, each with their own goals. The first phase concerns getting a rapport going and starting a conversation, moving towards discussing adherence and then raising the importance of change. The idea, of course, is to help your patient to talk about it and come up with the importance of changing themselves. This may produce some discomfort and they acknowledge the ambivalence they feel - for example realising that poor adherence is a real problem that they have tried not to think about. Finally, the other goal in phase one is to keep morale high, because if someone doesn't feel confident they won't attempt to change.

Phase 1 goals

Raise the importance of change
Enhance confidence
Resolve ambivalence

Phase 2 goals

Firm up your patient's commitment to change
Negotiate a change plan

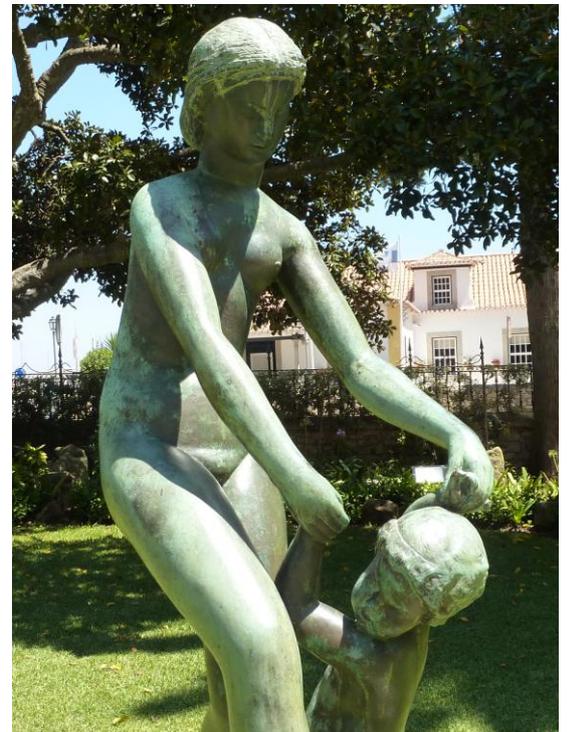
Phase two is all about what happens when someone has decided to change. The goals here are to work towards making sure someone is serious about changing - to firm up their decision - and to negotiate a change plan. We like to think of this stage as 'sealing the deal', and it is usually the main focus in the second MI workshop.

The main principles of MI

The main principles of MI can be summarised as:

- ❖ Avoid confrontation
- ❖ Listen
- ❖ People are more likely to change if they talk themselves into it
- ❖ People feel uncomfortable when they hold two incompatible beliefs (cognitive dissonance)
- ❖ If people are confident that they can change they are more likely to try (self efficacy)
- ❖ People often feel ambivalent – in two minds - about things

Recall too the importance of 'The spirit of MI' (Rollnick and Miller, 1995) - that "Motivational Interviewing is not a series of techniques for doing therapy but instead is a way of being with patients". By the spirit of MI, we mean: Collaboration (working alongside your patient), Autonomy (remembering that it is your patient that decides what to do, and takes responsibility for their decision) and Evocation (that your role is to draw out your patient's ideas and solutions).



Phase 1 goals

These are achieved through the four topics covered in the first workshop: expressing empathy and getting a conversation going, developing discrepancy, rolling with resistance, and building self efficacy.

A good way to begin a session is to discuss what you might discuss. We suggested an agenda setting chart in the first workshop as a way of listing the topics you'd like to cover whilst also acknowledging that the patient should feel free to bring up anything they feel is important too. This doesn't have to be written down - you could just talk about it, and it may be some patients find this easier than writing something down, particularly if it is a difficult topic pot bring up.

Expressing empathy - more OARS!

Last time we discussed the skills to develop in getting a conversation going. Mostly, these were the OARS: open questions, Affirmations, reflections and Summaries.

Open questions: remember that closed questions can be helpful at some times too, but overall open questions are better at opening up conversations. There is a danger that if you ask too many questions the session can turn into a bit of a question and answer session, but there are times that you need to ask questions to find out what's going on. It's unlikely that open questions alone are going to lead to any changes, however. People don't tend to have a sudden rush of insight and completely change their behaviour after you've asked a question, no matter how well put! Instead, reflections are much more useful in moving towards change as you are trying to get the patient to work things out for themselves. People that have been doing MI for a while still use questions, of course, but tend to use reflections more (around 2 reflections for every question)

Affirmations: these are ways in which you help someone to keep up their morale. Any genuine reflection about someone's strengths, what someone has already achieved or put up with helps, as long as it is genuine. This is better than a complement, which might come across as a bit shallow or bland. It's generally better to stick to reflections about facts - i.e. specific behaviours or achievements.

Reflective Listening: remember that the two most common types are content (simple) reflection and meaning (complex) reflections. Content reflection is where you stay close to what patient has said and communicate your interest in what they are saying. Meaning reflection is where you may go well beyond what was said, and include references to what you know about them from this or previous sessions. You may also refer to their emotions, or contrast different things they have expressed. These reflections are much more powerful in that they introduce something new into the conversation - your attempt to actually understand what is going on. There's a chance, then, that this will lead to more self awareness in your patient, and perhaps a new way of seeing things.

Last time we also described two other kinds of reflection. Amplified reflection is where you deliberately overstate what someone has said, in an attempt to provoke the opposite reaction - that they will disagree with you and back down from their earlier position, or see that the situation isn't entirely in black and white. Of course there is the possibility that they will agree with your exaggeration, which at least tells you a lot about the way they see things! The last kind of reflection discussed last time was double sided reflection, where you pair two sides of the discrepancy in one sentence, finishing with the side that points to change, and highlighting the ambivalence felt by the patient between beliefs, feelings, behaviour or a mixture.

Summaries: these can be an extremely powerful tool. When they work, they help a patient to organise their thoughts around an issue. In MI, 3 types of summary are sometimes described. First, Collecting, in which you gather information together from what someone has said (today or previously) and then feed it back. This helps you both to organise the discussion, and keeps the conversation flowing. The second kind is Linking, in which you contrast things the patient has told you with information shared previously. This can help to highlight discrepancy, and point to ways forward. Last, Transitions in which you pull everything together that someone has told you to draw that part of the discussion to a close, and to point to a new direction for you both to follow. This is particularly helpful when you are moving towards a decision to change.



Developing discrepancy & understanding your patient's motivation

Your aim is help your patient to become aware of their problems by themselves. To do this, you focus on any discrepancy between their beliefs and goals and what they are actually doing (i.e. cognitive dissonance). People often know this already, of course, but it's often kept away from conscious awareness as it may make them feel uncomfortable. People are very good at not thinking about uncomfortable things, so it will take more effort on their part to see the links and more effort on your part to raise awareness.

As discussed last time, a good way to do this is by integrating assessments such as test results, and using scaling questions to assess importance and confidence. Remember, though, that the purpose of the questions is to trigger a conversation more than complete an assessment. The good thing about scaling questions is whatever the answer it will suggest the next topic for your conversation.

When the possibility of change becomes the focus, a decision matrix - in which you both write down the pros and cons of changing or staying the same - can be useful

During this time you are looking for any signs that someone is contemplating change – so you can reinforce the notion. Remember, people persuade themselves much more than they are persuaded by others! So, look out for Desire, Ability, Reason and Need.

What can you do to reinforce change talk when you hear it? Basically, keep the conversation going – reflect this back, ask more about it, try to help your patient elaborate and say more etc.



Similarly, do what you can to subtly steer the conversation towards change talk, helping people put into words their feelings about change. Remember, you are drawing this out and not putting words in someone's mouth. The OARS are very handy for this, especially reflection. You can experiment with using reflection and open questions in different ways once you get more confident. For example, if a patient mentions feeling worried, ask more – “how long have you felt like this” “can you tell me about the last time this got to you” etc. So, when you ask someone to elaborate, the conversation stays on the topic connected with reasons to change.

In MI, people often describe other effective strategies at eliciting change talk:

- *The direct approach*: come straight out with a question – “why are you worried about this?”
- *Picking flowers (choosing chocolates)*: zooming in to something your patient has said that you think it would be useful to talk more about.
- *Presenting bouquets (pick ‘n’ mix)*: pulling things that your patient has said together and summarising it for them, leaving the road open for change.
- *Who are you? (Contrasting values and behaviours)*: asking about how your patient sees themselves, and contrasting their beliefs about how they feel they ought to be (or would like to be) with what they do in practice. E.g. ask “What things are important to you?”

When people feel ready to change, the language they use changes again, and people start using ‘mobilizing talk’, indicating commitment (“I’m definitely going to change”) or even that they are about to take steps (“I’m going to start this today”).



Rolling with resistance - resisting the righting reflex

So, you are trying to...get a conversation going, focus on change, encourage change talk. But, people do not change overnight, and you are bound to hear people talk about not changing. This comes in all sorts of varieties:

- Resistance talk – “I’m not changing”
- Status quo talk – “I want things to stay the same”
- Can’t do that talk – “I can’t change”
- Better as it is talk – “It’s better how it is”
- Don’t rock the boat talk – “I need things to stay the same – I can’t handle change at the moment”
- Been there done it talk – “I’ve tried that already”
- Yes but talk – “yes, but I can’t do that because....”

If we are honest, we have all said something like this at one time or another. It’s a sign that change is unlikely until the conversation is sprinkled with some more positive words. Remember, responding to any of these with an attempt to persuade – to ‘put someone straight’ – is almost certainly to lose you the argument. You may even get stuck for a while. If this happens, stop digging, step back and try another tack in the conversation, but this time remembering to ‘roll with resistance’.

How do you roll with resistance? Reflect and resist an argument. You might also try reframing - offering a new perspective on what someone has said. A good way to do this is to acknowledge what someone has said in a reflection, and then offer a slightly different take – an agreement with a twist.

Supporting self-efficacy & empowering your patient

Finally, it is important to recall that even if someone is now sure they need to change; if they do not feel confident they may not even try to change and may feel more stuck than ever. So, you always need to do your best to keep morale up.

Moving on to phase 2 – sealing the deal

The Phase 2 goals are to firm up your patient's commitment to change, and move on to negotiate a change plan.

So, when you pick up lots of change talk and feel that someone is getting ready to change, you have a window of opportunity – a chance to help them take the next step and start to change. Even now, of course, they may slip back into thinking about change and take a step back from changing. Actually, people sometimes take several goes before they finally take the plunge and have a go at changing. What can you do to help them to take that leap?

First, remember the signs of readiness, which should tell you that you need to shift your approach. Basically, if someone's resolve to change appears to go up and their resistance down, they are on their way. They may even start to ask you for advice about the way forward.

Next, there are two strategies that are useful in helping your patient to firm up their commitment to change: the recap and the key question.

The recap

This is a chance to summarise the story so far...Bring together what they have said about reasons to change and offer a summary of the conversation. This forms a bridge to the next stage, when they actually attempt to change.

"Let me try and pull together everything we've talked about so far..."

In this summary, you might include something about their beliefs about the need to change, and the reasons change would be a good thing. It's important, too, that you acknowledge that they may have been in two minds about changing, and some things will make change difficult. Finish, though, with a summary of what they have said about desire/ability/reasons/needs and their commitment to changing.

This recap leads up to the next, crucial step.....

The key question

“So, that’s’ where we are just now. “Where do you want to go from here? - What’s your next step?”

This is the crunch question, how you seal the deal on change. It’s easy to avoid asking, but it’s a very useful way of moving things on to the next level. You can ask it in whatever style suits you, but the important thing is that when you feel the time is right you ask the question and move things on.

Of course someone may still be reluctant and not quite ready. Sometimes they may just get cold feet and with a little support be ready to change. Sometimes they may not want to try just now. That’s fine, be patient and work with them until they are ready to try again. Whatever happens afterwards, stay in an MI style. If they are ready, you need to move on to the final step, negotiating a treatment plan.

Negotiating a treatment plan

It’s tempting to ease off the pedal at this stage. After all, your patient has decided to change and it looks like you’re on the home straight. The problem is, of course, that things can still go wrong. You can go about change in hundreds of different ways, and some of them will be better than others. Whenever someone starts to change, too, they meet obstacles. Sometimes these are enough to set them right back to the beginning. Luckily, you can do something about this with a bit of foresight. So, the first thing to do is sit down together and write a change plan. We’ve included an example blank one on the next page.

Right now is where all your experience and knowledge will prove very helpful for your patient. Remember not to slip into expert mode, telling them what to do, but instead ask if it would be helpful to tell them about what others have found useful etc. Guiding is a very apt description of this process – advising, listening and adapting to the needs of your patient. Don’t forget to use the elicit-provide elicit model when giving advice. The main focus is on planning, but keep checking in with your patient that they feel OK, and are still committed to change.

The plan is important, since it makes the ideas concrete. Generally, people are more likely to do something if they write it down and make more of a commitment to it. Similarly, it might feel that talking about possible obstacles is being very negative, but research over the years has shown that people who anticipate obstacles when making a behaviour change have more chance of developing a strategy to overcome them and succeed. So don’t be afraid to ask: “what might trip you up, and what do you think we might plan to do about it?” It’s also useful if you share any concerns about the plan – if it’s too vague or too complex, for example. Again, if you say this in the right style, it will be heard and help steer them to success.

Change plan

What will I change?

Why do I want to change?

My main goal is:

I'm going to achieve this with this plan:

<i>Action I'm going to take</i>	<i>When</i>	<i>What can help? (including people)</i>	<i>What obstacles might get in the way?</i>	<i>How will I deal with any obstacles?</i>

How will I know when I've succeeded?

Change plan: what to do...

First agree on what will be changed, and on a goal. This normally shouldn't be such a big step – it's usually best to start off small to build up confidence – but it should always come initially from the patient. It should be realistic, achievable and beneficial if accomplished. Allow enough time in the plan to see it through.

Once the goal is agreed, the next step is work out how to get there. The idea of breaking down a goal into a strategy and a clear target can be useful (e.g. improving adherence > doing my nebs more>doing my nebs in the morning). There will be many choices to be made in how to achieve the goal, and working out the detail is the most important thing now.

How do you choose between the different ways of achieving change? It might appear obvious, or it might be tricky to choose, or change might seem impossible. One useful technique is to use problem solving to generate possible solutions. This works particularly well when the patient or family is involved in generating them. There is a guide to problem solving and a blank pro forma to use on the next page. Briefly, it involves exploring possible ways of achieving change together, writing them down and choosing one to try. This approach actually has a long history in mental health where it is considered a powerful intervention in its own right.



Finally...

You've got the plan, you've got a clear idea of how to get there...don't forget to check in that they are still committed to trying to change, and be prepared to give them some more time if they are not.

A users guide to problem solving

STEP 1: WHAT'S THE PROBLEM?

Describe the problem as clearly as possible, and agree on what you've written.

STEP 2: WHAT'S THE GOAL?

Agree on the goal and write it down. Make sure it's realistic and achievable.

STEP 3: BRAIN STORMING

Everyone is asked to generate possible solutions to the problem. The rule here is that anything goes – from practical to fantastical or wish fulfilment. As they come up, write them down. If you can, write them on sticky notes and pin them up. The aim is to come up with as many solutions as everyone can think of.

STEP 4: WEIGHT THEM UP

For each of the possible solutions, write down the pros and cons as you all see them.

STEP 5: CHOOSE

Select the best and most feasible solution – this is the one to be tried out. Write down exactly how it is to be carried out.

STEP 6: HAVE A GO

Try out the chosen solution.

STEP 7: DID IT WORK?

Evaluate the solution. If it worked, carry one and perhaps extend it. If not, see if it can be adapted or start again.

Problem solving worksheet

Problem

Goal

Possible solutions	Weigh them up		Choose the best
	<i>pros</i>	<i>cons</i>	
1			
2			
3			
4			
5			
6			

The future

We hope you have found these workshops interesting or intriguing enough to spend time practicing and developing these skills, and trying them out with your patients. We can't guarantee that every patient will change, but we do genuinely feel that using this approach ups your chance of success. At the very least it also feels like a very natural, supportive way to talk with our patients.

If you want to develop your skills in MI, practice makes perfect, or at least we just feel more confident about using them! Talking about patients with colleagues and discussing how MI might be used is also incredibly useful.

Finally, if you fancy a read, the best book is still *Motivational Interviewing in Health Care* by Stephen Rollnick, Bill Miller and Chris Butler. If you are interested in developing your skills, there's another new book which is an excellent resource: *Building motivational interviewing skills, a practitioner's workbook* by David Rosengren.

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October 2010

