I. Introduction:
   A. Background
   B. Definition of Motivational Interviewing
   C. Spirit of Motivational Interviewing
   D. Efficacy data review

II. Key Techniques of Motivational Interviewing
   A. Basic skills (OARS)
   B. Advanced skills (EDARS)
   C. Useful Techniques for Creating Change Talk

III. Traps to Avoid

IV. Sample Questions

V. Bibliography

I. Introduction

A. Background
   - Nearly all top causes of mortality have behavioral components important for etiology and treatment
   - Medical providers are ideally suited to be key agents in promoting health behavior change
   - Motivational interviewing provides important tools to promote health behavior change
   - Implementing these skills is realistic but requires shift in attitudes and culture

B. Definition
   - Motivational interviewing (MI) is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence
C. Spirit of Motivational Interviewing

- MI is a method of interacting with patients to assess their readiness for change and to facilitate movement from one stage to the next. This is done by addressing a patient's ambivalence about change, examining their personal pros and cons of change, and facilitating exploration of their personal barriers to change.

- The tone and demeanor adopted when using MI is nonjudgmental, empathic, and encouraging.

- MI is used to selectively illuminate the discrepancy between the patient's desired goal and their current health behavior.

- Understanding change from the patient's point of view is an important aspect of the spirit of MI. Two particularly relevant points are (1) readiness to change is not a client trait but a fluctuating product of interpersonal interactions, and (2) the desire to change should be "elicited," not "imposed".

- MI has been used in many health settings to promote smoking cessation, weight loss, increased exercise, and reduced alcohol and drug use. Originating in the addiction field, MI has now been successfully adapted for brief medical consultations.

- Employing an MI-oriented approach is in keeping with the recommendations for patient-centered communication and is an effective tool used to promote health behavioral change.

D. Efficacy Data Review: Two high quality meta-analysis identified

1. Burke BL, Arkowitz H, Menchola M.
   (*The first meta-analysis of the motivational interviewing)

Table 1. Included Studies

<table>
<thead>
<tr>
<th>Numbers of Studies</th>
<th>Problem Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Alcohol</td>
</tr>
<tr>
<td>2</td>
<td>Smoking Cessation</td>
</tr>
<tr>
<td>5</td>
<td>Drug Addiction</td>
</tr>
<tr>
<td>2</td>
<td>HIV-risk Behaviors</td>
</tr>
<tr>
<td>4</td>
<td>Diet and Exercise</td>
</tr>
<tr>
<td>1</td>
<td>Treatment Adherence</td>
</tr>
<tr>
<td>1</td>
<td>Eating Disorders</td>
</tr>
</tbody>
</table>
**Sample Size:**
Ranged from 22 to 952, median of 206 participants

**Follow-up Length:**
Ranged from 4 weeks to 4 years, with a mean of 18 weeks

**Results:**
- **Comparative efficacy of “Adaptations of Motivational Interviewing” (AMIs):**
  - Of the 30 studies examined, 11 produced at least one statistically significant effect size in favor of the AMIs.

- **AMIs compared with no-treatment, placebo groups or other active treatments:**
  - AMIs were equivalent to other active treatments and superior to no-treatment or placebo controls for problems involving alcohol, drugs, diet and exercise.
  - The efficacy of AMIs for alcohol, drug, diet and exercise problems was in the median range overall (ds around 0.50)
  - AMI interventions were shorter than the alternative active treatments (e.g., cognitive behavioral therapy) by an average of 180 minutes, yet produced similar results.

- **Sustained efficacy of AMIs:**
  - Effects of AMI were sustained at follow-up as long as 4 years post-treatment

- **Clinical impact of AMIs:**
  - Overall, the percentage of people who improved following AMI treatments (51%) was significantly greater than the percentage who improved with either no treatment or treatment as usual (37%).
  - The combined effect size of 11 studies using AMI as stand-alone intervention was large (0.82), with patients reducing their drinking by 56% from about 36 SEC drinks/week to 16 SEC drinks/week after AMI treatment at follow-ups of up to 1 year.
  - 38% AMI participants reported abstinence vs. 18% in the no-treatment or treatment as usual group.
  - Research suggests AMI is efficacious both as a stand-alone treatment and as an adjuvant to enhance other treatments.
AMIs have not shown any significant effects in the areas of smoking cessation or HIV-risk behaviors based on the two studies conducted in each area.

**Benchmarks for comparison:**

- Other meta-analyses for alcohol treatments: brief interventions (4 sessions of treatment) reduced drinking by 4-5 drinks/week vs. AMI reduced average 20 drinks/week.
- 50% patients improved in 8 sessions of psychotherapy vs 50% patients improved in only 2 sessions of AMI.

Table 2.

**Basic Characteristics of Controlled Clinical Trials Involving Adaptations of Motivational Interviewing (AMIs)**

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Problem Area</th>
<th>Dose of AMI (min) Total</th>
<th>Longest Follow-up Interval (% completion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aubrey.1998</td>
<td>80</td>
<td>Alcohol</td>
<td>45</td>
<td>3 months (49)</td>
</tr>
<tr>
<td>Bien et al. 1993</td>
<td>32</td>
<td>Alcohol</td>
<td>60</td>
<td>6 months (72)</td>
</tr>
<tr>
<td>Bosari et al. 2000</td>
<td>60</td>
<td>Alcohol</td>
<td>60</td>
<td>6 weeks (98)</td>
</tr>
<tr>
<td>Brown et al.1993</td>
<td>28</td>
<td>Alcohol</td>
<td>100</td>
<td>3 months (89)</td>
</tr>
<tr>
<td>Gentiello et al.1999</td>
<td>762</td>
<td>Alcohol</td>
<td>30</td>
<td>3 years</td>
</tr>
<tr>
<td>Handmaker et al.1999</td>
<td>42</td>
<td>Alcohol</td>
<td>60</td>
<td>2 months (81)</td>
</tr>
<tr>
<td>Heather et al.1996</td>
<td>174</td>
<td>Alcohol</td>
<td>35</td>
<td>6 months (70)</td>
</tr>
<tr>
<td>Juárez.2001</td>
<td>122</td>
<td>Alcohol</td>
<td>70/50/50</td>
<td>4 years (83)</td>
</tr>
<tr>
<td>Marlett et al.1998</td>
<td>348</td>
<td>Alcohol</td>
<td>60</td>
<td>12 months (83)</td>
</tr>
<tr>
<td>Miller et al.1998</td>
<td>42</td>
<td>Alcohol</td>
<td>120</td>
<td>18 months (76)</td>
</tr>
<tr>
<td>Miller et al.1988</td>
<td>42</td>
<td>Alcohol</td>
<td>120</td>
<td>6 months (98)</td>
</tr>
<tr>
<td>Monti et al.1999</td>
<td>94</td>
<td>Alcohol</td>
<td>35</td>
<td>3 years (85)</td>
</tr>
<tr>
<td>Project MATCH 1997,98.</td>
<td>952/774</td>
<td>Alcohol</td>
<td>240</td>
<td>6 months (89)</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------</td>
<td>---------</td>
<td>-----</td>
<td>---------------</td>
</tr>
<tr>
<td>Sellman et al.2001</td>
<td>125</td>
<td>Alcohol</td>
<td>240</td>
<td>3 years (85)</td>
</tr>
<tr>
<td>Wertz.1994</td>
<td>42</td>
<td>Alcohol</td>
<td>60</td>
<td>6 months (98)</td>
</tr>
<tr>
<td>Butler et al.1999</td>
<td>536</td>
<td>Smoking Cessation</td>
<td>15</td>
<td>1 month (52)</td>
</tr>
<tr>
<td>Colby et al.1998</td>
<td>40</td>
<td>Smoking Cessation</td>
<td>30</td>
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<tr>
<td>Booth et al.1998</td>
<td>192</td>
<td>Drug Addiction</td>
<td>120</td>
<td>3 month (95)</td>
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<tr>
<td>Martino et al.2000</td>
<td>23</td>
<td>Drug Addiction</td>
<td>50</td>
<td>3 months</td>
</tr>
<tr>
<td>Sauders et al.1995</td>
<td>122</td>
<td>Drug Addiction</td>
<td>60</td>
<td>12 weeks (26)</td>
</tr>
<tr>
<td>Schneider et al.2000</td>
<td>89</td>
<td>Drug Addiction</td>
<td>120</td>
<td>6 months (60)</td>
</tr>
<tr>
<td>Stephens et al.2000</td>
<td>291</td>
<td>Drug Addiction</td>
<td>180</td>
<td>9 months (71)</td>
</tr>
<tr>
<td>Baker et al.1993</td>
<td>95</td>
<td>HIV-Risk Behaviors</td>
<td>75</td>
<td>16 months (89)</td>
</tr>
<tr>
<td>Baker et al.1994</td>
<td>200</td>
<td>HIV-Risk Behaviors</td>
<td>30</td>
<td>6 months (84)</td>
</tr>
<tr>
<td>Swanson et al. 1999</td>
<td>121</td>
<td>Treatment Adherence</td>
<td>60</td>
<td>6 months (44)</td>
</tr>
<tr>
<td>Harland et al.1999</td>
<td>523</td>
<td>Diet &amp; Exercise</td>
<td>240</td>
<td>1 year (85)</td>
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<tr>
<td>Mhurchu et al.1998</td>
<td>121</td>
<td>Diet &amp; Exercise</td>
<td>150</td>
<td>3 months (80)</td>
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<tr>
<td>Smith et al.1997</td>
<td>22</td>
<td>Diet &amp; Exercise</td>
<td>150</td>
<td>4 months (73)</td>
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<tr>
<td>Woodlard et al.1995</td>
<td>166</td>
<td>Diet &amp; Exercise</td>
<td>240</td>
<td>18 weeks (80)</td>
</tr>
<tr>
<td>Treasure et al.1999</td>
<td>125</td>
<td>Eating disorder</td>
<td>200</td>
<td>4 weeks (54)</td>
</tr>
</tbody>
</table>
Table 3. Combined Effect Sizes of Adaptations of Motivational Interviewing (AMIs) by Problem Area

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>AMIs compared with no-treatment/placebo control</th>
<th>AMIs compared with active treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(d) (95% CI)</td>
<td>TA</td>
</tr>
<tr>
<td>Alcohol (SEC)</td>
<td>0.25 (0.13-0.37)</td>
<td>0.21 (0.09-0.33)</td>
</tr>
<tr>
<td>Alcohol (BAC)</td>
<td>\textbf{0.53 (0.20-0.86)}</td>
<td>---</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>0.11 (-0.11-0.27)</td>
<td>0.11 (-0.66-0.27)</td>
</tr>
<tr>
<td>Drug Addiction</td>
<td>\textbf{0.56 (0.31-0.82)}</td>
<td>---</td>
</tr>
<tr>
<td>HIV-Risk Behaviors</td>
<td>0.01 (-0.29-0.31)</td>
<td>-0.11 (-0.30-0.29)</td>
</tr>
<tr>
<td>Diet &amp; Exercise</td>
<td>\textbf{0.53 (0.32-0.74)}</td>
<td>0.57 (0.33-0.81)</td>
</tr>
</tbody>
</table>

Effect sizes \((d)\) in bold are significant at \(p<.05\). CI=Confidence Interval; TA=total attrition; SEC=standard ethanol content (a measure of drinking frequency); BAC=peak blood alcohol concentrations (a measure of degree of intoxication); dashes indicates the data were not available.

*The effect size is the difference in outcomes between the intervention and control groups divided by the standard deviation. The effect size summarizes the results of each study in terms of the number of standard deviations of difference between the intervention and control groups. (Guyatt D, Rennie D. User’s Guide to the Medical Literature. AMA Press. P167)

**In this review, effect size means that a person receiving the AMI treatment improved by an average of \(d\) standard deviations on that measure relative to someone in the control group.

***The conventional values of effect size are:

- Small \(d = .20\)
- Medium \(d = .50\)
- Large \(d = .80\)

2. Hettema J, Steele J, Miller WR.

Table 1. Included Studies

<table>
<thead>
<tr>
<th>Numbers of Studies</th>
<th>Problem Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Alcohol</td>
</tr>
<tr>
<td>14</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>6</td>
<td>Smoking</td>
</tr>
<tr>
<td>5</td>
<td>HIV Risk Behavior</td>
</tr>
</tbody>
</table>
Sample Size:
Ranged from 21 to 952, mean of 198 participants

Table 2. Sample Characteristics

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male 54.8% (0-100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Mean Age 34 (16-62)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Minorities 43%</td>
</tr>
</tbody>
</table>

Results:
- Effects of MI across studies, within problem areas, appear early.
- Effects of MI diminish over time, except in additive studies.

Table 3. Effect Size of MI over time

<table>
<thead>
<tr>
<th>Time</th>
<th>Effective Size (d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-treatment</td>
<td>0.77</td>
</tr>
<tr>
<td>4-6 months</td>
<td>0.31</td>
</tr>
<tr>
<td>6-12 months</td>
<td>0.30</td>
</tr>
</tbody>
</table>

Table 4. Mean Combined Effects Size by Problem Area (N=72 Clinical Trials)

<table>
<thead>
<tr>
<th>Time</th>
<th>Effect Size</th>
<th>Problem Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Months</td>
<td>0.71</td>
<td>HIV Risk Behavior</td>
</tr>
<tr>
<td></td>
<td>0.51</td>
<td>Drug Abuse</td>
</tr>
<tr>
<td></td>
<td>0.51</td>
<td>Public Health</td>
</tr>
<tr>
<td></td>
<td>0.44</td>
<td>Gambling</td>
</tr>
<tr>
<td></td>
<td>0.42</td>
<td>Treatment Adherence</td>
</tr>
<tr>
<td></td>
<td>0.41</td>
<td>Alcohol</td>
</tr>
<tr>
<td></td>
<td>0.14</td>
<td>Diet/Exercise</td>
</tr>
<tr>
<td></td>
<td>0.04</td>
<td>Smoking</td>
</tr>
<tr>
<td>Follow-up</td>
<td>0.53</td>
<td>HIV Risk Behavior</td>
</tr>
<tr>
<td></td>
<td>0.29</td>
<td>Drug Abuse</td>
</tr>
</tbody>
</table>
Conclusions:

- Robust and enduring effects when MI is added at the beginning of treatment
  - MI increases treatment retention
  - MI increases treatment adherence
  - MI increases staff-perceived motivation

- The effects of motivational interviewing emerge relatively quickly

- The between-group effects of motivational interviewing tend to diminish over 12 months.
  - This is also true for other treatments.
  - This may not be true of MI’s additive effects with other treatment.

- Effects of MI are highly variable across sites and providers.
  - This is also true of other treatments, but may be more true with MI.
  - Provider baseline characteristics do not predict effectiveness with MI

II. Key techniques of Motivational Interviewing:

A. Basic Skills: Keys to patient-centered counseling: “Use your OARS”

- Open ended questions: *What concerns you about your current situation? Tell me about your drinking.*

- Affirm; *I admire you sharing your fears with me today, it takes a lot to share something so personal*

- Reflect: I. Simple (restate/paraphrase): *You are worried about your drinking.*
  II. Strategic
  A. Amplified: *You can’t see ANY possible benefits to cutting back on your drinking.*
  B. Double Sided: *On the one hand you like the fact a cigarette helps you relax, but on the other hand, you are worried about the health risk of smoking for so many years.*
  C. Reframing: “Nagging wife” reframed as “caring wife”
D. Agree w/ a twist: You don’t see any reasons to quit smoking yourself, since you are currently healthy, despite the fact you know that cigarettes led to your father having a heart attack at an early age.

- **Summarize:** “You are not quite sure you are ready to make a change. On the one hand, alcohol helps you relax and you enjoy going out drinking with your friends, however on the other hand, you are aware that your drinking has raised concerns from your wife and your boss, and you are worried it might even lead to problems with your liver if you keep on this path.”

**B. Advanced Skills: The ABCs of MI**

- **Express Empathy:** Express acceptance, affirmation in genuine, respectful way
- **Develop Discrepancy:** Explore patients’ concerns and perspectives, help pt see discrepancy b/w current behavior & future goals
- **Analyze Ambivalence:** Explore and help resolve patients’ ambivalence
  Use of decision balance (The good, the not-so-good)
- **Roll with Resistance:** Avoid arguing with patient
  Instead, try these tools:
  - Use reflections in response to resistance talk
  - Emphasize personal control
  - Ex. “Only you can decide what is best for you.”
  - Shift focus using a summarization
  - Give paradoxical challenge (arguing against change)
  - Ex. “You’re not even sure if you could quit, even if you wanted to.”
  - “This may not be for you”
  - “No matter what happens in life, your smoking will always be a part of it.”

- **Support Self-Efficacy:** Emphasize personal choice and control

**C. Useful Techniques for Creating Change Talk**

- Exploring personal goals/values
  What are your goals for your life? What do you value most?
- Decision balance (the good, the not-so-good)
  “There are always 2 sides to change, the good things, and the not-so-good things. Maybe we could spend a bit of time thinking about how you feel about your drinking. What are some of this good things about drinking? What are some of the not-so-good things?”
C. Useful Techniques for Creating Change Talk (continued)

- Imagine extremes
  *If you continue drinking, what do you think is the worst thing that could happen? If you tried to reduce your drinking, what do you think is the best thing that could happen?*

- Hypothetical change
  *Suppose you did make this change, what do you think it was that made it work? How did it happen?*

- Review a typical day (present)
  *Tell me a little bit about what life is like for you, describe your typical day.*

- Looking back (past)
  *“Tell me a little bit about what life was like for you before you started drinking.”*
  *“What’s different now?”*

- Looking forward (future)
  *“Looking ahead 5 years, what would you like your life to be?”*
  *“How does what you’re doing right now fit into that?”*
  *“What would your life be like in 10yrs if you kept on the same track?”*
  *“What would it look like if you did make the change to quit drinking?”*

- Imagining extremes
  *“What’s the worst thing you could imagine would happen if you continued the way you’re going now?*

- Assess importance, readiness, confidence (0-10 scale)
  *“How important is it for you, on a scale from 1-10, to change any aspect of your drinking?”*
  *“How ready are you to make that change right now, on a 1-10 scale?”*
  *“How confident are you that you can make that change, on a 1-10 scale?”*
  *“What made you say a ’4’ and not a ’1’?”*

- Review past successes, reframe past failures
  *What has worked for you in the past, when you made up your mind to make a change?*

- Review personal strengths/supports
  *What strong points do you have that could help you make this change?*

III. Traps to Avoid:

- “Expert” stance (goal is collaborative partnership, empower patient)
- Arguing for change (remember, let the patient be the one to argue for change when he/she is ready)
- Question-answer (leads to a passive role in the patient)
- Premature focus (a set up for failure, need to lay foundation first)
- Assigning blame, labeling (not conducive to lasting change)
- Advice without permission (avoid authoritative relationship)
- Doing most of the talking (the patients words have greatest impact)
IV. Additional Sample Questions

Openers:
- Would you mind spending a few moments talking about your drinking and how you see it affecting your health?
- How do you feel about your drinking?
- What concerns you about your current situation?
- How does alcohol affect your life?

Open ended:
- Tell me about...
- I’d like to know more about...
- What else?
- How do you think your drinking fits in with those goals?
- What do you think your wife would say are the not-so-good things about your drinking?
- What would have to happen for you to know that this is a problem?
- What would be some advantages of not drinking?
- How might you go about a change? What would be a good first step? What obstacles do you see? How might you deal with them?
- What barriers are keeping you from changing now?
- What things have helped you in the past?
- What would get in your way of stopping smoking?
- What would it be like for you to not drink?
- What is your plan? How are you going to do this?
- What would it take for you to consider thinking about a change?

Affirmations:
- You’ve obviously thought a lot about this issue.
- You really express yourself well and you have a lot of insight into this matter.
- Thank you for sharing this with me today.
- I admire you sharing your fears with me today, it takes a lot of courage to share something so personal.

Raise client awareness:
Give feedback with permission, non-confrontational, use objective data if possible
- What do you make of these results?
- Is this right for you? What do you think about it?
- Is there anything else you would like to know about the topic?
- Here are some options for change, what do you think would work best for you?

Closing:
Give advice w/ permission:
- “I have some ideas, would you like to hear them?”
- “Here’s something that’s worked for others, it may not be a fit for you, what do you think?”
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