



## REVIEW ARTICLE

## Motivational Interviewing Skills: A Tool for Healthy Behavioral Changes

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### Abstract

Applying the principles and essence of motivational interviewing in everyday primary care practice has been proven effective in promoting “behavioral change” which presents and improves positive health outcomes and enhances the patient-counsellor relationship.

### Introduction

A patient’s motivation consists of a dynamic state of constant behavioral change, which can be swung and influenced in response to the counsellor’s style. On the one hand, it may discourage change and increase the patient’s resistance if the counsellor’s style is authoritative or paternalistic in nature [1]. Nevertheless, if the counsellor adopts a “goal-directed approach” with a “patient-centered counselling style”, it may enhance the patient’s desire to change and decrease resistance [2]. Motivational Interviewing (MI) is a patient-centered counselling style; it is focused on patient coaching rather than on instructing the patient (Table 1) by increasing the levels of individual engagement and contribution in their treatment or behavioral change [3].

There are many aims of MI; to promote and increase patient motivation towards positive behavioral change, as well as to explore and then resolve any negative issue(s) or experience(s) of conflict. MI addresses a patient’s current functional state, and also considers the patient’s variable degree of readiness to change [3,4].

The benefits of MI uses are vast [5], it appears to be non-confrontational, non-judgmental and supportive type of counselling, with various empathetic styles. It

encompasses mentoring and non-direct coaching and is patient-centered [3]. MI is supported by many scientific researches, with successful favorable results in different high-risk populations. MI can be useful in brief sessions. It can also be used and learned by non-specialists [3,5].

### Case Study

A thirty-five years old male came to primary care clinic with a history of controlled hypertension for one-year duration of treatment. He was a chronic heavy smoker (30 cigarettes/day) for the past 20 years. The counsellor considers offering to counsel on smoking cessation. How can the counsellor offer evidence-based motivational interviewing skills for smoking cessation?

### Discussion

MI skills can apply to many candidates. MI can be used on a patient with an unhealthy behavioral problem (e.g. counselling for smoking cessation, better nutrition, starting physical activity, etc.). Additionally, it can be used on a patient with problems in treatment/medication adherence (e.g. to encourage taking medication routinely, maintaining medical appointments, individual and/or group counselling) [3-6].

MI has been recently used on patients with substance and/or alcohol abuse problems (e.g. cocaine, morphine, marijuana, alcohol). Psychologists can use MI on patients with harmful behavior(s) (e.g. anger management, resistant management, gambling management) or to patients with risky sexual behavioral problems (e.g. safe sex practice) [3-6].



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**Table 1:** Traditional (Instructor) Approach in Comparison with Motivational (Coach) Approach [4].

| Traditional (“Instructor”)   | Motivational (“Coach”)   |
|--|--|
| ~ Focused on correcting the patient’s perceptions.                   | ~ Focused on exploring the patient’s perceptions.                                  |
| ~ Emphasis on the sickness aspect of the problematic behavior.       | ~ Emphasis on how to improve personal choices in relation to problematic behavior. |
| ~ Focused on convincing the patient that there is a problem.         | ~ Focused on eliciting the patient’s concerns about the problem.                   |
| ~ If the patient displays denial, it will be met with argumentation. | ~ If the patient displays denial, it will be met with reflection.                  |

**Table 2:** Principles of Motivational Interviewing Applied on a Patient-Doctor Scenario [1,19].

| Principles                                | Patient Talk  | Counsellor Reply   |
|---|---|--|
| Ask Open - Ended Questions                | I have been smoking for a long time.<br>I have been diagnosed with hypertension recently (e.g. within the last year).   | I understand you have some concerns about your smoking. Can you tell me more about your smoking?   |
| Express Empathy                           | My work needs much concentration but I am always distracted.<br>Smoking helps me to focus on my work.   | I understand that work causes you stress. I am sorry to hear that.<br>I understand how important it is for you to excel at work.   |
| Make Affirmative Statements               | I am now worried about the other consequences of smoking, can it affect my health?  | Thanks for coming today.<br>I am sure it took much courage for you to come and talk about your smoking habit; I am here to hear you out.                                       |
| Use Reflection                            | I only enjoy smoking after I wake up or after a cup of coffee...that is all. Smoking helps me to relax and have fun...I do not believe I have a problem, but my wife sure does. | You enjoy the effects of smoking regarding how it helps you to increase your concentration during stressful days at work.  |
| Highlight Discrepancies                   | It is hard for people to understand how helpful smoking can be to me.   | Why do you think your wife has that impression?<br>So smoking provides good things for you...Now tell me about the not-so-good things you have experienced because of smoking. |
| Highlight Disadvantages of the Status Quo |   | What benefit do you think quitting might have on your health?  |
| Highlight Advantages of Change            |   |  |

Psychiatric counsellors use MI on patients with psychological diseases (e.g. stress management) or on patients who are hesitant to complete recommended screening, diagnostic tests or specialist/allied health/psychologist referral or even on patients with chronic pain (e.g. pain management) [3-6].

Primary care counsellors can use MI on patients with high early-outcome indicators of chronic disease (e.g. high HbA1c, high lipids or high albumin creatinine ratio) or patients with high late-outcome indicators of chronic disease (e.g. diabetes neuropathy, hypertensive with left ventricular hypertrophy) [6-17]. There are many barriers to effective implementation of motivational interviewing in practice such as time pressure and counsellors’ aversion towards adopting MI [18]. The essence of MI is an overall spirit of collaboration, evocation and honoring of the patient’s autonomy, with the role of a counsellor being a facilitator rather than advocate, authoritative, paternalistic or confrontational style [1] (Table 2).

When applying MI, some important key points should be taken into account, namely proposing different solutions and allowing the patient to explore and choose the most appropriate option. This will increase the patient’s chances to reach acceptable resolution to his/her own behavior changes [1,3,6,18,19]. MI aims to identify the patient’s personal goals and values and to stimulate behavior

change [1,18,19]. MI should be used in brief and collaborative sessions while maintaining a friendly relationship to have a dramatic positive result and resolve ambivalence [1,18,19-20]. A counsellor should avoid aggressive confrontation and/or arguments, and instead use a patient-centered approach to elicit, clarify and resolve ambivalence in a respectful counselling environment. Resistance and denial are generally not patients’ clinical trait, although it is a signal to the counsellor that their motivational strategies require change and modification [1,18,19]. Whilst a therapeutic approach is more likely to increase the patient-counsellor rapport, patients’ autonomy must still be respected. Most patients’ resistance to change is typically induced by environmental circumstances rather than as a result of a personal weakness. A counsellor should not take it personally nor label the patient as ‘resistant’, ‘unmotivated’ or ‘lacking insight’ [1,18,19]. There are four general principles behind motivational interviewing, which will be set out below [20,21]. Firstly, it is necessary to express empathy by seeing, considering, feeling, and sharing the patient’s experience. The counsellor’s attitude must gear towards a better understanding of the patient’s behavior by using skillful reflective listening techniques fully to understand the patient and his/her experience. This will enable the patient to be more willing to accept change, engage in a gentle open discussion of lifestyle issues and correct disbeliefs [20,21].

Secondly, the counsellor should have faith in the patient's self-efficacy to invoke proper personal change (an important motivator). The patient's responsibility is to choose and carry out action, whereas the counsellor's focus should be on helping the patient stay motivated and supporting their sense of self-efficacy. The counselor's role is to lift the spirits of patients through a range of available approaches; there is no one "right way" to change [20,21].

Thirdly, the counsellor should clarify any inconsistencies the patient might be transitioning through by opening the patient's mind to comprehend the difference between the patient's current behaviour and life goals. The counsellor should explore with the patient the potential consequences of the the patient's current behaviours. Fourthly, the counsellor should not fight the patient's resistance, but instead learns to "roll with it". As a result, the patient's resistance will decrease. However, if the patient's resistance persists, the counsellor should use another way to proceed. A new style of "small, focused and goal-approach" that the patient can surely succeed at such as; asks the patient: "If you had one eating habit that you could change, one that would improve your health, what would it be?" "What do you think you could cut that down to?" [20,21]. To have positive effects on patients' motivational levels, the counsellor should be able to invoke a sense of proximity and the skill of empathy [1]. Furthermore, the counsellor should avoid confrontation and arguments, whilst attempt to shift and clarify the patient's perception. The counsellor should also invite the patient to examine a new perspective, but without imposing it. Most importantly, the counsellor must value the patient as a resource for finding solutions to the problem [21] (Table 2).

The worthwhile requests of MI in practice are two

crucial phases: Building the motivation to change, and strengthening the commitment to change [1,19].

These basic counselling techniques assist in building rapport and establishing a therapeutic relationship that is consistent with the spirit of MI [3]. Strengthening commitment is by approving patient's goal, also to negotiate any change of action plan. The goal-directed approach will clear the patient's uncertainty and the counsellor's obstruction. The effective strategy is to avoid the trap of eliciting 'change talk'. There are many approaches to provoke 'change talk', by enquiring about disadvantages of continuing in the current situation or by asking the patient about some advantages of making a change. Ask the patient how they perceive to excel and ask the patient what are their intentions for change [1]. Lastly, to decide on using a 'Change Plan' together, rather than the counsellor instructing or directing the patient [1,18,19] (Table 3).

For easy (MI) practice, we should remember the acronym RULE: The counsellor should resist giving a direct plan to the patient or resist the correcting reflex; the counsellor should understand and enhance the patient's motivation; the counsellor should listen to the patient attentively with an empathetic approach; and then the counsellor should empower the patient for new change [1,20-22].

The counsellor needs to know "where" and "why" the patient's journey towards change has been stopped; by knowing been which stage of the change cycle has reached, and to understand why the patient was reluctant, ambivalent and frustrated to take the next step [1,20].

There are six stages of change which are useful for

**Table 3:** How to Elicit Change Talk with Patient-Doctor Scenario [1,19].

|                       | Patient Talk   | Counsellor Reply  |
|-----------------------|--|---|
| Support Self-Efficacy | I am going to give it a try, but I think I will fail just like I have before.<br><br>I am wondering if you can help me.<br><br>I hope things will be better this time.   | It seems confusing at first, however I am willing to provide you with all the support you need.<br><br>As long as you are willing to continue in the process.   |
| Optimism for Change   | I have an experience in which I quit for one year, and I felt so much healthier. It was challenging in the beginning but I succeeded later on. 'I want to manage my hypertension better'   | Yes, you are the hero in your life. I think you look at life differently, but how did you do it?<br><br>You have a lot of internal motivation and strength to make a change. You are the expert in your own life and I am an expert of different modalities of what the evidence shows us and what other people have done in your situation'. |
| Intention to Change   | I do not want to live in a weak state like this. I want to have some progress in my health and energy to enjoy my social life and my work.   | In what ways do you want your life to be different within the next year?<br><br>If you could take one small step, what would you start to change?   |
| Change Plan           | Counsellor, I want a full plan to quit smoking and to have better control over my blood pressure.  | If you fix the small changes, what do you think next?<br><br>We have started from here, where do we go next?<br><br>How would you like things to progress?  |
| Use Agreement         | Counsellor should identify a specific, simple and attainable goal for the patient, and then the patient should confirm the near-future achievement, then the counsellor should draft a patient-counsellor agreement in the patient's file. |   |

selecting appropriate interventions. By identifying the patient's position in the change process, the counsellors can tailor the method of intervention with skills they already have. The focus is not to convince the patient to change their behavior but to help the patient move along through the stages of change [1,19,23].

The initial "pre-contemplative" is the stage where the patient is not thinking about change and is unaware of any problem related to their risky behaviour, and is unconcerned about their behaviour and ignores anyone's belief that they are doing something harmful. The counsellor should not assume that the patient is ready to change; rather the counsellor should discuss the patient's feelings and experiences, and should provide the necessary health education and start with the small chunks [20-22].

Whilst the patient is at the second stage which is the "contemplation" stage, the patient is considering whether or not to change since they enjoy their normal lifestyle, but they are sometimes worried about the complications they might develop, and they are constantly debating with themselves whether or not they have a problem. The counsellor's roles are to consider the benefits and barriers to change, to identify the participant's personal reasons for wanting to make a change, and to have the patient identify his/her own motivation in order to encourage short-term achievable goals [20-22].

The third stage is the "determination/preparation" stage that in which the patient decides how they are going to change, and whether they may be ready to change their behaviour or at least get ready to make the change. The counselor's role is to be supportive, to reinforce all positive progress to help the patient build their self-confidence, and to help the patient monitor the barriers encountered in the gains and decreases and to consider that it may take a long time to move to the next stage (action) [20-22].

However, the second and third stage (contemplation and preparation stage) are phases of ambivalence, where Motivational Interviewing (MI) is an operational counselling method that augments motivation through ambivalence resolution. The three critical components of ambivalence motivation are; checking the patient's perception of the importance of change (willingness to change), checking the patient's level of confidence in connection with change (ability to change), checking the patient's urgency to change (readiness to change). Accordingly, the readiness phase is influenced by a mixture of two factors: How important is the change to the patient? Moreover, how confident is the patient to make the change? [23].

The ambivalence phase is an innate struggle, where conflicting attitudes or feelings coexist in an individual and they are interlocked simultaneously either wanting to change or not wanting to change [1].

The signs of a patient's readiness to change are many

such as they are less resistant, or they have fewer questions about the problem. Alternatively, the patient expresses more self-motivational statements, or the patient has more questions about change, or the patient is looking forward and is seeking to experiment new aspects in respect of change [23].

Successful progression through the ambivalence stages leads to the action stage (fourth stage), where the patient will take the essential footsteps to achieve the change, and start the changing experience. The patient will need help to identify practical steps and to recognize high-risk situations and new coping strategies. Accordingly, the role of counsellor is to provide continuous encouragement, and to discuss ways to slowly increase the Frequency, Intensity and Time (FIT) to help the participant to plan for changes in routine, such as vacations or illness, so that they can stay on track [23].

If the patient has successfully entered the action stage, which eventually will lead to the final stage, the maintenance stage (fifth stage), where the patients will seek to sustain and tolerate long-term changes beyond six months. The counsellor's roles are to praise and provide feedback, as well as offer community resources by way of further help and support [3].

In the event of the patient relapsing (sixth stage), there is still a re-initiation plan for the patient. People usually make several attempts to quit before being successful. The process of change is rarely the same in subsequent attempts. The role of the counsellor is to remind them that lapses are temporary and can be viewed as a learning situation about sustaining maintenance shortly rather than a failure. Likewise, it is an attempt to incorporate a new experience gained from the previous attempts. Someone who has relapsed is not a failure; instead it is a part of the recovery process [23].

## Conclusion

The counsellor should bear mind some essential principles that the patient's motivation cannot impose from an external entity; it is the patient's task to resolve their ambivalence. The counsellor should not concentrate on persuading patient to change their behavior. The counselling style should concentrate on the patient's thought process by using a partnership or companionship rather than expert/recipient roles. The counsellor needs to get a sense of what the patient's goals and interests are and not what you think they should be; which can be achieved by letting the patient set goals. If the patient is at the stage of "pre-contemplation" stage of the change cycle, the counsellor can move on and release the pressure off the counsellor's shoulders whereas criticizing them or trying to scare them is not beneficial and is also time-consuming. Patients dislike a lecturing style and they like to make changes on their own. Using the MI technique lets the patient feel comfortable in discussing their risky problematic behaviors with you. The MI approach is to present infor-

mation in a non-judgmental, neutral context about the risks of continuing such behavior vs. the benefits of adopting a new behavior. The counsellor should adopt the MI approach in ambivalent patients to help them to explore and resolve their inconsistencies and to increase their motivation so as to adopt a new change.

## Potential Conflicts of Interest

None.

## Competing Interest

None.

## Sponsorship

None.

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