CHAPTER 1

Why Another Book on Motivational Interviewing?

Motivational interviewing (MI) is a powerful patient-centered counseling approach that optimizes the possibility that patients will consider and implement health behavior change. In many organizations, it is the centerpiece in the implementation of the patient-centered medical home. MI requires that we attempt, in a caring, nonthreatening, nonjudgmental way, to understand and explore how patients make sense of health and illness. MI views the patient as a collaborative partner with expertise every bit as valuable as our own. As health care professionals (HCPs), we act as a caring resource to assist patients in making better decisions about their health. Ultimately, it is not we but the patient who decides.

The literature is replete with examples of studies demonstrating the effectiveness of MI in increasing patient and provider satisfaction and producing better outcomes. We conducted one such study for Biogen Idec involving its interferon beta-1a product Avonex for multiple sclerosis.[1] In a randomized, controlled clinical trial, a significantly lower proportion of patients in the MI intervention group (1.2%) than in the standard care group (8.7%) discontinued treatment with the drug. In addition, movement toward continuation of therapy was significantly higher in the intervention group. Given that the drug was a weekly injection that at the time of the study cost approximately $200 a dose, 9000 fewer dropouts from treatment with the

drug represented a $93,600,000 cost recovery per year (9000 patients × $200/dose × 52 weeks/year = $93,600,000). These powerful results demonstrate our belief that MI can bring about major health behavior change by patients.

Given the extensive literature on MI, we begin by answering the question, "Why another book on MI?" We believe we have unique experiences and expertise in health care that will make this book especially useful for physicians, pharmacists, nurses, physical therapists, dietitians, social workers, and other professionals who work with patients. We will present a new and exciting theoretical basis for MI that will help HCPs understand why MI, when fully implemented, is so powerful. We believe that knowing this theoretical basis will help HCPs understand how to better respond to their patients and to positively influence their patients' decision making. The book will provide HCPs with insights into what kind of talk behaviors and introspective reflection are needed to assist patients in moving forward with health behavior change.

We would be remiss if we did not acknowledge our gratitude to the landmark work and thinking of William Miller and Stephen Rollnick in developing and refining the concepts and principles of MI. Their initial conception of MI and their ongoing commitment to compassionate care for patients and clients have inspired thousands of disciples of MI, including us. Without these foundations, this book would not have been possible.

Teaching MI in health care

The book is the culmination of our more than 20 years of teaching and research on MI with HCPs. We describe what we have learned about teaching MI to HCPs and health professional students. We believe there are three fundamental differences between teaching MI in health care and teaching MI as originally conceptualized for substance abuse: (1) the training of HCPs, (2) the nature of the patient or client, and (3) the context of treatment. The relationship between an HCP and a patient is often vastly different from the relationship between a counselor or psychologist and a client.

First, the training of counselors is vastly different from that of HCPs. Counselors are taught to talk differently to patients. They are taught that their role is to explore patients' problems and that the patients must eventually draw their own conclusions if change is to occur. Counselors see their role as being supportive and caring and providing insight. The patient is in charge, because it is the patient's life and therefore the patient's decision.

HCPs are taught that they are the experts and that they are in charge. This orientation creates many problems for HCPs in adopting patient-centered approaches. HCPs have to learn an entirely different way of talking, which counselors have already learned before they are exposed to MI. When learning MI, HCPs must learn that they are *not* in control and that they are *not* the only expert in the room. Patients are experts, too. They are experts on their lives, their goals, and their aspirations. Equally important, they are experts on their sense making. How do patients make sense of what is happening to them? What is their understanding of diabetes, or high cholesterol, or hypertension? What is their understanding of what can happen if these illnesses are not treated? How does the way patients make sense of their illness and treatment affect their motivation for change and their emotional responses to the diagnosis and treatment? Generally speaking, patients will develop their own theories and lines of reasoning about all of these things.

Before our expertise can be useful, we need to understand what the patient knows, understands, and believes. And we must respectfully acknowledge these things at the outset. Without understanding how patients construct their ideas about illness and risk, HCPs really cannot know what information or education might be useful or meaningful to the patient. Unfortunately, the medical model (implemented as a clinical workup) often is mechanical and formulaic and does not thoroughly take into account the patient's perspective. The clinical workup is quite linear: Do this, then this, and finally this. But patients are not linear. They may not be ready to be "worked up," and it is folly to skip to the workup without first finding out how patients are making sense of what is happening to them. It is their story, not ours. In many ways, MI must undo and replace the medical model in which the clinician is the sole expert and in control. This is no easy task. HCPs have been used to giving directions, telling patients what to do, and then blaming patients when there is "failure." The approach taken by MI is one of guiding patients, not dictating to them. It is about providing patients with options that fit the patient's larger goals. This requires learning how managing asthma or diabetes or cholesterol, for example, aligns with the patient's broader aspirations.

Another profoundly important distinction between HCP training and the training of counseling and clinical psychologists is the issue of introspection. Counseling and clinical psychologists are trained to be introspective and conscious of how their own needs or issues could affect or contaminate the relationship. Through practicums and mentoring in their training, they are made aware of these needs

so that they do not interfere. Interestingly, despite the fact that HCPs are going to work directly with patients concerning their health and critical decisions about their health, the curricula experienced by many HCPs now in practice did not in any appreciable way broach the subject of introspection, consciousness, and transference and countertransference. Current curricula do focus on reflective practice; however, the focus is often on decision making, knowledge, and skills. Greater emphasis is needed on personal and introspective reflection by HCPs to assess how one's self-concept affects interactions with patients. Moreover, personal reflection of this nature must be guided and mentored by someone with expertise at identifying and resolving these issues in practitioners and students. Any training of HCPs must address this subject. It is simply too important to ignore—especially in learning MI.

A simple example should help: After intensive training in MI a nurse expressed her frustration with many of her patients. She said, "I'm a doer. I get things done. Many of them just don't want to move forward, and then I find myself getting frustrated and I forget what I have learned about MI." The nurse was asked the following questions: "When your patients don't move forward as fast as you would like, what rewards that you get as a doer have to be suspended? How does that affect how you see yourself and your success with the patient? In other words, can you see a time when you will be able to bear not defining your success through your patients' decisions? Can you suspend being a doer?" These questions had a profound impact on this nurse, and she began to see how her definitions of success and self were actually undermining her ability to be fully present (caring, nonjudgmental, and patient). So, in addition to having to learn and master the skills and spirit of MI (which fly in the face of the standard medical expert model), HCPs also must learn to become introspective and aware of how their personal assumptions and issues can interfere with their ability to influence patient decision making in a positive and nonthreatening way. This makes learning and mastering MI even more difficult for HCPs.

In addition to issues surrounding HCP training, patients with chronic illness are different from clients struggling with substance abuse or marital discord. Traditional MI assumes that patients have everything they need internally to make changes. The role of the counselor is to help patients discover and activate those resources and come to better conclusions about their behaviors. Keep in mind that MI was developed in work with patients with substance abuse problems. We agree that at some level patients with personal or substance abuse problems often know all the pros and cons associated with their behavior. On the other hand, although patients managing

chronic illness have the same set of internal psychological resources, they often do not have everything they need to manage an illness (e.g., diabetes). Patients often have misconceptions about the illness and its severity, especially if it is left untreated. This is particularly true if the illness is asymptomatic. Sometimes patients don't see the point in treating their illness because they "feel fine." A well-trained HCP, using MI, can assist the patient in making healthier decisions by filling in gaps in the patient's understanding or knowledge and then inviting the patient to respond to this new information. A well-trained HCP using MI is aware that without a strong foundation of rapport with the patient, information provided by the HCP can be interpreted by patients as a way of putting them in their place or correcting them, rather than as an extension of the caring provided by the HCP.

Finally, HCPs often use MI in a different treatment context than substance abuse counselors, because HCPs often do not have the luxury of repeated 50–60 minute encounters. Many times, the HCP may have only one chance to make an impact on the patient, because continuity of care is not where it needs to be in health care. Therefore, the approach taken here leans toward brief MI in the form of 5–30 minute encounters.

We have made the argument that training HCPs in MI is different from and often more difficult than training counseling or clinical psychologists. The previous training of HCPs often is in opposition to MI principles. In addition, patients with chronic illness often lack knowledge or information to make good decisions; they need to be presented with new information to reformulate their sense making before they can make a decision to engage in behavior change. And the context of the patient–client relationship in health care makes brief encounters even more critical.

Having realized these differences, we attempted to improve our teaching of MI to HCPs. We quickly found that we had to recast the basic explanation of MI in order for HCPs to understand what was happening in the course of their interaction with patients. What was self-evident to counselors was thoroughly puzzling to HCPs. For example, counselors could be presented with a simple description of basic MI tools (summarized in the form of the READS or OARS acronyms, which we discuss in later chapters) and could envision how these tools might be used with the patient. In contrast, HCPs struggled with where, when, and how to use these tools. They struggled to be able to see the smooth flow of MI that develops when MI tools are used appropriately to respond to the issues and concerns expressed by the patient. So, we started to use communicative and psychological concepts familiar

to us to explain and illustrate the flow of MI. Slowly, over time we have developed a theoretical description of MI that helps HCPs to grasp the profundity of what is happening in MI. In our theoretical description of MI we are not only describing the heart of MI in a different way but also starting to specify two underlying dimensions of MI that are essential for its optimal implementation. In this sense, we view our theoretical formulation of MI as a response to the call by Miller and Rose[2] for a more developed theory of MI.

Relational resistance and rapport building

Recently, in the latest edition of their classic work on MI,[3] Miller and Rollnick have refocused the theory of MI on how to work with ambivalence in the patient. In doing so, they no longer discuss the READS principle of "roll with resistance," and they postpone the discussion of resistance until late in the book. We have taken the opposite direction in our theoretical description of MI, by highlighting resistance over ambivalence. Although we concur that ambivalence is alive and well in patients who have chronic illness, we also believe that resistance is active in many patients. Furthermore, HCPs are much more inclined to think of patients as being resistant rather than ambivalent. Consequently, we have focused on how to use MI to address resistance in patients. We have distinguished two kinds of resistance: issue resistance and relational resistance. Issue resistance (or ambivalence) resides in the patient's reasoning or sense making about a behavior: "I'm not ready to quit smoking right now, because I just have too much stress in my life"; "I feel fine, and I don't see why I need this medicine"; "I'll take the medicine, but I am not changing my eating habits." Relational resistance concerns *how* we respond to the patient about issue resistance. When we fail to build rapport with the patient and disrespect the patient's thoughts and concerns, the patient suffers loss of face and may react with resistance to any possibility of change. Chapter 4 details our formulation of this dynamic and how it can affect health outcomes. Although we concur with Miller and Rollnick that importance and confidence on the part of the client are critical to behavior change, we have found that

1. The interaction between rapport and addressing the patient's judgments of importance and confidence is more than additive; it is synergistic, and
2. This synergy energizes the possibility of change.

When HCPs accurately empathize with the core concerns and lines of reasoning at the heart of the patient's sense making, the resulting rapport gives HCPs the leverage to use their expertise in a way that allows the patient to see that expertise as an extension of caring rather than as a way of putting the patient down. This has been a critical discovery that we will present as the heart of our approach to MI.

REFERENCES

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