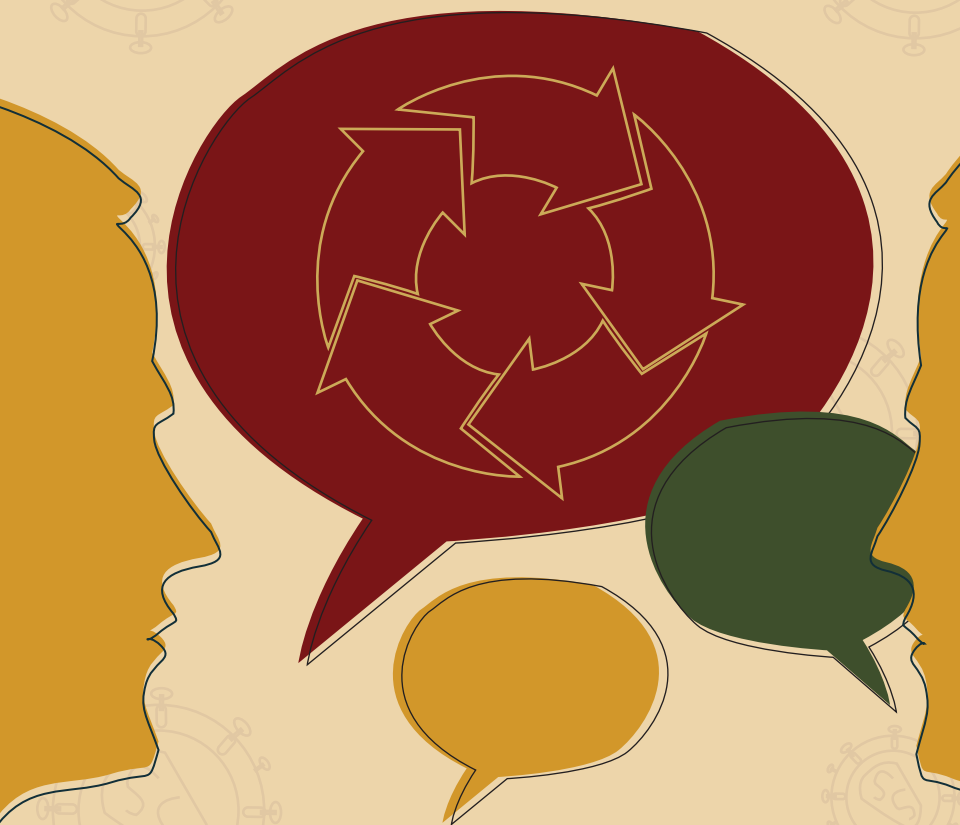


# MOTIVATIONAL INTERVIEWING & HIV REDUCING RISK, INSPIRING CHANGE

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**Motivational Interviewing and HIV:  
Reducing Risk, Inspiring Change  
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## REDUCING RISK, INSPIRING CHANGE

Nowhere is the need to change behaviors more important than in HIV infection. Changing risky behaviors can prevent infection and people living with HIV (PLWH) have better outcomes when they are able to change to healthier behaviors. Some important changes individuals can make to prevent or live better with HIV include:

- Modifying use of tobacco, alcohol, and illicit drugs
- Adopting consistent condom use
- Exercising regularly
- Eating foods high in nutrients
- Taking antiretroviral therapy (ART) and other medications as prescribed
- Keeping regular appointments with a care provider

**The “spirit” of MI is like dancing rather than wrestling. It is collaborative, evocative, and honoring of patient autonomy**

This publication provides a succinct overview of Motivational Interviewing strategies within the context of the Stages of Change Model to reduce risk and support PLWH in the pursuit of healthy behaviors.

### What is Motivational Interviewing?

Motivational Interviewing (MI) is a communication strategy that is directive and patient-centered. The goal of MI is to help patients explore and resolve ambivalence in order to change unhealthy or problematic behaviors. The heart of MI is a spirit of empathy, acceptance, respect, honesty, and caring (Moyers, Miller, & Hendrickson, 2005).

Originally published in 1991 for substance abuse counseling, the MI approach has been studied in more than 200 randomized controlled trials for various health behaviors (Miller & Rollnick, 1991; Rollnick, Miller, & Butler, 2008).

Research has shown that:

- MI enhances change for a range of behaviors, including diet, exercise, medication adherence, reducing the use of alcohol and illicit drugs, safer sex practices, and medication adherence (Burke et al., 2003; Hettema et al., 2005; Rubak et al., 2005).
- MI also works for smoking cessation, although its effects are less dramatic than for other health behaviors (Hettema & Hendricks, 2010). MI does work as well as other smoking cessation methods, potentially in a shorter amount of time.
- Adding MI to other active treatments improves outcomes.
- When MI is compared to other established counseling methods, outcomes are similar despite the lower intensity of MI. MI produces positive outcomes at lower cost and effort.
- MI works well with patients who are angry, resistant, or less ready to change. One of the original studies offered a “drinker’s check-up” to patients with unacknowledged alcoholism. MI helped these patients change their drinking, without first requiring them to admit to having a problem (Miller & Rose, 2009).
- MI is less effective with patients who are already clearly committed to change and ready for action. These patients may benefit from more active problem-solving support instead.
- MI works well with minority populations. It has characteristics that fit with the Latino cultural values of *respecto* and *personalismo* (Anez, Silba, Paris, & Bedregal, 2008), and has larger effects with African American patients than with White patients (Miller & Rose, 2009). MI has also been adapted specifically for Native American patients (Tomlin, Walker, Grover, Arquette, & Stewart, n.d.; Venner et al., 2006).
- MI has been tested primarily in adults, but it is also effective in changing behaviors for adolescents (Berg-Smith et al., 1999) and children (Lozano et al., 2010; Resnicow, Davis, & Rollnick, 2006; Schwartz et al., 2007; Suarez & Mullins, 2008; Weinstein, Harrison, & Benton, 2006).

- MI has also been adapted for use in palliative care (Pollak, Childers, & Arnold, 2011).
- MI works quickly; you get results from your efforts right away (Rollnick, et al., 2008).
- Training in MI improves patient communication and lifestyle counseling behaviors (Söderlund, Madson, Rubak, & Nilsen, 2011). Primary health care providers report that using MI improves and enriches their practice (Brobeck, Bergh, Odencrants, & Hildingh).

## WHO CAN USE MOTIVATIONAL INTERVIEWING?

MI can be delivered by patient counselors from many different professional backgrounds, including nurses (Cook & Sakraida, 2006), pediatricians (Lozano et al., 2010), dentists (Weinstein et al., 2006), patient educators (Cook, Bremer, Ayala, & Kahook, 2010), pharmacists (Basiago, 2007), school nurses (Robbins, Preiffer, Maier, LaDrig, & Berg-Smith, 2012), teachers (Cook, Richardson, & Wilson, 2012), and mental health and substance abuse professionals (Miller & Rollnick, 1991).

- Although MI has traditionally been delivered in a one-to-one in-person format, research suggests that it is also effective when delivered in a group setting (Santa Ana, Wulfert, & Nietert, 2007), or by telephone (Cook, 2006).
- Ongoing studies will help to determine whether MI can be effectively delivered via email, text messaging, or social networking. Current data suggest that MI messages delivered in an electronic format work as an addition to telephonic MI counseling (Battaglia, Benson, Cook, & Prochazka, in press).
- Motivational interviewing training can use either in-person or self-study methods but is most effective when supplemented with individual or group supervision (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). Alternate training methods such as virtual reality have also been tested (Mitchell et al., 2011).

**OARS.** One easy way to start using MI is to apply the acronym OARS (Miller & Rollnick, 1991). You are practicing MI when you use:

**Open** (rather than closed) questions

- “How do you feel about that?” (open) versus “Did that make you mad?” (closed)
- “Tell me about the last time you used meth.” (open) versus “You quit using drugs – right?” (closed and leading)

**Affirmations** (for positive reinforcement)

- “You’re doing a good job of keeping your appointments.”
- “Congratulations on taking your medications regularly – that can be difficult for some people!”

**Reflections** (repeat, rephrase, paraphrase)

- “It sounds like you are worried about your headaches.”
- “Are you saying that you are afraid to ask your partner to use condoms?”

**Summary** (2 or 3 key points raised by the patient)

- “So the main things you want to do today are to see your lab values and find out about the support group.”
- “It looks like we have your new exercise plan in place and you will start with Step 1 tomorrow.”

**LURE.** We have rearranged these suggestions to help you avoid unhelpful communication patterns. Rollnick et al. (2008) originally published the following as RULE, but we feel that Listening has to take place before understanding can occur.

**Listen** to your patient:

- MI involves at least as much listening as informing, and you can only understand your patient’s motivation by listening.
- Good quality listening is part of good general health care.
- Listening is a display of empathy that shows your patients you are really interested in them.

## Understand your patient's motivations:

- The patient's reasons, rather than the provider's, are more likely to trigger behavior change.
- The provider helps by expressing interest in the patient's values, concerns, motivations, and life context.

Resist the urge to correct the patient. Rollnick and colleagues (2008) refer to this as the "righting reflex."

- Care providers have a powerful desire to heal, prevent harm, and "set the patient straight," but this can have a paradoxical effect because people don't like to be told what to do.
- The MI practitioner resists the righting reflex through the use of reflective listening:
  - "You're saying that if you tell your partner you want to use condoms, he will become angry at you."
  - "You don't want to take antiretroviral medications because they will place an extra burden on your liver on top of your current alcohol consumption."

## Empower your patient:

- Health outcomes are better when patients take an interest in and play an active role in their care.
- You empower your patients when you help them explore the ways they can take control of their health.
- Patients are essential consultants on their own lives and the on ways in which they can successfully build behavior change into their daily routines.
- Empowered patients are more likely to sustain changes that sacrifice short-term convenience for long-term risk reduction.
- Practitioners empower patients by soliciting options from the patient, and by maintaining a balance of power in the health care relationship. Options and solutions generated by the patient are more likely to be successful than options generated by the provider. Patients do best when they take an active role in their care.



**Elicit-Provide-Elicit.** It is possible to teach new information in an MI framework, but it should be done differently from the usual method of providing information. MI practitioners begin by assuming the patient already knows something. They then fill in the blanks and ask the patient for a reaction to the new information presented.

**Elicit** what the patient already knows:

- “Tell me how smoking affects your health.”
- “What do you think about using condoms?”

**Provide** new information to fill in the blanks:

- “Something you might not know is that simply reducing the amount you smoke can have benefits for your health.”
- “Right – condoms can prevent HIV transmission, and they also protect you from other sexually transmitted diseases.”

**Elicit** the patient’s response to the new information provided:

- “What do you think about what I just told you?”
- “What is your reaction to that?”

## MATCHING TO A PATIENT’S READINESS FOR CHANGE

**Assess readiness for change.** People may be more or less ready to change their behaviors at any given point in time, and different messages are appropriate for people at different stages of readiness for change.

*Your goal is to identify where the patient is in the change process in order to determine what interventions might work best.*

**Start with an open-ended question or statement:**

- “I see your nurse practitioner recommended that you start taking ART. Tell me what you think about that.”
- “What’s been happening with your plan to quit smoking?”

The Stages of Change Model (Prochaska & Velicer, 1997) provides a framework you can use to help your patients make positive health changes at every level of readiness. Understanding these stages will help you determine your patient’s readiness to change and provide appropriate guidance.

The questions in the following sections are intended to be examples or conversation starters to help you and your patients have a discussion about change. They are not a script to follow or a research survey; you can use several of them or none in any given encounter. Remember that making an authentic connection with your patient and trying to truly understand his/her perspective is the key to success in MI.

## PRECONTEMPLATION STAGE

Patients in the Precontemplation Stage of readiness may not realize there is a problem and have not yet thought about changing.

*Your goals are to:*

- *bring awareness of the problem to the surface so the patient can start thinking about it, and*
- *keep the patient engaged in the process.*

It is easy to turn these “uncommitted” people off during this stage, so choose appropriate messages. Remember that you want to keep the door open for future discussions.

### LISTEN to concerns

- **Reflect content:**
  - “It sounds like you want to be sure that our discussion here is confidential.”
  - “I heard you say that you have a cough but don’t think you can stop smoking.”
  - “You would like your partner to stop nagging you.”
- **Reflect emotion:**
  - “So you feel overwhelmed?”
  - “It sounds like you’re feeling depressed.”
- **Summarize:**
  - “You really enjoy smoking.”
  - “It seems that you don’t think you can say no when your partner wants to have sex.”

## ELICIT more information

- **Past experiences:**
  - “Tell me about when you tried to quit smoking before.”
  - “What happened when you asked him to use condoms?”
- **Current strengths:**
  - “How do you manage to exercise so consistently?”
  - “You’re so good about coming in for your appointments. What helps you remember?”
- **Current attitudes:**
  - “What do you think about changing your medicines?”
  - “How do you feel about using condoms when you have sex with new partners?”
  - “More and more people are hooking up online. What do you think about that?”

## COMMUNICATE caring

- **Empathy:**
  - “That sounds really hard. How did you handle it?”
- **Honesty:**
  - “I might be scared too if my CD4 count were dropping.”
- **Acceptance:**
  - “You get to decide; it’s your health.”
  - “You’re the only one who can make these decisions, but I can help you look at the issue and explore your options.”

## CONTEMPLATION STAGE

Patients in the Contemplation Stage are willing to think about making a change, but not yet ready to do something about it.

*Your goal is to move the patient toward action by:*

- *keeping the patient talking about change,*
- *boosting the patient’s awareness of change options, and*
- *increasing the perceived benefits of change.*

## **DEVELOP discrepancy**

- **Reflect ambivalence:**

- “You see benefits to changing, and also some drawbacks.”
- “It sounds like you feel stuck.”

- **Explore concerns:**

- “How do you think using condoms would affect your sex life?”
- “What concerns you about going on ART?”

- **Explore values and goals:**

- “What are you hoping to gain from treatment?”
- “Tell me how protecting your partner would make a difference.”

- **Reflect intention:**

- “It sounds like you want to be safer in your drug use, but you aren’t sure how.”
- “So you’re thinking about creating a plan to take your medications consistently.”

- **Explore context:**

- “What has changed in your life that makes now a good time to stop using drugs?”
- “How did your partner’s concerns make you decide to use condoms?”
- “Has something changed that is encouraging you to start ART?”

- **Give feedback:**

- “Your doctor will tell you why she thinks you need to start ART. I can tell you what others have said, and give you a brochure if you like.”

**ROLL with resistance.** Resistance means that it’s time for the provider to change tactics. Try precontemplation strategies instead of arguing or trying to persuade the patient!

- **Apologize:**

- “I’m sorry; maybe I misunderstood. Let’s go back.”

- **Affirm:**

- “I hear your concern about the side effects of the drugs, and it’s valid. Let’s talk about it.”

- **Accept:**
  - “Maybe using that herbal remedy wasn’t the best idea. If it isn’t working for you, we can explore some other options.”
- **Reflect others’ concerns:**
  - “You’re not worried, but your partner is. What are his concerns?”
- **Reframe “yes but” as “yes and”:**
  - “It sounds like you want your plan to work, and you also have some reservations about it.”
- **Clarify:**
  - “What do you need to move your plan forward?” “How can I help you?”
- **Amplified reflection:** (If you use this strategy, be careful that your tone isn’t dismissive or pejorative. If this is said respectfully, most patients will respond with reasons they are ready to change.)
  - “Maybe you aren’t ready to start ART now.”
  - “It could be that using condoms is not for you.”

## SUPPORT self-efficacy

- **Self-Monitoring:**
  - “Would you be willing to keep track of how you take your medications for a week? This will help us see any patterns that could indicate when you have trouble remembering your pills.”
- **Past Successes:**
  - “What strategies have worked for you in the past?”
  - “Tell me about the last time you were able to use a condom.”
- **Optimism:**
  - “What is different now that makes change possible?”
- **Explore Extremes:**
  - “What is the best/worst thing that might happen when you start using this plan? What’s the likelihood it will happen?”
- **Commitment:**
  - “Where do you stand on this issue, at least for today?”

- **Decision Making:**

- “Which of those ideas might you be ready to try?”
- “Do any of these ideas to decrease your alcohol use sound possible for you?”

- **Autonomy:**

- “You are in charge – no one is going to go home with you to check on your progress.”
- “You can decide whether you want to do this.”

## **ACTION STAGE**

Patients in the Action Stage are ready to make an initial attempt to change behaviors, but may not be confident yet about their abilities to succeed.

*Your goal is to decrease the barriers to change.*

### **ENCOURAGE progress**

- “I’m impressed with what you’ve been able to achieve.”
- Ask the patient to help you “scale” change:
  - “On a scale of 1-10, where were you before? And where are you today?”
  - “A 7 is great. You’ve come a long way compared to the 2 where you were at when you started.”
  - “Is a 7 where you want to be right now? If not, what would it take to get you to an 8?”

### **REDUCE barriers**

- “What has worked best so far?”
- “What other actions would make that strategy work even better?”
- “Here are some resources that might help you (plan nutritious meals, develop a schedule for taking your medication, etc.).”
- “How can I help you get past this?”

## **RESTRAIN excessive change**

- “It’s better not to change too many things all at once. How can you take a small step in this direction?”
- “Where is the best place to start?”
- “What do you think you can do to improve your health this week?”

## **MAINTENANCE STAGE**

Patients in the Maintenance Stage have succeeded in changing a behavior, and have sustained the change for at least 6 months.

### ***Your goals are to:***

- *help the patient stay focused, and*
- *anticipate and reduce the chance of a relapse.*

## **NORMALIZE ups and downs and offer ENCOURAGEMENT**

- “It is not unusual for people who have changed a behavior to occasionally move backward; it is normal. If you know this can happen, you can be prepared to deal with it.”
- “A lapse is not a relapse.”
- “You did it before and you can do it again. I believe in you.”

## **ENLIST support**

- “Is there anyone who can remind you to take your meds?”
- “What other activities could help you stay away from the bars?”
- “Are you ready to share your success with others?”

## **PLAN ahead**

- “What situations may make it hard to maintain your new behavior? How do you think you will handle those situations?”
- Set a follow-up: “When can we meet again to talk about how things are going?”

Relapses are a normal and expected part of the process of change. When one occurs, you have an opportunity to help the patient step back and re-assess personal goals, readiness, and the strategies used so far.

*Your goals are to:*

- *help the patient avoid becoming discouraged and*
- *help the patient re-engage in the change process.*

Use all of your MI skills to help the patient discuss these issues. Some questions that might help start this conversation:

- “Did something trigger your drug use this time?”
- “What affected your ability to take your medications?”
- “You can be proud of not smoking/using/drinking for the last 14 months. That was a big success.”
- “Tell me what happened. What do you make of this?”
- “It can be very helpful to know what didn’t work. What can you learn from this relapse?”
- “What might you do differently next time?”
- “You have the skills to make this change; you’ve done it before and you can do it again.”
- “Where do we go from here?”
- “A relapse is not a collapse.”



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