An Introduction to Motivational Interviewing for Healthcare Professionals  
Continuing Education Seminar for Physical Medicine & Rehabilitation Professionals  
Presentation for Infinity Rehab, Denver Convention Center, Denver, Colorado, April 22nd, 2017.

**Presenter:** Robert Scales, Ph.D., Director of Cardiac Rehabilitation & Wellness, Mayo Clinic-Arizona; Adjunct Associate Clinical Professor, Arizona State University, College of Health Solutions. Tel: (505) 307-1142; Email: connect@robertscales.com; Website: www.robertscales.com.

**Background:** Motivating patients to adopt a healthful treatment plan during brief office visits is a major challenge facing healthcare providers. Therefore, effective communication strategies that can be successfully employed during time-pressured consultations are worthy of consideration. Traditional approaches to patient care often rely on advice giving and direct persuasion. This can easily lead to confrontation and may result in resistance (dissonance), particularly in patients who are ambivalent or not ready to change behavior. Motivational interviewing is an alternate style of communication that has demonstrated success with clients that are recovering from drug and alcohol addiction. More recent adaptations of this approach to medical settings have been effective in improving a wide range of health behaviors, including those that are promoted in a physical medicine and rehabilitation setting. This motivational approach is well suited to the daily practice of a busy clinic where improved patient compliance is a priority. Skillful application by a clinician provides the platform for patients to talk about change instead of exhibiting dissonance. Consequently, clinical consultations will not only be more effective, but also less frustrating for the provider.

**Purpose:** To give a group of physical, occupational and speech-language therapists an introduction to motivational interviewing strategies for use in clinical settings.

**Objectives:** The objectives for a 6.0-hour presentation are outlined as follows:

Participants will be able to:

1. Recognize ways in which patient resistance (dissonance) is exhibited during clinical consultations.
2. Demonstrate an increased understanding of the research and theoretical framework upon which motivational interviewing is based.
3. Identify the key components of motivational interviewing and how they can be used to lower patient resistance (dissonance) and promote behavior change.
4. Explore options for incorporating motivational interviewing strategies into their own clinical setting.
5. Identify tools that can be used to assess the communication skills of both students and practitioners to provide feedback and ongoing skill development.

**References:**

An Introduction to Motivational Interviewing for Healthcare Professionals
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Teaching Methods:

The seminar will incorporate handout material and a PowerPoint presentation that combines a didactic presentation with an interactive discussion with attendees that is supplemented with video demonstrations of motivational interviewing in the clinical setting. This will set the stage for willing attendees to practice some of the skills and strategies of motivational interviewing with structured real/role playing exercises in small groups.

It should be noted that the standard 2-day workshop is the recommended format to teach motivational interviewing and improve competency. This usually involves a 1:16-20 Trainer: Attendee Ratio. Therefore, the 6.0-hour seminar will be an introduction to motivational interviewing in the healthcare setting.

Agenda:

8:00 am – 10:15 am

- Pre-seminar self-evaluations, introductions, needs assessment and seminar goals.
- Motivational Interviewing: Background and Overview.
- The Stages of Readiness to Change: A theoretical model to help explain behavior change.
- What the research shows: Current review of the research involving motivational interviewing in healthcare settings.
- What is Motivational Interviewing? Demonstrating the motivational style.
- Exploring a continuum of communication styles:
  - What Goes Wrong with Persuasion? Pitfalls of Traditional Communication Tactics.
  - Recognizing Resistance (Dissonance) and Using this as a Signal to Change Strategy.
  - How to Have a Productive Conversation about Change: A Person-Centered Approach to Consultations.
- The Flow of Motivational Interviewing: The Four Processes.
  - Engaging-Focusing-Evoking-Planning.
- Integrating Key Components of Motivational Interviewing into a Routine Consultation in the Clinic.
- Establishing a Respectful ‘Opening’ Conversation: Using the AIDES Acronym.
  - Acknowledge the Person with an Affirmation.
  - Introduce Yourself and Role within the Clinic.
  - Define the Duration of the Visit.
  - Explain the Expectations and the Flow of the Appointment.
  - Set a Collaborative Tone.

10:15 am – 10:45 am (Break and Networking)
An Introduction to Motivational Interviewing for Healthcare Professionals
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10:45 am – 12:30 pm

- Key Components of Motivational Interviewing (continued): The ‘History’
- Building Motivation for Change with the Application of Fundamental Skills
  - Open-Ended Questions
  - Affirmations
  - Reflections
  - Summarizing (OARS)
- Help People Talk Themselves in Behavior Change: Identifying Change Talk.
- Practicing an initial discussion about behavior change.
- Transitioning to a ‘Physical Evaluation’.
  - Affirmations, Structuring Statement and Informed Consent.
  - Body Awareness, Self-Discovery and Increasing Self-Efficacy.
- Expressing Optimism for Change.

12:30 noon- 1:30 pm  Lunch

1:30pm – 2:30 pm

- Key Components of Motivational Interviewing (continued).
  - Transitioning to ‘Education’ Using the Motivational Style (Ask-Ask-Provide-Ask):
    - Offering PM&R Related Information, Personalized Feedback and Advice.
- Recognizing Readiness to Change and Asking for a Commitment to Take Action.
  - Strengthening Commitment & Planning for Change.
  - Goal Setting and Negotiating a Behavior Change Plan in the Motivational Style

2:30 pm – 2:45 am (Break and Networking)

2:45 pm – 3:45 pm

- Transitioning to ‘Closure’:
  - Summarizing for Clarification and Direction.
  - Strengthening Commitment by Assessing Confidence to Change.
  - Closing Structuring Statement & Option of Follow-up.
- Integrating Motivational Strategies into the Clinical Setting and Overcoming Obstacles.
- Tips for Continued Learning of Motivational Interviewing: Self-Evaluation with Coding, Feedback and Coaching.
- Questions, Evaluations and Adjournment.
Key Components of Motivational Interviewing

EXPRESS APPRECIATION AND OFFER APPROPRIATE PRAISE WHENEVER POSSIBLE for the positive steps being taken, for their honesty, for their willingness to consider change, for showing up . . .

BEGIN WITH A STRUCTURING STATEMENT & SET A COLLABORATIVE TONE. During your introduction give a brief outline of what the patient can expect and step out of the expert role to let them know they will have a say in any decisions about change. e.g. AIDES Acronym. They are the experts on what will work for them.

SHARE OPTIMISM ABOUT THE POSSIBLITY OF CHANGE. Instill a belief that patients are capable of changing behavior, now or in the future, and that the patient’s health may improve as a direct result of that change.

USE OPEN-ENDED QUESTIONS to build rapport and focus the discussion.

SUPPRESS A WELL-INTENTIONED REFLEX TO ADVOCATE FOR CHANGE.

RECOGNIZE THAT IT IS NORMAL TO HAVE MIXED FEELINGS ABOUT MAKING A CHANGE. Invite patients to look at the pros and the cons of their current behavior as well as the pros and cons of making a change.

AVOID ARGUMENTS. Arguments are hard work, counter-productive and a signal to use an alternative approach. Let the patient make the case for change. Provide opportunities for them to see the gap between the way things are now and the way they would like things to be.

LISTEN WITH EMPATHY. Use respectful attention. Demonstrate a desire to gain mutual understanding by giving short summaries of what you hear the person say, what you think it means, and, as appropriate, what you think the person is feeling.

MATCH YOUR STRATEGIES WITH THE PERSON’S READINESS TO CHANGE. Assess the stages of change across multiple behaviors and use appropriate strategies.

ASK EVOCATIVE QUESTIONS to encourage talk about change.

RESPOND TO WHAT YOU HEAR WITH STRATEGIC REFLECTIVE STATEMENTS to highlight the thoughts and feelings that reinforce the person’s own reasons for making a positive change.

PROVIDE FEEDBACK & INFORMATION WITH PERMISSION and in a caring, collaborative manner. Let the patient come to their own conclusions about how useful it is, if at all.

GIVE ADVICE SPARINGLY and with respect for freedom of choice.

USE SUMMARIES to clarify and to reinforce what the person is saying about making or maintaining a change. (“Let me make sure I’m getting this right...”)

ASK FOR A DECISION TO CHANGE. “What would you like to do about ________?”

NEGOTIATE A CHANGE PLAN only when the person expresses readiness to change. Continue to invite the patient to explore their own ideas and solutions.

PROVIDE A MENU OF OPTIONS FOR CHANGE. Let the patient choose what they think will work best for them.

Adapted by Robert Scales and Joseph. H. (Bo) Miller (2016) from the following references:

GETTING PEOPLE TO TALK ABOUT CHANGE

Sample of Open-ended Questions to Encourage Change-related Statements

The questions fall into four areas. Keep in mind that these questions usually come after more general open-ended questions have gotten the ball rolling and you have established some rapport with your client (e.g., "Tell me what brings you here today." "How can I be helpful to you?" "How have things been going for you?" etc.) Be aware that the interviewer's use of words like "problem" or even "concern" can sound confrontational to some clients. Take your cue from your clients about how to describe their current situation.

1. **Disadvantages of the way things are now (problem recognition & concerns)**
   - What worries you about your current situation?
   - What difficulties have you had in relation to your management of diabetes?
   - What makes you think that you need to do something about your use of alcohol?
   - How has your weight gain stopped you from doing what you want to do?
   - What is there about your drinking that you or other people might see as reasons for concern?
   - In what ways does this concern you?
   - What do you think will happen if you don’t make a change?

2. **Advantages of change**
   - How would you like for things to be different?
   - What would be the advantages of making this change?
   - The fact that you’re here indicates that at least part of you thinks it’s time to do something. What are the main reasons you see for making a change?
   - If you could make this change immediately, by magic, how might things be better for you?

3. **Optimism about change**
   - What makes you think that if you did decide to make a change, you could do it?
   - What encourages you that you can change if you want to?
   - What do you think would work for you, if you decided to change?
   - When else have you made a significant change like this? How did you do it?
   - What personal strengths do you have that will help you succeed if you decide to make a change?

4. **Intention to change**
   - What makes you think that you may need to make a change?
   - If you were 100% successful and things worked out exactly as you would like, what would be different?
   - What things make you think that you should keep on with your diet the way it is now?
   - And what about the other side? What makes you think it’s time for a change?
   - What are you thinking about your smoking at this point?
   - What would be the advantages of making a change?
   - I can see that you’re feeling stuck at the moment. What’s going to have to change?

*Adapted by Bo Miller from Miller and Rollnick (1991; 2002)*
GETTING PEOPLE TO TALK ABOUT CHANGE (CONTINUED)

Nine Strategies for Evoking Change Talk

1. Ask Evocative Questions

Ask open questions, the answer to which is change talk. (See previous page.) The questions used in the “Taste of MI” exercise are also good examples:
   “Why would you want to make this change?” (Desire)
   “How might you go about it, in order to succeed?” (Ability)
   “What are the three best reasons for you to do it?” (Reasons)
   “How important is it for you to make this change?” (Need)
   “So what do you think you’ll do?” (Commitment)

2. Ask for Elaboration

When a change talk theme emerges, ask for more detail. “In what ways?” “Tell me more about that.” etc.

3. Ask for Examples

When a change talk theme emerges, ask for specific examples. “When was the last time that happened?” “Give me an example.” “What else?”

4. Look Back

Ask about a time before the current concern emerged. How were things better, different?

5. Look Forward

Ask what may happen if things continue as they are (status quo). “If you were 100% successful in making the changes you want, what would be different?” “How would you like your life to be five years from now?”

6. Query Extremes

“What are the worst things that might happen if you don’t make this change?” “What are the best things that might happen if you do make this change?”

7. Use Change Rulers

Ask, “On a scale from zero to ten, how important is it to you to [target change] -- where zero is not at all important, and ten is extremely important?” Follow up: “And why are you at ____ and not zero?” “What might happen that could move you from ____ to [higher score]?” Instead of “how important” (need), you could also ask “how much do you want” (desire), or “how confident are you that you could” (ability), or “how committed are you to ____” (commitment). Asking “how ready are you?” tends to be a bit confusing because it combines competing components of desire, ability, reasons and need.

8. Explore Goals and Values

Ask what the person’s guiding values are. “What do they want in life?” Using a values card sort can be helpful here. If there is a “problem” behavior, ask how that behavior fits in with the person’s goals or values. Does it help realize a goal or value, interfere with it, or is it irrelevant?
9. Come Alongside

Explicitly side with the negative (status quo) side of ambivalence. “Perhaps ____________ is so important to you that you won’t give it up, no matter what the cost.”

NOTE: With any attempt to encourage people to talk about making changes when you are using the motivational style, listen and reflect back what you hear them saying.

Adapted by Bo Miller from: MI Training for New Trainers, Resources for Trainers; Motivational Interviewing Network of Trainers: (2008), pp. 102-103.
1. Please rate the following statements about today’s consultation. Please check one box for each statement and answer every statement.

<table>
<thead>
<tr>
<th>How was the provider at ...</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Making you feel at ease.... (introducing himself/herself, explaining his/her position, being friendly and warm towards you, treating you with respect; not cold or abrupt)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>2. Letting you tell your “story”.... (giving you time to fully describe your situation in your own words; not interrupting or diverting you)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Really listening .... (paying close attention to what you were sayings; not looking at the notes or computer as you were talking)</td>
<td>☐</td>
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</tr>
<tr>
<td>4. Being interested in you as a whole person ... (asking/knowing relevant details about your life, your situation; not treating you as “just a number”)</td>
<td>☐</td>
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<tr>
<td>5. Fully understanding your concerns.... (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)</td>
<td>☐</td>
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<tr>
<td>6. Showing care and compassion.... (seeming genuinely concerned, connecting with you on a human level; not being indifferent or “detached”)</td>
<td>☐</td>
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<tr>
<td>7. Being Positive...... (having a positive approach and a positive attitude; being honest but not negative about your problems)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>8. Explaining things clearly....... (fully answering your questions, explaining clearly, giving you adequate information; not being vague)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>9. Helping you to take control...... (exploring with you what you can do to improve your health yourself; encouraging rather than “lecturing” you)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>10. Making a plan of action with you .... (discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)</td>
<td>☐</td>
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Comments:
Information

The Consultation and Relational Empathy (CARE) Measure is a consultation process measure that has been developed by Dr Stewart Mercer and colleagues in the Departments of General Practice at Glasgow University and Edinburgh University. It is based on a broad definition of empathy in context of a therapeutic relationship within the consultation. The wording reflects a desire to produce a holistic, patient-centred measure that is meaningful to patients irrespective of their social class, and has been developed and applied in over 3,000 general practice consultations in areas of high and low deprivation in the west of Scotland.

The scoring system for each item is ‘poor’=1, ‘fair’ = 2, ‘good’ = 3, ‘very good’ = 4, and ‘excellent’= 5. All ten items are then added, giving a maximum possible score of 50, and a minimum of 10. Up to two ‘Not Applicable’ responses or missing values are allowable, and are replaced with the average score for the remaining items. Questionnaires with more than two missing values or ‘Not Applicable’ responses are removed from the analysis.

The theoretical background and validation of the CARE measure can be found in:


Mercer SW and Reynolds W J. Empathy and quality of care. BJGP 2002, 52 (Supplement); S9-S12.

The CARE measure can be used free of charge. The Intellectual Property rights rest with the Scottish Executive. The measure may not be used on a commercial basis without the consent of the author and the Chief Scientist Office of the Scottish Executive Health Department, on behalf of the Scottish Ministers. If you would like more information, please contact;

Dr Stewart Mercer
General Practice and Primary Care, Division of Community-based Sciences, University of Glasgow, 1Horselethill Road, Glasgow G12 9LX
Email; Stewmercer@blueyonder.co.uk

For further information, and to download the measure please visit;

http://www.gla.ac.uk/departments/generalpractice/caremeasure.htm
Behaviour Change Counselling Index (BECCI)

BECCI is an instrument designed for trainers to score practitioners’ use of Behaviour Change Counselling in consultations (either real or simulated). To use BECCI, circle a number on the scale attached to each item to indicate the degree to which the patient/practitioner has carried out the action described.

Before using BECCI, please consult the accompanying manual for a detailed explanation of how to score the items. As a guide while using the instrument, each number on the scale indicates that the action was carried out:

- 0. Not at all
- 1. Minimally
- 2. To some extent
- 3. A good deal
- 4. A great extent

**The Topic:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Practitioner invites the patient to talk about behaviour change</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
<tr>
<td>2. Practitioner demonstrates sensitivity to talking about other issues</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
<tr>
<td>3. Practitioner encourages patient to talk about current behaviour or status quo</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
<tr>
<td>4. Practitioner encourages patient to talk about change</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
<tr>
<td>5. Practitioner asks questions to elicit how patient thinks and feels about the topic</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
<tr>
<td>6. Practitioner uses empathic listening statements when the patient talks about the topic</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
<tr>
<td>7. Practitioner uses summaries to bring together what the patient says about the topic</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
<tr>
<td>8. Practitioner acknowledges challenges about behaviour change that the patient faces</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
<tr>
<td>9. When practitioner provides information, it is sensitive to patient concerns and understanding</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
<tr>
<td>10. Practitioner actively conveys respect for patient choice about behaviour change</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
<tr>
<td>11. Practitioner and patient exchange ideas about how the patient could change current behaviour (if applicable)</td>
<td>not at all 1 2 3 4 a great extent</td>
</tr>
</tbody>
</table>

Practitioner BECCI Score: ____________________________

**Practitioner speaks for (approximately):**

- More than half the time □
- About half the time □
- Less than half the time □

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For enquiries about BECCI, please contact Dr. Claire Lane LaneCA1@cf.ac.uk
Motivational Techniques for Improving Compliance with an Exercise Program: Skills for Primary Care Clinicians

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Introduction
One would think that the disabling effects of a heart attack, diabetes, obesity, or orthopedic injury would be enough to motivate patients to comply with an exercise program; however, as every provider knows, this is not always the case [1••]. The traditional approach to patient care often relies on advice-giving and direct persuasion. Miller et al. [2] observed that this can easily lead to confrontation and may result in resistance, particularly in patients who are ambivalent about changing their behavior. Patient resistance is observable behavior that can be divided into four broad categories: interrupting, negating, ignoring, and arguing with the provider (Table 1) [3]. This type of behavior sends a signal to the provider that the strategies being used may be inappropriate. This led Miller on a search for an improved method of communication, and after observing both clinical and research-based provider-patient interaction, resulted in the development of an alternate approach called motivational interviewing (MI), which is now receiving attention from health care providers all over the world.

The research of Miller and Rollnick [1••,4••] has shown that as little as one or two brief MI sessions, either as a stand-alone intervention or in conjunction with other forms of treatment, can successfully motivate problem drinkers or drug addicts to seek help from a treatment program, stay with the program, and eventually change the problem behavior. More recent adaptations of this approach to medical settings have been effective in improving a wide range of problem behaviors [5,6].

Probably the most compelling evidence to date supporting the efficacy of MI on physical activity is the Cardiovascular Health Initiative and Lifestyle Education (CHILE) study [7••]. This randomized controlled trial found that, compared with traditional cardiac rehabilitation, the addition of MI coupled with brief skill-building sessions significantly enhanced multiple health-related behaviors simultaneously in patients recovering from heart disease [8–10]. This included exercise [11] and physical activity [12]. At the completion of the traditional 12-week program, patients in the intervention group were exercising at energy expenditures equivalent to 7.5 hours per week of brisk walking, compared with 3.5 hours per week in the control group. The results of the Heidelberg-II trial [13•,14] identified that disease stabilization or reversal is more likely to occur when patients exercise at these higher volumes, whereas disease will more readily progress in patients who exercise less than 4 hours per week. Three months after completing the traditional program, patients in the intervention group of the CHILE study [7••] were significantly more active, and unlike those in the control group, continued to increase their level of activity, which included activities performed at work, in the home, and during recreation.

What Is the Motivational Approach?
Stages of readiness to change
It is misguided to assume that all patients who enter a clinician’s office intend to do what they are told is good for...
them. Many patients continue along a path of noncompliance, despite the risk of exacerbating their health problem. Prochaska and DiClemente [15] developed a theoretical model to explain the process of behavior change, which provided the framework upon which MI is based.

The authors identified that people change behavior by progressing through a series of differing levels of motivation called the stages of change. There are five stages of readiness to change (Fig. 1) [16]. In stage 1 (precontemplation), the individual is not thinking about change; in stage 2 (contemplation) he or she is unsure about change; in stage 3 (preparation) he or she is ready to change; in stage 4 (action) he or she is actively making the change; and in stage 5 (maintenance) he or she is sustaining the behavior change. Rather than viewing motivation to change as a static personal trait, a patient’s stage of readiness to change fluctuates in response to a variety of factors, including interpersonal interaction. Prochaska et al. [17••] also identified that interventions designed to change behavior were more likely to fail if they were not matched with the individual’s stage of change. In the earlier stages of change (precontemplation and contemplation), it is appropriate to use strategies that increase awareness about the problem behavior and to help the patient resolve their ambivalence about change. However, in the later stages of change (preparation, action, and maintenance), it is appropriate to apply a skills-based approach, which helps the patient put a plan into action. In addition, the model recognizes that is necessary to consider the possibility of relapse in those who succeed in changing behavior.

Physical activity assessment
To assess a patient’s stage of readiness to change, one must first clearly define the behavior in question. For example, the definition of what is considered regular exercise has been expanded because of recent revelations related to the therapeutic response. The US Surgeon General’s report on physical activity and health [18•] helped clarify this definition and underlined the importance to health. Traditional recommendations regarding exercise were expanded to now recognize the therapeutic effect of intermittent bouts (≥ 10 min) of physical activity performed at work, in the home, and during recreation. Therefore, it is now recommended that people accumulate at least 30 minutes of moderate-intensity physical activity or exercise on most, if not all, days of the week [18•,19,20]. Those who maintain a regular regimen of activity that is longer in duration or of more vigorous intensity appropriate to their capacity may derive greater benefit [21]. However, fewer than 20% of US adults participate at this level [18•].

Algorithms have been designed to help providers assess where a patient may be along this continuum of readiness to become physically active (Fig. 2) [16,22]. In our experience, it is useful to determine the patient’s motivation to exercise regularly first. After establishing the patient’s stage of readiness, it is appropriate to ask the patient if he or she is physically active (which includes activity at work, in the home or yard, and during recreation time). This information can be used to skillfully match the provider’s communication style and strategy with the patient’s stage of readiness to change. A variety of structured interviews and questionnaires have been developed for those interested in a more extensive assessment of physical activity and exercise [23•,24]. The Lo-PAR (Low Level Physical Activity Recall) [25,26] is considered appropriate for use in clinical populations because it recognizes low-level activities performed by deconditioned individuals [27,28].

Motivational style
An encouraging revelation to emerge from the investigation into provider-patient interaction is that relatively brief intervention can, under certain conditions, trigger change [29]. Furthermore, the way in which a provider interacts with a patient early on can influence both short- and long-term outcomes [30,31]. In consultations, patients who are given the opportunity to talk about increasing their commitment to change tend to be more compliant in the future. Research involving problem drinkers indicates that an empathic listening style encourages change talk, whereas a more directive confrontation method increases resistance. In one study [2], it was observed that during a consultation the counselor could trigger a specific patient response by intentionally alternating his or her style of communication.

Miller and Rollnick [1••] define MI as a “patient-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.” MI relies heavily on empathic listening backed by simple reflections that avoid judging, criticizing, or blaming the patient; it also has a strong directive component, in that it involves selectively reinforcing positive change talk that

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**Table 1. Four categories of patient resistance behavior**

<table>
<thead>
<tr>
<th>Arguing</th>
<th>Patient contests the accuracy, expertise or integrity of the provider (e.g., challenging, discounting, or expressing hostility)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interrupting</td>
<td>Patient breaks in and interrupts the provider in a defensive manner (e.g., talking over or cutting off the provider)</td>
</tr>
<tr>
<td>Negating</td>
<td>Patient expresses unwillingness to recognize problems, cooperate, accept responsibility, or take advice (e.g., blaming others, disagreeing, making excuses, claming impurity, minimizing, or exhibiting pessimism, reluctance, or unwillingness to change)</td>
</tr>
<tr>
<td>Ignoring</td>
<td>Patient ignores or does not follow the provider (e.g., exhibiting inattention, remaining silent, being nonresponsive to questions, or sidetracking the discussion)</td>
</tr>
</tbody>
</table>

(Adapted from Chamberlain et al. [3].)
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may be buried under irrelevant material or potential barriers to change. Similarly, skillful reflective statements can build confidence by focusing on prior successful efforts, reframing past attempts as practice rather than failure. Deeper reflections attempt to reveal and explore the meaning or feeling behind what has been spoken.

For this reason, the underlying spirit behind MI has been likened to dancing with patients and leading them in the intended direction, rather than trying to wrestle them into submission [1••]. In a successful motivational intervention, the patient will be doing much of the work, taking the burden of behavior change away from the provider.

Useful Skills and Strategies to Motivate Patient Compliance: Key Components of the Motivational Style

In our experience of training health care providers in MI, it is common for trainees to discover that they are already using some of the skills and strategies during their more successful consultations with patients. Furthermore, MI is not the first and only endeavor to use a patient-centered approach that relies on the skill of reflective listening [32–35]. However, MI is different because of the selective nature of the reflections [36], which makes it directive when dealing with behavior change. It provides a structure for health care providers to apply these motivational skills and strategies more consistently during time-pressured consultations, and subsequently enhance patient compliance with behavior change.

The following elements, adapted from a variety of sources [1••, 4••, 37, 38], are key to employing a motivational approach in any setting, whether in a brief clinical encounter (5–10 minutes) or in a formal MI session (1–2 hours). This includes a mixture of skills and strategies that can be used in a way that is relevant to the patient’s stage of readiness to change. An attempt has been made to sequence these skills and strategies roughly in the order in which they might be applied during a consultation with patients [39••], although most are important throughout the motivational enhancement process.

Express appreciation and offer appropriate praise whenever possible

Genuine expressions of appreciation, support, and admiration are reinforcing throughout the change process. Although this is easily understood by most providers, it may often be neglected in practice. Regardless of readiness for change, patients can be affirmed for their honesty, their willingness to consider change, the positive steps they are taking, and at the very least, for showing up for a consultation.

Be optimistic about the possibility of change

It is important that the provider instill his or her personal belief that the patient is capable of changing behavior, either currently or in the future, and that the patient’s health condition may subsequently improve as a direct result of that change.

Use open-ended questions

Skillful use of open-ended questions can build rapport and target the discussion. This is a familiar strategy used to elicit more detail from the patient than might be obtained from “yes-no” responses to close-ended questions. It also builds rapport by showing interest in the patient’s point of view, as opposed to just asking questions to obtain specific information during an assessment. When there is limited time with patients, there may be concern that open-ended questions will lead to irrelevant information. However, it is possible to structure the open-ended questions to target a specific topic of interest or time frame (eg, “Tell me more about the pain you have been feeling since our last meeting”). An open-ended question we have found to be extremely effective with cardiology patients is, “What do you think caused the blocked arteries in your heart?” This often sets the stage for the patient to talk about what he or she needs to change. One possible response to this question might be, “I used to exercise when I was younger, but prior to my heart attack I didn’t exercise much. I really should get back to some kind of regular exercise program.”

Listen with empathy

Listening with empathy to what the patient has to say, a communication skill also called “reflective listening.”
works in conjunction with open-ended questioning. It requires respectful focused attention from the provider, followed by brief summary statements to reflect back to the speaker the thoughts and feelings being expressed. This is a key component of MI, and is used strategically throughout any consultation. In addition to helping the provider gain an understanding of the patient’s situation, it promotes trust and rapport by showing respect and interest. Patients are also able to hear what they are saying through the filter of another person who is trying to understand them.

Here are examples of statements made by patients and a corresponding reflective response:

**Patient:** “I have started exercising, but I am disappointed that I don’t seem to be losing any weight.”

**Provider:** “It sounds as though you are trying, but you are frustrated you have not seen some results yet.”

**Patient:** “Why should I be exercising on a treadmill at my age? I only have a few good years left and I want to enjoy myself.”

**Provider:** “Exercising on a treadmill is not your idea of fun.”

Even though the reflective statements are guesses about meaning and feelings, it is important not to pose them as questions; questions have a tendency to put patients on the defensive. In MI, it is desirable to make at least two reflective statements to every question. A skillful motivational interviewer may go on to provide more elaborate or deeper reflections; however, the basic principle is to listen more than tell, particularly when dealing with an ambivalent patient.

**Work as a collaborator**

Another key component of MI is the recognition that it is the patient’s responsibility to make changes. One way to promote that concept is to step out of the expert role when the topic is behavior change. Providers can help patients increase self-confidence by operating in the role of collaborator, and encouraging patients to explore what they think will work for them.

**Recognize it is normal to have mixed feelings**

Making a decision to change can be like a seesaw, with different factors exerting pressure at different times. The advantages and disadvantages of making a change weighted against the advantages and disadvantages of staying the same [40]. The ambivalence associated with the decision to change may resurface throughout the change process. The role of the provider is to help resolve ambivalence by enabling the patient to see both sides and subsequently stimulate self-evaluation. An effective strategy to help resolve ambivalence involves asking the patient to tell you what he or she likes about a particular behavior (e.g., sedentary lifestyle), then ask for a description of the negative aspects of the behavior. By using skillful reflective listening, the provider may then give the patient the chance to hear, perhaps for the first time, his or her own thoughts and feelings about the problem behavior. Discussion of the positives and negatives associated with a problem behavior can be a quick way to raise discrepancy about the status quo [41,42].

**Avoid arguments**

Part of dealing effectively with ambivalence is letting the patient make the arguments for change. Arguing one side of the ambivalence (e.g., “You really should start exercising more”) almost invariably elicits the other side of the
argument (eg. “Yes, but”). Instead, the goal is to give patients the opportunity to hear themselves talking openly about their concerns. Trying to convince people that they should change is an exasperating exercise, and is a signal for the provider to change strategy.

**Match your strategies with the patient’s stage of readiness**

Talking to someone about taking steps to change behavior may not be effective if the person has not yet made the decision to change. Many exercise therapy programs focus on action- and maintenance-based strategies before establishing the patient’s true stage of readiness for change. Likewise, trying to raise awareness about the hazards of physical inactivity may be inappropriate for patients who are ready to change, and may need strategies that will help them put a plan into action (eg. goal-setting, skill-building, coping strategies). In addition to algorithms by Prochaska et al. to assess the stage of readiness to change, Rollnick et al. [42] recommend assessing how important the behavior change is to the patient, and how confident he or she is in making the change. The assessment of importance and confidence can be conducted in a timely manner during brief consultations by asking the patient to rate himself on a zero to 10 scale, where zero equals not at all important and 10 equals very important. Patients who rate themselves low on importance can be moved toward change by being asked, for example, “What makes this a 2 for you rather than a zero?” or “What would have to happen to make exercising more important to you?” The same scaling questions can be asked about confidence (eg. “How confident are you that you can exercise regularly if you decided to do so?”). Those who are high on importance but low on confidence may need additional support for change to take place. Providers can help identify the barriers to change by asking patients what keeps them from being higher on the confidence scale. The provider can also ask what he or she can do to help increase a patient’s confidence (eg. provide medical assistance, facilitate a referral for professional support and skills training, such as physical therapy or cardiac rehabilitation). It is important throughout the discussion to reflect and summarize the patient’s response.

**Provide feedback with permission**

Providing feedback in a caring, collaborative manner is vital to the success of MI. Health care providers may have specialized or personalized information that can be a powerful motivating factor for some patients. To maximize the impact in a motivational intervention, it is important to give the information in a neutral, nonjudgmental way, and then ask for the patient’s interpretation of the information [43,44,45]. For example, a provider might say, “It has been shown that in other heart patients who exercised at a moderate intensity for at least 4 hours per week, there was stabilization or reversal of disease, whereas patients who fell into this other category saw a rapid progression of disease. I’m wondering what you make of that?” The provider can then reflect back the patient’s response including, if possible, the emotional content (eg. “So this is new information for you, and it gives you hope and new meaning to your future exercise”). An easy way to remember this motivational approach to giving information or feedback is to think about “ask/provide/ask.” Ask permission to give the information, provide the feedback in an objective fashion, and then ask for the patient’s response [41,42].

**Give advice sparingly**

Advice should be given sparingly, and with respect for freedom of choice. Health care providers are accustomed to giving patients advice about their clinical condition. However, when patients need to be motivated to comply with a particular behavior, giving advice is not always the best opening strategy. MI downplays direct advice-giving, and recommends using it only as a last resort or in the context of offering several other options.

**Provide a menu of options**

Rather than prescribing one particular course of action, it is consistent with the motivational approach to describe several alternatives, and ask the patient what he or she thinks will work (eg. “You can decide what is best for you; however, if you like, I would be happy to share some ideas that have been successful with other patients who have the same type of condition as yourself. Tell me if you think any of these approaches would work for you”).

**Use summaries**

Clarify and reinforce what the patient is saying about making or maintaining the behavior change by summarizing his or her statements. A summary is a continuation of the listening process. It allows patients to hear once again what they are telling themselves about making a change. The tone for the provider is one of understanding (eg. “Let me see if I’m getting what you’ve said so far”). Summaries can also be used to elicit more information to confirm an understanding with the patient (eg. “Did I cover everything?”), or to shift focus toward making a commitment to change.

**Ask for a decision to change**

When patients appear to be leaning toward change, either on their own or after receiving feedback, it is appropriate to ask questions that seek a decision to change (eg. “What do you make of all this? Where does this leave you now? What would you like to do about your weight gain, uncontrolled blood sugar level, participation in physical therapy, or cardiac rehabilitation program?”).

**Conclusions**

Motivational interviewing is not a panacea. It is one of several useful approaches [46–48] that can be used by a primary care clinician to improve patient compliance with
physical activity and exercise. MI has demonstrated efficacy in brief consultations, and therefore lends itself well to the primary care setting, where time is often a limiting factor. The communication style, skills, and strategies that characterize MI are not exclusive to counselors or psychologists. A growing number of experienced trainers in MI now provide training workshops that are customized to the needs of a broad range of health care providers. Research is underway to identify ideal training methods to ensure that proponents of MI continue to develop their own skills of communication and consistently apply MI in clinical practice.

References and Recommended Reading
Papers of particular interest, published recently, have been highlighted as:
• Of importance
• Of major importance


The full document, available through interlibrary loan, contains specific information about the adaptation of MI to improve the health-related behaviors of patients recovering from heart disease, which includes physical activity and exercise.


This paper contains scientific evidence supporting specific recommendations for exercise in heart patients.


Extensive overview of the transtheoretic model of behavior change, otherwise known as the stages of change.


This report is the culmination of an extensive review of the literature, and provides physical activity recommendations for the nation.


This is a useful reference for those who are interested in quantifying physical activity in terms of energy expenditure.


This paper reviews several studies involving MI, and provides a concise description of this method of communication and the theoretic framework upon which it is based.


