The motivational interview

In practice

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Our first article on the motivational interview was a discussion about the justification for and relevance of using this type of intervention in a regular clinical practice.[1] Miller et al[2] and Rollnick et al[3] developed this systematic approach to treat alcoholism and substance abuse. The motivational interview is a structured intervention designed to motivate the patient. This article discusses the principles that guide this approach. Its application will be illustrated using examples of clinical cases.

Definition

The motivational interview is defined as "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence."[2] The various interpretations of the definition of this motivational approach are as follows:

- a patient-focused approach in the Rogerian[4] sense, where the approach is centred on the patient's perspective, as well as on the patient's interests, values, and concerns;
- a directive approach versus the nondirective Rogers' approach;
- a method of communication, designed to facilitate natural change (the patient's intrinsic motivation);
- an approach that encourages the clinician to look for and choose suggestions that promote change; and
- an approach that encourages the clinician to explore and resolve the patient's ambivalence as the key to change (as ambivalence is often what stands in the way of action).

Reducing ambivalence

It is interesting to note that Miller and Rollnick are interested in change more than in resistance to change. They suggest focusing on the willingness of patients to change, rather than on their fears or what they would like to avoid (eg, a deterioration in condition). The goal is to stimulate and build upon a patient's predisposition toward change. The motivational approach developed by these psychologists works with 5 hypotheses:

- Change occurs naturally.
- Change is influenced by the interactions between people.
- The expression of empathy is a means of effecting change.
- The best predictor of change is confidence, on the part of the patient or the practitioner, that the patient will change.
- More patients who say they are motivated to change actually do change.

While change does occur naturally, Miller and Rollnick stress the ambivalence associated with it. Ambivalence is a fairly common phenomenon; thus, a key concept in the motivational interview is the reduction of this ambivalence to enable patients to choose change. According to Miller and Rollnick, there are 4 main strategies to reduce the ambivalence regarding change (**Table 1**). In short, in order to change, patients must be ready, willing, and able (feel confident) to change.

Table 1. Strategies to reduce ambivalence to change

STRATEGY	EXAMPLE
1. Show the disadvantages of the status quo.	"How does the excess weight affect you in your daily activities?"
2. Show the benefits of change (**Figure 1**).	"Losing weight should help get your blood pressure under control."
3. Show that change is possible (optimism for change).	"You have succeeded in losing weight before. You can do it again."
4. Support patients in their intention to change.	"I understand you're considering joining a weight-loss organization. I encourage you to do so."

The medical consultation

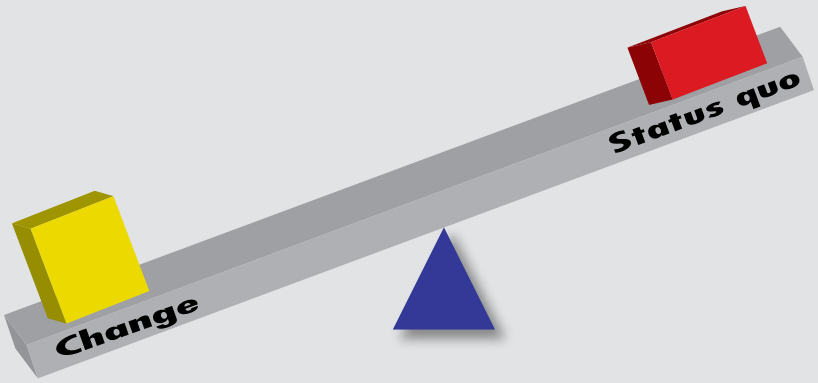
To help a patient adopt a new behaviour, we suggest applying the motivational interview approach during a medical consultation. To explain this process, we'll use the example of taking a medication.

First, we suggest that as a professional personifying medical knowledge, a physician should offer his or her viewpoint on a patient's problem and its treatment. This should not be expressed as a personal opinion, but as the position taken by the medical profession. For example, "The problem appears to be asthma. The recommended treatment for moderate asthma is …"

In the second step, it is important that the physician goes beyond simply informing the patient. The physician also needs to provide guidance by identifying the solution he or she considers to be most appropriate for the patient. For example, "However, in your case, given the problems you have with … I would suggest instead that you …"

Third, with respect to the suggested treatment, the physician should ask whether it seems reasonable or feasible and whether the patient would agree to try it; that is,

Figure 1. Assessment of advantages and inconveniences of both change and status quo



the physician needs to explore what the patient is able to do. "What do you think about this? Do you think you can follow this treatment? It is important to talk about it now, because if you have any reservations, we can discuss them and perhaps find a solution that is more suitable for you. Are these goals achievable? If not, why?"

This is where the physician needs to pay particular attention to any ambivalence the patient might express. The physician needs to acknowledge the patient's ambivalence and attempt to reduce it by focusing on the aspects conducive to change or adoption of a new behaviour. Treatment often presupposes a change in the patient's lifestyle and habits, as well as the adoption of new behaviour. This comes at a psychological cost to the patient, who must weigh the benefits of the treatment against the disadvantages.

Finally, analyze the patient's reasons not to change and discuss his or her confidence in being able to implement change. "Are there any alternatives or ways of getting around the problem?" Then redefine the objectives until new achievable objectives are identified.

Clinical situations vary considerably, depending on the presence or absence of symptoms, whether the treatment is intended to solve a major, immediate problem, or whether its purpose is long-term prevention. In the event of a more acute situation, it is desirable to insist on the need for adoption of a new behaviour and to obtain the patient's viewpoint and commitment to the treatment required. In this instance, the acute aspect is, in itself, a motivating factor for the patient. Conversely, in the case of a preventive treatment, there is no emergency and the avoided illness remains a hypothetical gain. In this instance, however, the physician has more time and can revisit the matter during future consultations. The key is to continue insisting on the need for the new behaviour, even after several failures. Insisting is not harassment but a demonstration of professionalism. Repetition (without pressure) can go a long way toward helping the patient make an ongoing change.

Conclusion

Remember that it is appropriate to help a patient follow a treatment by intervening to increase patient motivation. Introducing a new behaviour into a patient's life (eg, taking a medication) is not as easy as it appears. There could be several false starts, but the best guarantee of success lies in making continued efforts. It is especially important for the physician to support the patient's efforts to change and to continue encouraging the patient. The ambivalence can always return; thus, the physician must continue to provide support until the new behaviour becomes routine for the patient.

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