Behavioral Health in Prevention and Chronic Illness Management

Motivational Interviewing

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KEYWORDS

• Motivational interviewing • Prevention • Behavior change • Chronic illness
• Primary care • Collaborative care

KEY POINTS

- Health outcomes, including chronic illness morbidity and mortality, are directly influenced by patient choices.
- Motivational interviewing (MI) techniques were originally developed to address substance abuse disorders but are now being used to address the primary and secondary prevention of a variety of health behaviors and chronic illnesses.
- MI is a tool clinicians can use to actively engage patients in their care.
- The spirit of MI, as described by the creators of MI, is based on collaboration, compassion, evocation, and patient autonomy with an emphasis on empathy and empowerment.

INTRODUCTION

Motivational interviewing (MI) was developed approximately 30 years ago by psychologist William R. Miller, PhD as a tool for evoking behavior change, primarily for use with clients in addressing substance abuse.[1] It has been widely used and validated as effective in this setting. Its usefulness has also spread to a variety of conditions unrelated to substance abuse. The purpose of this article is to address the effectiveness of MI in prevention of illness and in management of long-term chronic disease, with an emphasis on its use in primary care.

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DEFINITION

MI was originally described in 1983 as "a patient communication style that utilizes guidance and goal directing in order to elicit and emphasize individual motivations for change."[1] A comprehensive theoretic model for MI has been developed and refined over time.[2] Rollnick and Miller[3] defined MI as "a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence."[3] In 2009, the creators of MI offered an updated definition stating "Motivational Interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change."[4] The spirit of MI arises from the assumption of collaborative partnership, acceptance of the client's autonomy and perspective, compassion (keeping the client's best interests in mind), and evocation (an understanding that "the best ideas come from the client").[5,6]

The focus of the method is based on a set of skills often referred to as OARS: asking *o*pen questions; providing *a*ffirmations of patients' positive behaviors, beliefs, and accomplishments; *r*eflective listening; and *s*ummary statements.[5,7] **Box 1** describes key principles guiding the implementation of MI. Comprehensive formal training in MI can be obtained online or in person from a variety of sources, including a framework and curriculum for training resident physicians in family medicine and psychiatry[8] as well as other prescribing providers (nurse practitioners and physician assistants).[9]

IMPORTANCE OF THE TOPIC: SCOPE

With the advent of cutting-edge biomedical technologies and the advancement of evidence-based medicine during the past century, the ability to diagnose and respond to life-threatening illness has positively contributed to the prolongation of life and prevention of long-term morbidity. In spite of the historic advances, the current health care system is not designed to support prevention or to reduce the progression of chronic illness.[10]

Most deaths among individuals in the United States are related to chronic illnesses. such as heart disease, cerebrovascular disease, diabetes, and certain cancers. These conditions are, simultaneously, common and costly for individuals and institutions. In 2012, nearly 50% of adult Americans had at least one chronic illness and approximately 26% of adults had multiple chronic illnesses.[11] Analysis has shown that nearly

Box 1
Capturing the spirit of motivational interviewing

1. Motivation to change is elicited from the patients, not imposed from outside.
2. It is the patients' task, not the physician's, to resolve their ambivalence.
3. Direct persuasion is not an effective method for resolving ambivalence.
4. The counseling style is a quiet one, with a focus on eliciting the patients' thoughts.
5. The physician is directive in helping patients examine and resolve ambivalence.
6. Readiness to change is not a patient trait but a fluctuating product of interpersonal interaction.
7. The therapeutic relationship is more like a partnership or companionship; expert/recipient roles can impede the process.

For more information, visit http://www.motivationalinterview.net.

From Stewart EE, Fox CH. Encouraging patients to change unhealthy behaviors with motivational interviewing. Fam Pract Manag 2011;18(3):21–5.