Readiness for Change and Motivational Interviewing
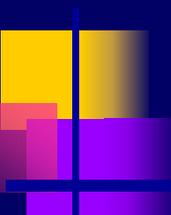
Craig Rosen, Ph.D.

Stanford University School of Medicine &

VA Palo Alto Health Care System

People Don't Always Do What We Think They Should

Primary Care Patients	Psychiatric Patients	Health Care Professionals
Drink too much; use drugs	Drink too much; use drugs	Can also abuse substances
Don't exercise, don't eat right	Smoke	Don't exercise, don't eat right
Don't take medications	Don't take medications	Don't use self-care for stress

4 Reasons Why People Are Ambivalent About Change
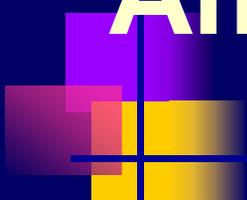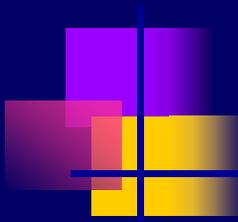
- Behaviors seem to "work".

- Behaviors seem "normal".

- Patients are accustomed to passive role (Doc, fix it for me).

- Seems too hard to change.
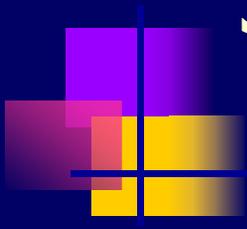
Stages of Change Model

Pre-contemplation	Don't plan to change	*"What problem?"*
Contemplation	Considering change	*"Should I change"*
Preparation	Taking first steps	*"Can I change?"*
Action	Changing behavior	*"How do I change?"*
Maintenance	Sustaining change	*"Is it worth it?'*

In Treatment

- Many interventions assume that patients are at the Action stage…

- Not always so!
  - Patients may be there to be treated for a *different* problem, not substance abuse.
  - Patients may recognize a problem but still feel ambivalent about changing.
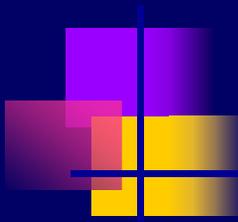
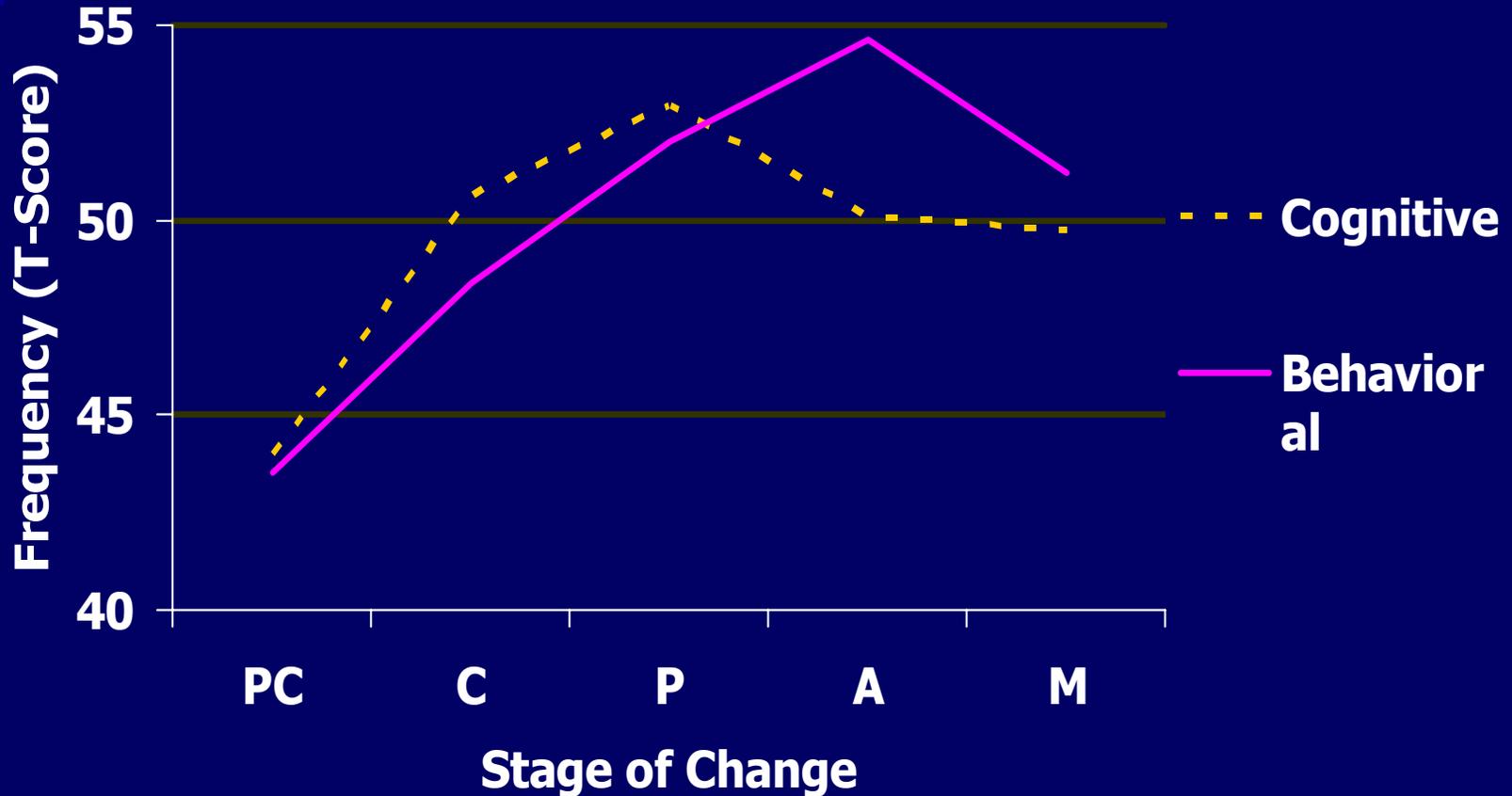# Transtheoretical Model: Processes of Change

Cognitive/Affective

- Seek information
- Weigh consequences
- Consequences on others
- Notice social norms
- Express feelings

Behavioral

- Resolve to change
- Control cues
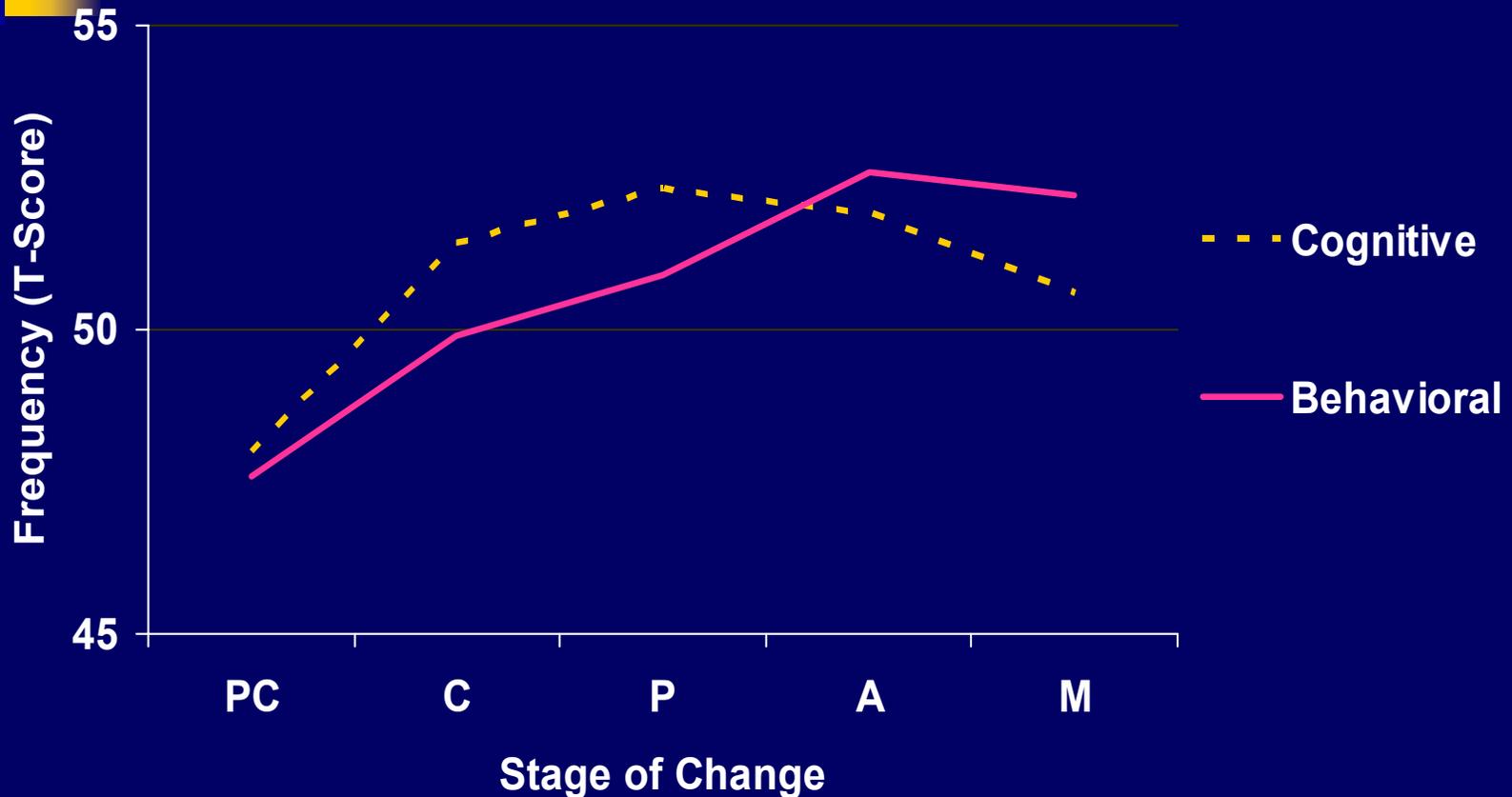- Substitute behaviors
- Get rewards
- Use social support

(Prochaska & DiClemente, J Consult & Clin Psychol, 1983)
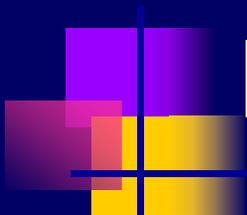
Change Processes by Stage: Smoking

(Rosen, CS. Health Psychology, 2000).

Change Processes by Stage: Substance Abuse
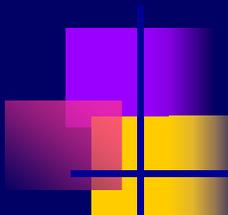

(Rosen, CS. Health Psychology, 2000).

# What If Patients and Staff Disagree About Problems?

- Reactance ("Don't tell me my problem")
- Leave treatment
- Obedience/Faking It (If being watched)
- Internalization (Real attitude change)

How do we help patients to make decisions about the need to change behaviors when the patient has not recognized or acknowledged these as problems?

Therapeutic Stance

- Adopt a consultative stance.

- Allow the patient to define the problem.

- Allow the patient to grapple with decisions – it is OK to be ambivalent.

- Allow the patient to evaluate new input and determine whether she/he needs to change.
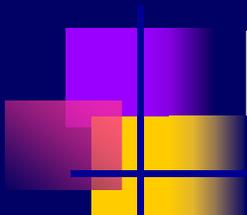
Respecting Patients While Mobilizing their Resources

- Empathy.
- Highlight Discrepancies Between Patient's Behavior & their Own Goals/Values.
- Avoid Argumentation.
- Roll with Resistance.
- Support Self Efficacy.
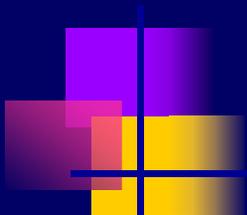
(Miller & Rollnick, Motivational Interviewing, 1991).
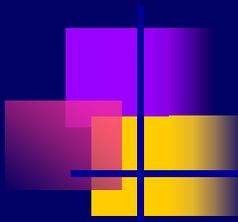
FRAMES

- Feedback (direct, factual input)
- Responsibility (you decide)
- Advice (concrete recommendations)
- Menu (provide options for change)
- Empathy (work from the patients' agenda)
- Self-Efficacy (empowerment, hope)

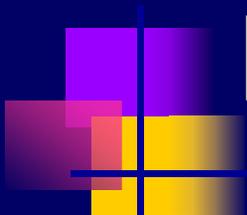(Miller & Rollnick, <u>Motivational Interviewing</u>, 1991).

Motivation Enhancement Group

Session Sequence. **Every session begins with an introduction to the group.**

- <u>**Session 1:**</u>   **Form 1**
- <u>**Sessions 2 & 3:**</u>   **Comparison to the Average Guy**
- <u>**Sessions 4 & 5:**</u>   **Pros & Cons**
- <u>**Session 6:**</u>   **Roadblocks**
- <u>**Session 7**</u>:   **Repeat Session 1**

(Murphy, Rosen, Cameron, & Thompson. <u>Cognit & Behav Prac</u>, in press).

Form 1: Problem Lists

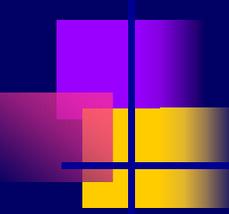| Definitely have	Might have	Others say I have	Definitely do not have

(Murphy, Rosen, Cameron, & Thompson. Cognit & Behav Prac, in press).

Form 1: Problem Lists

Definitely have	Might have	Others say I have	Definitely do not have
PTSD Depression Alcohol	Anger Guilt	Authority Weapons	Crazy Drugs Cancer

(Murphy, Rosen, Cameron, & Thompson. Cognit & Behav Prac, in press).

Form 2: Comparison to Average Guy
(Example: *Hypervigilance)*

|	"Average" Guy	Moderate Problem	Extreme Problem
Frequency, how much			
Negative Conse-quences			
Purpose			

(Murphy, Rosen, Cameron, & Thompson. Cognit & Behav Prac, in press).

Form 2: Comparison to Average Guy
(Example: *Hypervigilance)*

	"Average" Guy	Moderate Problem	Extreme Problem
Frequency, how much	-Check locks before bed	-Check locks twice a night	-Rechecks locks constantly
Negative Consequences	-Cost of lights and locks	-Gun makes family nervous -Distant from neighbors	-Sees threats everywhere -Kids at risk from gun under pillow
Purpose	-To feel even more secure	-To feel safe	-Survival, life or death
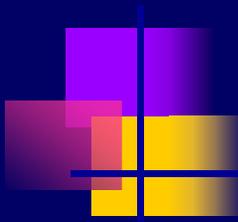
Form 3: Pros and Cons
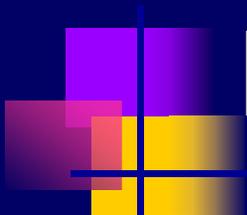## (Example: *Need to be in control)*

Pros (Benefits)

- Get things done quickly
- Get things done right
- Self-confidence
- Don't need input to make decisions

Cons (Disadvantages)

- Often make mistakes
- Hurt others' feelings
- Feel isolated, lonely
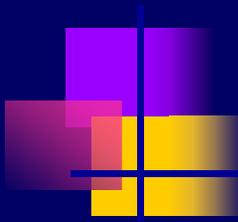- Don't know how to ask for help

(Murphy, Rosen, Cameron, & Thompson. Cognit & Behav Prac, in press).

Roadblocks

- Stereotypes

- Fears

- Not Seeing Clearly (Cognitive Distortions)

(Murphy, Rosen, Cameron, & Thompson. Cognit & Behav Prac, in press).

Summary

- Two strategies to increase motivation
  - Control contingencies
  - Change attitudes
- For changing attitudes, collaborative, factual approach reduces reactance and power struggles and facilitates change.
- Growing research supports effectiveness of motivational interviewing approaches.
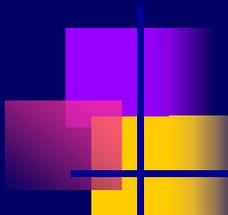
Additional Information

- **Enhancing Motivation for Change in Substance Abuse Treatment**
  Treatment Improvement Protocol (TIP) Series 35

  William R. Miller, Ph.D., Consensus Panel Chair
  U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
  Substance Abuse and Mental Health Services Administration
  Center for Substance Abuse Treatment
  Rockwall II, 5600 Fishers Lane, Rockville, MD 20857
  DHHS Publication No. (SMA) 99-3354
  Printed 1999

  http://hstat.nlm.nih.gov/hq/Hquest/db/local.tip.tip35/screen/TocDisplay/s/51139/action/Toc