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Motivational Interviewing as a Prelude to Coaching in Healthcare Settings

Nancy Houston Miller, RN, BSN, FAHA

Motivational interviewing is a unique counseling technique that was developed to help individuals give up addictive behaviors and learn new behavioral skills. This counseling technique relies on using communication skills to understand an individual's motivation for change. Motivational interviewing uses techniques such as open-ended questions, reflective listening, affirmation, and summarization to help individuals express their concerns about change. For those willing to change, motivational interviewing provides an opportunity for coaching including helping individuals set goals and arrive at a change plan. A 3-step approach to coaching may simplify the process of change and offer techniques for healthcare professionals to better equip them facilitate the change process.

KEY WORDS: behavior change, coaching, communication, counseling techniques

> If you treat an individual as he is, he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be.
>
> Johann Wolfgang Von Goethe

Healthcare professionals can play an important role in helping patients to acquire motivation to change their behavior. Addressing the ambivalence they may have about change and the lack of motivation for change is key to an effective counseling technique known as motivational interviewing. Motivational interviewing recognizes that for change to take place an individual must be willing to change and be able and ready to change. First described by Dr William Miller[1] in 1983 in relation to his work with alcoholics, motivational interviewing is a directive, patient-centered counseling method to help individuals explore and resolve their ambivalence about behavior change. Motivational interviewing is based on the theoretical underpinnings of Festinger's[2] cognitive dissonance theory: when faced with an internal contradiction, we tend to change our thoughts to resolve it; Bem's self-perception theory[3]: we are influenced by our own observations of our behavior, so we are influenced by what we say ourselves; and Bandura's self-efficacy theory[4]: the stronger a person believes that he/she can be effective at a task, the more likely he/she will attempt to complete the task. Also relevant is Carl Roger's[5] work on nondirective counseling described in 1953. His theory involves empathy, congruence, and positive regard, which are essential conditions that create an atmosphere of safety and acceptance for individuals to explore and change behavior. In addition, motivational interviewing draws from an important set of data about the effective components of brief interventions for change known as FRAMES—feedback, an emphasis on personal responsibility, advice, a menu of options, an empathetic counseling style, and support for self-efficacy.[6]

Motivational interviewing is also informed by the theoretical stages of change, which help counselors determine how ready an individual is to change and is most useful for those in the precontemplation or contemplation stages of the model.[7] For those ready and willing to change, problem-solving skills, which are described later in this article, are also relevant to help individuals through the change process.

The effectiveness of motivational interviewing for cardiovascular risk reduction including hypertension, cholesterol, smoking, physical activity, and overweight/obesity has been empirically tested. In a systematic review of 72 randomized controlled trials using motivational interviewing as an intervention, Rubak and colleagues[8] assessed the clinical relevance of this technique and the effectiveness of its use by healthcare providers. Motivational interviewing was effective in 75% of randomized controlled trials evaluating outcomes such as body mass index, hemoglobin A_{1c}, total cholesterol, systolic blood pressure, cigarette smoking, and blood alcohol. Ninety-four percent of studies used individual interviews, whereas

Nancy Houston Miller, RN, BSN, FAHA
Associate Director, Stanford Cardiac Rehabilitation Program, Stanford University School of Medicine, Palo Alto, California.

Correspondence
Nancy Houston Miller, RN, BSN, FAHA, Stanford Cardiac Rehabilitation Program, 703 Welch Rd, Suite F1, Palo Alto, CA 94304 (nhm@stanford.edu).

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the remainder was conducted in groups. The median duration of an individual encounter session was 60 minutes (range, 10-120 minutes). A single encounter was less effective than 5 encounters (40% vs 87%). Psychologists and physicians obtained equal effects in approximately 80% of cases. Other healthcare providers obtained efficacy in 46% of the studies. Finally, when motivational interviewing was used in brief encounters in practice settings of 15 minutes, 64% of all studies demonstrated a positive effect.[8] Most importantly and relevant to a healthcare context, motivational interviewing seems to be enhanced by the addition of other interventions such as education or health style counseling once motivation has been developed.[9]

Key Elements of Motivational Interviewing

As shown in Table 1, motivational interviewing relies on understanding an individual's motivation for change. This is achieved by both listening and empowering a person to initiate the change process.[10] There are 2 phases to motivational interviewing. Phase 1 is to elicit change talk to promote intrinsic motivation for change, and phase 2 once motivation is present focuses on strengthening commitment to change through setting goals and developing a plan for change.

The 4 general principles of motivational interviewing are shown in Table 2.[11] Empathy is a powerful skill that permits healthcare professionals to promote behavior change especially when ambivalence and/or self-perceived inability to change are obstacles. Empathetic expression by the healthcare professional establishes the relational atmosphere in which change takes place. In addition to this accepting, client-centered stance when talking to patients, techniques such as "developing" (focusing on) the "discrepancy" between where patients are versus where they would like to be, enables them to see contradictions perhaps previously pushed out of mind. The cognitive discomfort fostered by this process is a powerful force toward change. Clarifying with patients their personal goals for life and highest-held values, while also nonjudgmentally listening to their current lifestyle and even the difficulties associated with changing, becomes a way of bringing those contradictions to the foreground of their consciousness. Rolling with the resistance that may arise from such discussions (ie, purposely avoiding advocating either for the desirable goals or against the status quo, but merely mirroring back the conundrum the patient seems to be caught in while empathizing with the discomfort of such position) helps patients to start making their own choices and taking responsibility for their outcomes. This approach frees up the patient's productive, creative energy trapped in the all-too-human compulsion to preserve one's freedom and explain to the healthcare professional how change is really not necessary or possible. Unencumbered by such external distraction, the patient is then enabled to do real work and confront what is now clearly his/her own incongruity, not the healthcare professional's agenda. Finally, supporting self-efficacy by affirming the patient when any signs of competence, ability, or resources for change are heard throughout the patient's narrative can enhance an emerging sense that perhaps change is possible. Carefully listening for and simply reflecting back to patients (with a view of enhancing their self-awareness) their successes with any previous change can further support a better attitude toward change.[9]

During the first phase of motivational interviewing, a healthcare professional is curious about and helps the individual to express his/her opinions. Motivational interviewing permits healthcare professionals to use techniques such as open-ended questions, reflective listening, affirmation, and summarization to

TABLE 1 Fundamental Guideline for Motivational Interviewing

Resist the righting reflex
Understand a person's motivation
Listen
Empower
Guide more than direct
Dance rather than wrestle
Listen as much as tell
Make collaborative conversation
Evoke from persons what they already have
Honor a person's autonomy

Data from Rollnick et al.[10]

TABLE 2 Four General Principles of Motivational Interviewing

Express empathy
Offer acceptance and understanding that facilitates change
Convey unconditional positive regard
Recognize that ambivalence is normal
Develop discrepancy
Facilitate change talk
Help the person see the contraindications between what he/she wants and what he/she is doing
Roll with resistance
Confront the problem, not the person
Resistance is a signal to respond differently
Focus on alternative change options
Resistance often stems from fear of change
Support self-efficacy
Promote belief in ability to change
Identify previous successful experiences
Focus on skills

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help individuals express their concerns about change. Open-ended questions using "what" and "how" serve to open a conversation with an individual about health behavior change. Questions such as "What makes you feel it might be time for you to change this behavior?" or "What is most difficult about changing this behavior?" evoke both the positive and negative aspects of the ambivalence about making changes. Affirming one's willingness to adopt a new behavior or modify an existing negative behavior while recognizing the difficulties perhaps associated with such a move conveys acceptance, appreciation, and understanding.

Reflective listening is a communication technique used to ensure that a healthcare professional understands what an individual is feeling and stating about his/her current situation including the possibility of change. Consistently with the spirit of motivational interviewing, reflective listening is used to (*a*) signal listening, understanding, and acceptance on the part of the healthcare professional, (*b*) help individuals develop awareness of the many aspects involved with their inability to change (eg, emotional currents, such as fear, shame, etc, or cognitive misconceptions or habits such as black-or-white thinking), (*c*) help individuals develop awareness of their ambivalence about changes (a part of them wants it, but another does not—an all-too-human feeling), and (*d*) help evoke resources to work through ambivalence. Simple reflective listening involves restating what an individual has said or rephrasing it by rewording it slightly. More complex techniques include reframing statements to help individuals think differently about their situation, reflecting the emotional undertones of what is said (amplified reflection), and reflecting both sides of an individual's ambivalence (double-sided reflection). Examples of opening phrases using reflective listening techniques are noted in Table 3.

A healthcare provider using motivational interviewing is constantly attentive at opportunities to hear "change talk." Change talk is critical because individuals can be more influenced by what they hear themselves say than by what someone else tells them.[3] Change talk can be elicited in several ways by asking evocative questions such as "What worries you about your diet?" or "What might be better for you if you changed this behavior?" Simply elaborating can also be useful. This is undertaken by a simple statement such as "Tell me more about that." Another method includes exploring "decisional balance." One way to explore the pros and cons is to ask a person to draw 4 squares. Within the squares, an individual can record the positive and negative consequences about changing the behavior and the positive and negative consequences of continuing it. This often engages an individual in the process of reflecting on the pros and cons of giving up the behavior or continuing it. Moreover, simply discussing the negative/positive consequences of giving up an addictive behavior may encourage an individual to moderate that behavior. For example, individuals unwilling to quit smoking may contract to reduce the number of cigarettes smoked as a prelude to eventually quitting smoking.[12] Another method for eliciting change talk is to use a "readiness ruler." Simply asking an individual on a scale of 0 to 10 how ready he/she is to adopt or change a behavior is a way of assessing readiness. When an individual says he/she is at a 6 (where 0 is no change at all and 10 is ideal change), the provider asks a follow-up question such as "How come not a 5 or a 4?" The provider can also elicit change talk by "looking back" at a time when things were going well (with a view of bringing to the foreground of consciousness the good things associated with health) or "looking forward" (eg, "How would you like things to be a year from now?"). Finally, by "querying about extremes" (eg, "If you do nothing at all, how do you imagine you would be in 3 years?"), providers may help some disadvantages of the status quo to emerge. Consistently with the spirit of motivational interviewing, providers should respond to change talk using a lot of reflective listening, affirmations, summarizations, and open-ended questions.

TABLE 3 Examples of Reflective Listening

Simple reflections: ''You don't really think there is really any way you can change your diet.''
Double-sided reflections: ''On the one hand you love to be fit, and on the other hand the work seems too much for you.''
Reframing reflections: ''I can hear how your wife is really afraid of losing you.''
Amplified reflections: ''You are feeling overwhelmed by all of the changes since your heart attack.''

Coaching

Coaching is reserved for individuals who are in a more advanced stage of readiness to change—typically preparation or action.[7] This includes setting goals, considering options, arriving at a change plan, and eliciting one's commitment. Motivational interviewing may be needed during this phase of health behavior change to examine when individuals have failed experiences. Moreover, during this period, it is important to continually be aware of ambivalence, including the importance and confidence one sees about the change process.

People view healthcare professionals as credible sources of health information and support. A coaching method enables a healthcare professional to support individuals who state a readiness to change. As shown in Figure, coaching involves 3 steps: educating

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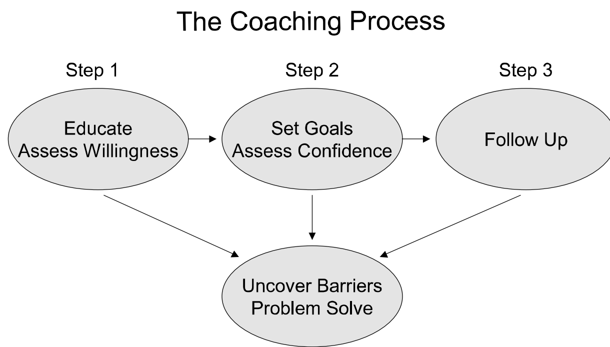

FIGURE. *The Coaching Process. Source: Houston Miller N.*[13]

and assessing willingness (step 1), setting goals and assessing readiness (step 2), and follow-up (step 3).[13] The first phase of motivational interviewing is primarily aimed at establishing the importance of change. An assessment on the past of the provider as to where the patient stands in the continuum of change (ie, how ready they are for change) is helpful in choosing techniques to emphasize at difficult moments of the process.[7] Step 2 in the process of coaching involves helping individuals to set goals that are specific, measurable, and achievable within a defined period. An example of a very specific goal is: "Can you walk on level ground at 2 miles per hour in 20 to 30 minutes for at least 5 days each week over the next month?" Asking an individual to rate his/her confidence to achieve such a goal is accomplished by using a self-efficacy scale. Self-efficacy can be measured on a scale of 0 to 100 or 0 to 10. A confidence score of 70 or greater generally indicates a high likelihood of one's success with the behavior.[14] Ratings of less than 70% indicate the need to identify barriers to success. As noted previously, asking questions such as "Why is your confidence a 4 instead of a 6?" or "What might help you to increase your confidence from a 3 to a 5?" helps to explore the difficulties people encounter with change and identify what might move them along a continuum of readiness. Self-monitoring of their performance among people ready to adopt new behaviors helps them to achieve goals. Tools such as diaries, calendars, and logs kept in plain site or on the computer are successful in helping people sustain the behavior during the early stages of adoption. Daily self-monitoring is especially useful with behaviors such as exercise, weight loss, and dietary changes. Although little is known about the frequency of the need for long-term self-monitoring, it is useful during the first 3 months of a new behavioral change. It may be reduced to weekly for a period of 3 to 6 months thereafter.[14] Self-monitoring should be reinstituted if individuals lapse back into old behaviors. Researchers suggest that, for sustained behavior change, monitoring for 12 to 18 months is essential.[15]

Step 3 in the process of health behavior change through coaching involves follow-up. Whether by telephone, mail, or face-to-face, follow-up by healthcare professionals gives individuals the impetus and motivation to continue change.[14] Goals should be recorded, patients questioned about their progress, and a problem-solving approach should be reinstituted when goals are unmet. Goals may need to be reformulated for individuals who have not been successful. Among successful individuals, setting new goals or helping people maintain their goals is the shift in coaching.

As shown in Figure, barriers may occur. Three of the most common barriers to change include misinformation or lack of information, previous negative experiences with the change process, and lack of support.[14] Techniques such as offering additional information about the behavior or clarifying misconceptions, challenging individuals to overcome previous negative experiences, and helping them to identify resources within their existing circle of family and friends or the community as well as reworking through ambivalence, should that prove to be a barrier, all promote success.[8] Also, educating individuals about how to undertake a problem-solving approach may support them through the difficulties they may encounter along the way. Relapses with any behavior are normal in the process of change. Anticipating distressing or challenging situations that might predict relapse is beneficial so individuals can plan for difficult times. A problem-solving approach involves 6 steps: identifying the problem and reasons for it, selecting the main reason and possible solutions, weighing the pros and cons of each solution, selecting 1 or 2 solutions to try, attempting that solution, and repeating the process if the initial solution is not successful.[14] Consistent with the spirit of motivational interviewing, problem solving (typically most relevant through preparation, action, and maintenance) always requires the healthcare professional to remain aware of the possibility of ambivalence creeping back in and hampering motivation. In this case, it is incumbent upon the healthcare professional to be true to motivational interviewing and to work on motivation again, revisiting ambivalence, even regenerating it, recognizing that change is a dynamic process, not a static outcome.

In summary, motivational interviewing has been shown to be an effective evidence-based communication style to help individuals with lifestyle changes for cardiovascular risk reduction.[8] Using this technique in clinical practice settings enhances skills that support individuals in adopting new or modifying unhealthy behaviors. Coaching incorporates motivational interviewing, setting goals, and following up with individuals to increase the likelihood of health

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behavior change. Healthcare professionals who practice these skills are better equipped to facilitate the change process.

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