INNOVATIONS in pharmacy

Volume 7 | Number 1 Article 3

2-9-2016

A New Conceptualization and Approach to Learning and Teaching Motivational Interviewing

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Introduction

The purpose of this article is to describe three innovations: 1) the development of traditional motivational interviewing within substance abuse counseling; 2) our development of a new conceptual approach to motivational interviewing in health care; and 3) our development of an eight hour e-learning program to teach this approach to motivational interviewing in a more accessible, affordable and standardized format. The progression of the article is as follows: 1) we briefly describe the development of motivational interviewing (MI) and its impact on health behavior change (assuming the reader has had some exposure to motivational interviewing concepts); 2) we describe how and why we have reformulated Miller's original approach to MI to fit the training and needs of health care professionals (HCPs); and 3) we describe the thinking and reasoning that went into the development of an eight hour MI e-learning program. Our overarching purpose is to describe how we came to formulate our approach to motivational interviewing in health care based on 25 years of teaching MI using both traditional approaches to MI and our new approach. The reader is referred to our book, *Motivational Interviewing for Health Care Professionals: A Sensible Approach*[1] for further elaboration of these concepts and their evolution in health care.

The Origins of Motivational Interviewing

Motivational interviewing (MI) is a client centered approach to care, originally developed by psychologist William Miller, (who was later joined by Stephen Rollnick).[2] Miller's insightful reaction to the typical confrontational approach widely used in the field of addiction counseling in the 1980s was the start of MI. In the confrontational approach, substance abusers were seen as liars with severe personality defenses, in denial and out of touch with reality. Counselors were taught that confrontation was necessary to address this denial in order to establish what these substance abusers had to do to re-engage reality and return to health. However, Miller experienced something different with these patients. He eventually came to the profound realization that the patient's openness to change is directly affected by how the counselor talks to the patient. When people are treated with contempt or disrespect, change is unlikely. When they're treated with care, concern, and respect, change is possible.[2] Here is this principle in Miller's own words:

> "Counsel in a way that evokes defensiveness and counter-argument and people are less likely to change. . . . I set out, then, to discover how to counsel in a way that evokes people's own motivation for change rather than putting them on the defensive. A simple principle that emerged from our earliest discussions was to have the client, not the counselor, voice the reasons for change.[2] "

Miller's new counseling approach was eventually called Motivational Interviewing because the term "interviewing" carries the sense of: 1) respecting patients, and 2) inviting patients to talk about their own motivation to change.[3] MI was widely adopted in addiction counseling and proved to be very effective in helping patients to change their behavior. Consequently, many people thought that it could be effective for other health behavior issues. In fact, subsequent research has shown MI to be effective in helping patients to change a wide range of health behaviors.[4]

It is important to keep in mind that MI was developed specifically for patients who are ambivalent about change (those who might say, "I'm not sure I want to quit smoking now") or resistant to change (those who might say, "I am not going to quit smoking. Stop bugging me"). In contrast, MI is not as necessary with patients who are ready to change and have asked you for guidance ("Just tell me what to do and I'll do it"). However, MI can still be used to support their readiness to change and to provide information about what they can do to change. It's still beneficial to ask patients who are ready to change what they believe is the best approach for them.

MI is a patient-centered form of counseling that helps *patients* to reason *their* way to the conclusion that they need to change their behaviors in order to achieve their goals. It is founded on Carl Rogers' client-centered counseling.[5] Rogers emphasized that the relationship with the patient has to be based on unconditional positive regard for the patient as a

person and therefore must avoid shaming and blaming the patient. Only by valuing and supporting the patient as a person does the patient have the *freedom* and *safety* to examine his or her behaviors and their consequences for self and others.[5]

While embracing the relationship advocated by Rogers, Miller modified Rogers' nondirective method for talking with the patient. Rogers believed that if the counselor accurately and consistently reflected back what the patient was saying, the patient would eventually achieve self-insight and start to see the need to change.[5] Although this Rogerian approach to counseling was effective, it can be slow and time consuming. Miller sought a more directive or guiding way of addressing the patient that doesn't cause defensiveness and helps the patient to conclude that change is both needed and possible. The counselor provides care and respect, along with information to guide the patient to new or healthier options. Patients are invited to draw new conclusions about their goals and behaviors. The counselor is thus a caring and respectful resource for the patient.[5]

MI does two important things: (1) it accurately and nonjudgmentally reflects the concerns and emotions of the patient, and (2) it provides insight or new information to address those concerns in a nonjudgmental and nonthreatening manner. This combination of actions is powerful. It creates safety so that the patient can be open to and learn new ideas, draw new conclusions, and, consequently, engage in new behaviors.

Here is a **critical** point. If a patient is ready to do something (e.g., quit smoking, lose weight, or take a medication), then telling the patient what to do and cheering them on might actually be useful. However, when the patient is ambivalent or resistant, this telling or persuasive approach actually produces the opposite effect. That is, when people are not ready to change, telling them what to do actually forces them to defend the very behavior we're attempting to influence. As a result, the patient digs in and presents arguments to counter the proposed change.

Various studies demonstrate the effectiveness of MI in increasing patient and provider satisfaction and producing better outcomes. One such study was conducted in 2005 for Biogen Idec concerning the specialty drug Avonex® for multiple sclerosis.[6] In a randomized controlled clinical trial, patients in the MI intervention group had a statistically and clinically significantly lower proportion of Avonex® treatment discontinuation (1.2%) than the standard care group (8.7%). This reduction in treatment discontinuation represented a potential $93,600,000 cost recovery per year.[6]

Many more studies support the use of MI in reducing cholesterol, blood pressure, blood alcohol, weight, etc.[7-14] As a result, healthcare systems are increasingly looking to MI for the reduction of treatment nonadherence and the adoption of healthier behaviors by patients.

So, why a new approach to MI?

We have taught motivational interviewing to health care professionals (HCPs), health care students and health plans for over 25 years. As we taught MI using Miller and Rollnick's[2,3,7] approach with its reliance on acronyms representing the skills involved (READS, OARS, DARN, etc.), we consistently observed something very interesting while watching HCPs role play after a full day of training:

1. HCPs became so focused on trying to remember what a particular letter of an acronym stood for that they didn't listen to the patient.
2. HCPs seemed to believe that they had to use all of the skills that the letters represented regardless of whether or not the skill was an appropriate response to the patient ("I already used the 'D'; I need to use something else").
3. HCPs could not clearly discern when it was appropriate to use each skill represented by the letters of the acronyms. For example, they could not sense when to use an open ended question or give information or express empathy or develop a discrepancy.

Generally speaking, HCPs became relatively proficient at reflecting and empathizing, but then they would get stuck. They did not know how or when to transition to exploring an issue and addressing it. Often, they lapsed into familiar paternalistic patterns of giving information, advice and orders. As a result, HCPs floundered in applying MI whereas psychological counselors didn't. We started to recognize that a set of systematic differences in the training and practice context of psychologists and HCPs account for why psychological counselors learn MI whereas HCPs struggle with MI. Recognizing these differences led us to conclude that we needed to teach MI quite differently to HCPs than to psychological counselors. Here are some of those important differences that influenced our new approach to MI.

First, psychological counselors are trained in a vastly different way than HCPs. Counselors are taught to talk (and listen) very differently to patients. Counselors are taught to explore patients' problems and that patients must eventually draw their own conclusions if change is to occur. Counselors see their role as being supportive, caring, and providing insight. The patient is in charge because it is ultimately their life (their illness) and therefore their decision. Counselors are also taught to be explicit in their reflections and empathy. Rather

than using every day conversational responses like, “Uh huh” or “I see” or “I understand”, counselors are trained to explicitly reflect their understanding. For example, when a patient says, “I’m worried about taking this pain medication. I’m hurting but I don’t want to become addicted,” rather than saying, “I see”, a counselor would be trained to say, “You want to reduce the amount of pain you’re having but you don’t want to become addicted to the medication. That makes you reluctant to start taking it.” This explicit empathic response lets the patient know that the counselor has listened and fully understands the patient’s dilemma. This empathic reflection creates trust and confidence that the counselor understands the patient’s perspectives and feelings. It also allows the patient to confirm or correct the response so that clarity is reached and rapport is built.

In contrast, HCPs are taught that they are the experts and they are in charge. This orientation creates many problems for HCPs in adopting patient centered approaches. HCPs have to learn an entirely different way of talking that counselors have already learned before they are exposed to MI. HCPs must learn to stop correcting patients as a first response. When learning MI, HCPs must learn that they are NOT in control and that they are NOT the only expert in the room. Patients are experts too. They are experts on their lives, their goals, and their aspirations. Equally important, they are experts on their “sense making”. How do patients make sense out of what is happening to them? What is their understanding of diabetes, high cholesterol, hypertension, etc.? What is their understanding of what can happen if these illnesses are not treated? How does the way patients make sense of their illness and treatment affect their motivation for change and their emotional responses to the diagnosis and treatment? Generally speaking, patients will always develop their own theories and lines of reasoning about all of these things. HCPs are used to “imposing” a solution on the patient’s problem(s). With MI, HCPs need to understand what a particular patient knows, understands and believes BEFORE their expertise can be useful for this particular patient. Plus, because MI was developed for patients who are ambivalent or resistant to change, telling patients what to do or persuading them to do something before they are ready is sure to backfire. HCPs must respectfully acknowledge the patient’s ambivalence or resistance first. Without understanding how patients construct their ideas about illness and risk, HCPs really cannot know what information or education might be useful or meaningful to the patient. Unfortunately, the medical model (implemented as a clinical workup) is often mechanical and formulaic and does not thoroughly take into account the patient’s perspective.

In summary, MI must undo and replace the medical model that puts the clinician as the sole expert and in control. This is no easy task. HCPs are used to giving directions, telling patients what to do and then blaming patients when there is “failure”. The approach taken by MI is one of guiding patients, not dictating to them. It is about providing patients with options that fit the patient’s larger goals. How does managing asthma or diabetes or cholesterol align with the broader aspirations of the patient?

Second, psychological counselors have been trained to be very aware that patients who are ambivalent or resistant to change are easily threatened by persuasive strategies. Counselors realize that information and education can be threatening if the patient is not ready for that information, which is the case when patients are ambivalent or resistant about change. The default position of the human brain is threat and avoidance, not safety and approach. When patients are ambivalent or resistant to change, they tend to be hypersensitive to or vigilant about threat[15]. By threat, we don’t mean just physical threat such as posed by a snake. Our brain does not make a distinction between physical and emotional threat. It just knows to react very quickly when faced with threat. So when patients feel threatened, they will respond with fear or aggression. If patients feel fearful, they will either flee or freeze. If they feel aggressive or defensive, they will fight or push back. These responses take place in the limbic part of the brain (specifically, in the amygdala). Consequently, information, education or instruction that the patient isn’t ready to accept can be seen as threatening if it’s not clear to the patient that the source of the information, education or instruction is safe. Ambivalent and resistant patients will openly consider and fully process information from a HCP only if they feel safe with that HCP.

Expressed somewhat differently, persuasive strategies don’t work with patients who are ambivalent or resistant because persuasive messages that push for change are perceived as social threats. In fact, when the patient is not ready to change or the patient does not yet trust the HCP, persuasive messages can cause patients to dig in and defend the very behavior we hope will change. And ironically, we end up calling such patients difficult, stubborn or in denial. Alternatively, patients can resist persuasive messages by nodding their heads in agreement with the HCP while they really have no intention to change. Then later we are left wondering why nothing happens. To summarize, counselors take for granted that patients can be threatened by persuasive messages. In contrast, HCPs have to give up trying to persuade their patients before they can even engage with the specific principles of MI.

Third, just as patients can feel threatened by HCPs and counselors, so too HCPs and counselors can feel threatened by their patients. Sometimes HCPs can feel anxious and threatened when patients don’t want to engage in a health behavior, such as taking medication appropriately for

diabetes, high blood pressure or high cholesterol. This sense of threat and anxiety occurs because at some level HCPs feel as if they are failing. As a result, rather than showing compassion or patience in their responses, HCPs push harder and try to "fix" the patient. In the end, a sense of threat and a lack of safety pervades the interaction between the HCP/counselor and the patient. It's unlikely that such interaction will ever invite patients to consider constructive health behavior change.

Psychological counselors have been trained to use introspection to become more aware of how they feel threatened by their patients. Consequently, psychological counselors have often reformulated their standards of success with a patient so that they are not threatened by the patient's decisions. In contrast, HCPs have usually received little training in introspection and are relatively unaware of how, when and why they may feel threatened by their patients. So, in addition to having to learn and master the skills and spirit of motivational interviewing (which really fly in the face of the standard medical expert model), HCPs also must learn to become introspective and aware of how their personal assumptions and issues can actually interfere with their ability to influence patient decision making in a positive and non-threatening way. This makes learning and mastering MI even more difficult for HCPs.

For example, after eight hours of initial training in MI a nurse expressed her frustration with many of her patients. She said, "I'm a doer. I get things done. Many of them just don't want to move forward and then I find myself getting frustrated and I literally forget what I have learned about MI." In effect, this nurse was expressing a basic truth: *motivational interviewing cannot be done out of the limbic brain (or amygdala).* MI is patient centered. In contrast, the limbic brain is "me centered". Because the limbic brain is about MY survival, empathy and compassion are impossible in the limbic brain. To understand this better, if you are being chased by a bear, you don't look back and say, "I bet he's hungry." You have no compassion for the bear. You simply want to survive. MI takes place in the prefrontal cortex where compassion, empathy and complex problem solving take place. Consequently, we have found it very helpful for HCPs learning MI to focus at some point on those "oh crap" moments when the HCP feels threatened by not knowing how to respond to a challenging comment by a patient. By describing and analyzing the variety of patient centered options that MI provides in reacting to such stressful moments, HCPs are able to appreciate how much MI can reduce their sense of stress because they can talk easily and openly with their patients rather than trying to manipulate their patients. Any MI training must address the issue of introspection.

In addition to these three differences in how HCPs are trained differently than psychological counselors, HCPs deal with different patients than counselors. Patients with chronic illness are different than clients struggling with substance abuse or marital discord. Traditional MI assumes that patients have everything they need internally to make changes. The role of the "counselor" is to help the patient discover and activate those resources and come to better conclusions about their behaviors. We agree that patients with substance abuse problems often know all the pros and cons associated with their behavior. However, while patients managing chronic illness have the same set of internal psychological resources, they often don't have the knowledge and information they really need to manage an illness, such as diabetes. For example, they often have misconceptions about the illness and its severity-- especially if left untreated. Sometimes they really don't see the point in treating the illness because they "feel fine". A well trained HCP using MI can assist the patient in making healthier decisions by filling in gaps in the patient's understanding or knowledge and by then inviting the patient to respond to this information. A well trained HCP using MI is aware that without a strong foundation of rapport with the patient, information can be interpreted by patients as a way of putting them in their place or correcting them, rather than as an extension of the caring provided by the HCP.

Finally, HCPs often use MI in a different treatment context than psychological counselors because HCPs often do not have the luxury of repeated 50-60 minute encounters. In fact, the HCP may have only one chance to make an impact on the patient because continuity of care is not where it needs to be in health care. Therefore, our approach to MI in health care emphasizes brief motivational interviewing in the form of 5-30 minute encounters.

In summary, we have made the argument that training HCPs in MI is different and often more difficult than training psychological counselors in MI. The previous training of HCPs often is in direct opposition to MI principles. In addition, patients with chronic illness often lack knowledge or information to make good decisions and have to be presented with new information to reformulate their "sense making" before making a decision to engage in behavior change. Finally, the context of the patient-client relationship in health care makes brief encounters even more critical.

Consequently, we have improved how we teach MI to HCPs. We quickly found that we had to recast the basic explanation of MI in order for HCPs to understand what was happening in the course of their interaction with patients. What was self-evident to counselors was thoroughly puzzling to HCPs. For example, counselors could be presented with a simple description of basic MI tools (summarized in the form of the

READS or OARS acronyms) and could envision how these tools might be used with the patient. In contrast, HCPs struggled with where, when and how to use these tools. They struggled to see the smooth flow of MI that develops when MI tools are used appropriately to respond to the issues and concerns expressed by the patient. So we started to use communicative and psychological concepts familiar to us to explain and illustrate the flow of MI. Slowly over time we developed a theoretical description of MI that helps HCPs to grasp the profundity of what is happening in MI. In our theoretical description of MI we are not only describing the heart of MI in a different way than Miller and Rollnick but we are also specifying two underlying dimensions of MI that are essential for fully understanding the optimal implementation of MI. In this sense, we view our theoretical formulation of MI as a response to the call by Miller and Rose[16] for a more developed theory of MI.

Recently, in the latest edition of their classic work on motivational interviewing (Motivational Interviewing, 3rd edition), Miller and Rollnick[7] have refocused the theory of MI on how to work with ambivalence in the patient. In doing so, they no longer discuss the READS principle of "Roll with Resistance" and postpone the discussion of resistance until late in the book. We have taken a different approach in our theoretical description of MI by highlighting resistance over ambivalence. While we concur that ambivalence is alive and well in some patients who have chronic illness, we believe that resistance is active in many more patients. Furthermore, HCPs are much more inclined to think of patients in terms of resistance than ambivalence. Consequently we have focused on how to use MI to address both resistance and ambivalence in patients.

In doing so, we have distinguished two kinds of resistance: issue resistance and relational resistance. Issue resistance resides in the patient's reasoning that leads to the conclusion that the patient doesn't need to change his/her behavior(s), either because it is not important enough or because the patient lacks confidence that he/she can make the needed change. The following comments express such issue resistance:

> "I'm not ready to quit smoking right now; I just have too much stress in my life."
> "I don't see why I need this medicine. I feel fine."
> "I'll take the medicine, but I doubt that I can change my eating habits. I've always failed every time I tried before. What's the use in even trying?"

Relational resistance concerns ***HOW*** we respond to the patient about issue resistance. When we fail to build rapport with the patient and disrespect the patient's concerns and reasoning, the patient suffers face loss and reacts with resistance to any possibility of change. While we concur with Miller and Rollnick that importance and confidence on the part of the client are critical to behavior change, we have found that:

1. the interaction between building rapport and addressing the patient's judgments of importance and confidence is more than additive[16]; it is synergistic, and
2. this synergy literally "energizes" the possibility of change.

When HCPs accurately empathize with the core concerns and lines of reasoning at the heart of the patient's sense making, the resulting rapport gives HCPs the leverage to use ***their*** expertise in a way that allows the patient to see that expertise as an extension of ***caring*** rather than as a way of putting the patient down. This has been a critical discovery that we emphasize at the heart of our approach to MI.

<u>Our New Conceptualization of MI – sense making, face loss and resistance</u>

Human beings are sense makers. We make sense out of everything. Even as you are reading this article you are deciding what makes sense and doesn't make sense based on your knowledge and experience. Similarly, patients make sense of their illnesses and their treatments. They use their understanding of the illness and its treatment to reason their way to a decision. One patient may say, "I want to get my diabetes under control. I don't want to go blind or have amputations or kidney failure." This patient's sense is that diabetes is a serious illness with serious consequences. The patient understands the importance of treating her diabetes and is therefore (at least for now) motivated to do something. Another patient with diabetes may say, "I don't think it's all that bad. The doctor said I have 'sugar', but I feel fine." This patient's sense is that his diabetes is not serious and he is probably not overly motivated to do anything. This is not a character flaw. It is simply how this patient understands or makes sense out of what is happening to him. We have come to believe that when patients are resistant (or ambivalent) about behavior change (taking medication, losing weight, quitting smoking, etc.), it is often because they are making sense of their situation using incomplete and/or faulty information. As a result, their sense making is misguided.

When HCPs are faced with such misguided reasoning by a patient, the temptation for the HCP is to immediately correct how the patient sees the world and to inform the patient about "the truth." This strategy has a high probability of failure. We have had the opportunity to listen to hundreds of hours of conversations between patients and HCPs. Far too often, HCPs use an immediate corrective response ("Just

because you feel ok doesn't mean you are ok. You can't feel when your blood pressure is elevated" or "The medicine is not enough to get your blood sugar under control. You need to eat healthier and get more exercise"). Even though the HCP is giving accurate information, the amount of **face loss** created by this corrective approach causes patients either: 1) to stop listening, 2) to discount or reject the information; or 3) to indicate agreement ("OK, OK....sure") just to get the HCP to stop correcting them even though they don't plan to change their behavior.

The concept of **face loss** is critical to understanding how a HCP can provide accurate information, yet have it ignored or discounted. When patients are made to look incompetent ("No, you can't feel when your blood pressure is elevated") or deprived of their autonomy ("You need to take the medicine AND change your eating habits and exercise"), they not only defend and affirm their own reasoning even more (**issue resistance**), but they also resist the HCP on a personal level (**relational resistance)**. The patient ceases to want to listen to or work with the HCP. Consequently, competence and autonomy face loss must be avoided at all costs, especially for resistant or ambivalent patients who are the focus of motivational interviewing.

As stated previously, two things have to happen to dramatically increase the probability of behavior change. First, HCPs must **reflect back** their patients' sense making with **high rapport:**

> "Because you feel ok, you're wondering why you need this medication at this point."

Secondly, HCPs must **address the patient's issue(s) directly** by asking permission to share information:

> "You raise a great question. Would you mind if I share some thoughts with you to address your concerns and you tell me what you think?"

and then by providing information to help the patient understand how he can feel ok but still be at risk for stroke or heart attack if his blood pressure remained elevated:

> "Mr. Jones, unfortunately high blood pressure doesn't have any symptoms. The first symptom is usually a stroke or heart attack. Your blood pressure is elevated. I would hate to see you have a stroke or heart attack when you can prevent it by taking the medication to lower your blood pressure. What are your thoughts about this?"

Notice, this approach does not cause competence or autonomy face loss and allows the patient to make the decision. What is crucial in all of this is that we continuously listen to patients NOT to correct them, but to reflect **how they are making sense** of their illness and treatment. We do not pass judgment when they employ misguided reasoning. We nonjudgmentally listen to what they have to tell us and view their sense making as neutral data that reveals 1) what to reflect in order to create rapport, and 2) what specific information to provide in order to address the patient's issue(s). Please note that this is consistent with Miller's concept of the spirit of motivational interviewing, which is prerequisite to being able to use MI skills effectively and appropriately.[17] The spirit of MI is a way of being with the patient that requires a collaborative and nonjudgmental approach to care. It requires a desire to understand, not correct, the patient's ideas and perspectives. The appropriate use of MI skills is predicated on this caring approach. The crucial point here is that neither empathic rapport with the patient by itself nor addressing the patient's issues by itself are sufficient to optimize behavior change when patients are ambivalent or resistant to behavior change. But when empathic rapport is coordinated with specifically addressing the patient's sense making, the probability of behavior change by the patient increases dramatically because of massive synergy lying at the heart of fully implemented MI.

A dissertation by Abhishek Pillai[18], one of our former graduate students, used the methodology of message effects research to confirm that two independent dimensions of MI messages (namely, building empathic rapport with the patient and addressing the patient's issue) are systematically related to patient reactions to these messages. Most importantly, he identified the massive synergistic interaction effect that occurs when building empathic rapport is simultaneously coordinated with addressing the patient's issues. In effect, Pillai[18] found that if the impact of building rapport with the patient is taken to be 1, and if the impact of addressing the patient's issue is also taken to be 1, then the total impact of fully implementing MI on both dimensions is not 1 + 1 = 2; instead it is 1 + 1 + 4 = 6, where 4 represents the massive synergy of MI. If you wish to explore this study in greater detail, we invite you to watch the following video: https://www.youtube.com/watch?v=ccgQF0OdX2o
This video first explains the experimental design of the study, then presents the results that identify the massive synergy at the heart of MI, and finally discusses the implications of these results for the optimal implementation of MI.

Teaching the Synergy of MI

Given this realization of the enormous synergy undergirding the impact of MI, we have focused our teaching of MI on the simultaneous coordination of building rapport and addressing patient issues. We have found that this focus is most easily attained by 1) delineating the sequential steps involved in

addressing the patient's sense making and reasoning, and 2) discussing how to build and maintain rapport at each step of this process. These steps are consonant with Miller's stages of learning MI[17]. Training programs with this focus have been very successful in helping HCPs to know what to listen for and how to respond. Numerous healthcare organizations, left confused by previous acronym based MI training, have found our sense making approach to be easier to adopt, learn and implement. We observed the same thing while interacting with learners during application exercises; especially, role playing. The quality of initial roleplayed interactions went up dramatically using this approach. We believe that the primary reasons this dramatic improvement occurred was because: 1) participants now clearly understood what to listen for (sense making); and 2) understood more clearly when to use each of the MI skills we taught.

At this point we wish to give examples of specific skills that are appropriate for different issues in addressing a patient's sense making and practical reasoning. We shall stress how these skills not only address the patient's reasoning process but also create and preserve empathic rapport with the patient. As such these skills help to build the synergy of MI and thereby optimize the power of MI to assist patients in making healthier decisions. These skills and examples are further expounded on in our book, Motivational Interviewing for Health Care Professionals: A Sensible Approach (APhA Press, 2013)[3].

The first step in addressing a patient's sense making is to listen for how patients make sense of their illness and its proposed treatment. Reflecting back and/or empathizing with the patient's sense making is a major step in addressing the patient's issues and building rapport with the patient. While abbreviated everyday responses such as "uh huh", "okay", "yeah", and "I hear you" do avoid the problems of an immediate corrective response as we discussed earlier, these abbreviated responses do not exhibit what it is that the HCP understands. Even saying "I understand" doesn't establish that in fact the HCP understands. Establishing understanding requires the HCP to reflect back fully what the patient has said and for the patient to affirm that indeed the HCP understands. When this occurs, the patient realizes that the HCP has nonjudgmentally understood what the patient has said, the patient feels safe with the HCP and can start to dialogue with the HCP because they are talking about the same issue. These explicit reflections also allow the patient an opportunity to correct the reflection if it is not accurate. That is not the case with abbreviated responses. For example consider the following dialogue that focuses on medicine for high blood pressure.

> Patient: I don't know why I need this medicine. I feel fine.
> HCP: I understand. Let me assure you that you do need this medicine.
> Patient: Well, I don't know about that. I feel just fine.

Here the HCP's abbreviated reflection of "I understand" has not given any evidence that she has in fact heard the patient's full line of reasoning. The remainder of her response, even though politely phrased, has ignored the patient's focus on "feeling fine" and instead has merely reiterated that he needs the medicine. In effect, the patient's line of reasoning has not been fully respected and addressed. In addition, the HCP has maintained a superior position above the patient by declaring that she "understands" when that's really the patient's judgment to make. Additionally, by completely ignoring the patient's thought about feeling fine the HCP has lost face for the patient. In the end, the patient's issue resistance has not decreased and little rapport has been established with the patient.

Let's look at a fully explicit reflection of the patient's utterance that takes a positive step toward rapport with the patient and creates mutual understanding of his issue.

> Patient: I don't know why I need this medicine. I feel fine.
> HCP: Because you feel okay, you don't understand why you need the medicine at this point in time.
> Patient: Right.

In this example, the HCP's response explicitly reflects back the patient's full line of reasoning by first acknowledging that the he feels ok and then by moving nonjudgmentally to his skepticism about why the medicine is needed. At this point, the HCP has clearly established that she has heard and respected the patient's line of reasoning. When the patient says "Right", there's mutual understanding of his issue that can serve as the basis for further discussion. Furthermore, the HCP now knows what information is required to address the patient's issue. The HCP must explain why the patient needs the medication even though he feels good right now.

We've observed many HCPs do well in reflecting patient comments such as this one, only to falter in making a smooth transition to the provision of the required information addressing this issue. The temptation is to say:

> HCP: Well, you need to understand that with this condition you won't notice any symptoms until it's too late. You need to take action now.

Providing information is an inherently face threatening act. In this case, the HCP has created both competence and autonomy face loss for the patient. The rapport that was built in the first response by the HCP has been promptly lost in her

second response. This is a common problem faced by HCPs learning how to respond to skepticism expressed by a patient. Consequently we recommend the use of a strategy that we call "You're wondering". Essentially, instead of reflecting back an assertion of doubt by the patient, the HCP reflects back that the patient is wondering about something. Note that if the patient accepts this reframing of the issue, it's relevant for the HCP to provide information to answer the patient's question. Here's how this strategy works.

> Patient: I don't know why I need this medicine. I feel fine.
> HCP: Because you feel ok, ***you're wondering*** (vs. you don't understand) why you need the medicine at this point in time.
> Patient: Right.
> HCP: You raise a great question. Would you mind if I shared some thoughts with you and you tell me what you think?
> Patient: I suppose so.
> HCP: Okay …

Now when the patient says "right", he is not only affirming that the HCP has understood but is also implicitly assenting to her provision of information to answer his question. Of course, the subsequent affirmation of the patient's question, the request to share information with the patient, and the desire to hear the patient's reaction all work to respect the patient's face and to build further rapport with him. Note that this episode has a clear structure that flows smoothly because of how the HCP works simultaneously on the two dimensions of building rapport and addressing the patient's issue. We have found that HCPs learning MI are able to assimilate the structure of the "You're wondering" strategy relatively quickly.

At this point in the dialogue, the HCP would talk about how high blood pressure does not have symptoms and the risks involved if it is not treated. Notice that "You're wondering" allows the HCP to reframe the patient's statement in the form of a question. The beauty is that because the patient realizes that the HCP has listened without judgment, the patient is highly likely to assent to the provision of information answering his question. Again, the patient's sense was that he didn't need the medicine because he felt fine. The information to be provided is how he can feel fine and still be at risk. After the new information is provided, the patient is invited to reconsider behavior change ("Where does this leave you need in regard to taking the medication?"). And again, the HCP listens nonjudgmentally to what impact this new information has had on the patient's sense making and decisions.

While the "You're wondering" strategy is used in response to a patient's expressed skepticism or doubt, there is a similar strategy that is used when a patient is saying, "I get why I need to do this, but there is a barrier." The conditional commitment is a way of reframing the patient's sense making and of asking if he will reconsider. Here is a dialog:

> Patient: I want to get my cholesterol down, but I heard this medicine can cause severe muscle weakness.
> HCP: So on the one hand you're worried about your cholesterol being elevated. On the other hand, you're very reluctant to take a medication that can cause muscle weakness.
> Patient: Right. My job requires heavy lifting. I can't afford muscle weakness.
> HCP: ***It sounds like if you were able to avoid severe muscle weakness or had other options to treat your cholesterol, you would take steps to lower your cholesterol and even take the medication.*** (*conditional commitment)*
> Patient: Right, but is that possible?
> HCP: Yes. I really believe I can help you avoid any problems associated with the rare side effect of muscle weakness and also explore with you other steps to lower your cholesterol. How does that sound? Ultimately, I want to help you make the best decision for you.

Next, the HCP would share with the patient 1) how to identify muscle weakness associated with the medication, 2) what action should be taken if such muscle weakness is experienced, and 3) other dietary changes and physical activities that can also lower cholesterol. The muscle weakness is reframed as a manageable problem instead of being totally dismissed as an invalid concern. The same skill can be used when patients are concerned about manageable side effects. Notice the amount of relational work done to support the patient's face both before and after the reframing of the barrier as a manageable problem. The conditional commitment was preceded by fully empathizing with his feeling caught between wanting to get his cholesterol down and his worry about getting muscle weakness. Then the conditional commitment was followed by requesting his reaction to possibly taking steps to avoid muscle weakness and by affirming that what he does is his decision. The conditional commitment sequence is a smooth easy way to create rapport while at the same time introducing the patient to the idea that a seemingly insurmountable barrier may in fact be quite manageable.

In summary, both of these MI strategies ("You're wondering"; conditional commitment) are just two excellent examples of how to develop the fine grained synergy at the heart of MI. Building rapport with the patient must be closely intertwined

with addressing the patient's issues on an utterance by utterance basis. We believe that our conceptualization of MI and its synergy provides a clearer and more understandable basis for HCPs to learn and master the flow of MI than the traditional conceptualization of MI with its heavy reliance on acronyms. Essentially, acronyms identify singular actions that are involved in MI. But they provide little guidance about how one action coordinates with other MI actions to form the smooth flow of MI. In our approach, when the HCP is faced with a challenging response from a patient, the HCP can always ask the following two questions:

1. Where am I in building and/or maintaining rapport with this patient?
2. Where am I in addressing the patient's sense making?

The answers to these questions usually help the HCP to think through the variety of options they have for using MI to respond in a difficult situation with a patient. The more HCPs sense the rapport building and sense making dimensions of MI, the more fluent and flexible they become in using MI to facilitate constructive patient decision making. Like Miller and Rollnick, we also use exploration questions to hone in on the patient's sense making and what would make engaging in the target behavior more important to the patient.

An e-learning approach

Having conceptualized MI as grounded in sense making and practical reasoning, we have made our approach more available to the healthcare community with the development of an eight hour MI e-learning program. This e-learning program was formulated in response to several major constraints associated with teaching MI in an intensive workshop. It was not meant to replace all other approaches to training and is not for all learners (people have different learning styles and approaches). It was meant to address a need in the market place for MI training that allowed flexibility in learning and low cost training. It also allowed us to take the ideas in our book and make them "come alive" in a way that is often more difficult with just words.

1. Live training of HCPs is expensive: Live training requires bringing in one or more trainers to an organization. Experienced trainers are expensive; so too are their travel costs. The HCPs being trained also have to be paid their salary for their time away from practice and for their travel costs. In addition, their replacements have to be paid salary and travel expenses as well. We estimate that our 8 hour MI e-learning program is 50% - 90% less expensive than the same 8 hour program conducted as a live workshop. Please keep in mind that in our experience a minimum of 8 hours of MI training is required in order for participants to start to successfully implement MI in patient counseling. Workshops of 1-2 total hours can introduce HCPs to basic MI principles but generally leave them struggling with how to use MI in actual patient counseling and tempted to abandon using MI altogether. Consequently, trying to substitute 1-2 hour workshops (either live or e-learning) for 8 hours of MI training will only decrease the organization's ultimate return on investment.
2. Time requirements and participant fatigue: An 8 hour workshop that introduces HCPs to the basic framework of MI and then provides facilitated practice with expert feedback is an intense and fatiguing experience for the participants, especially if the workshop occurs over one day. In contrast, e-learning avoids such fatigue because shorter 30-60 minute modules can be flexibly spread out over a number of weeks or months to fit the HCP's needs and schedule. With e-learning participants can resume exactly where they left off in the middle of a module or can restart at the beginning of a module or with a previous module. And, of course, the learner can go over and listen to the training multiple times; a luxury not possible in live training unless it is recorded.
3. Standardization of the experience: Organizations seeking to train large numbers of HCPs desire a standardized approach to MI that builds a shared level of competence among their professionals. Unfortunately, training in MI can vary widely in the market place because of the varying expertise of the trainers. Some inexperienced trainers will emphasize only those aspects of MI that they feel comfortable with. Undesirable variability in training has been the experience of some organizations who have sought to train their own MI trainers. There can also be considerable variability in the experiences of learners within the same workshop. For example, early exercises in the application of MI skills often involve group work that inherently allows some participants to dominate and other participants to hide or opt out. As a result some participants actively engage in practicing MI while other participants avoid practicing MI as much as possible. In the face of such problems, e-learning is an effective pedagogical approach that allows for standardization of content presented by experts in MI and for consistent engagement of all participants in required individual practice activities with expert feedback still provided.
4. Repetition: While handouts are commonplace and should be required in live training, not everything can be included clearly and comprehensively in a

handout. While sessions can be audio or videotaped, there are many points made, stories told, and examples shared during spontaneous workshop interaction that are not comprehensible in playback and hence cannot be reexamined for further thought and consideration. In contrast, e-learning allows for individuals to control their own pace so they can easily back up to reexamine interesting material or to review difficult material for greater clarity of understanding. In fact, e-learning modules that are available over an extended period of time are similar to books; both can be accessed repeatedly to assimilate added layers of meaning and significance.

5. Management of focus: Learning MI requires HCPs to recognize and manage a range of interactional dynamics that differ considerably from everyday conversational practices that most HCPs take for granted. During live workshops we have successfully presented videotaped examples of non-MI interaction followed by an MI version of the same interaction. The contrast can be deeply felt and often sparks discussion of the respectful caring manner in which the patient's decision making is facilitated with MI. However, trying to focus upon the use of specific MI skills that occur in sequence (as illustrated above in the analysis of "You're wondering" and conditional commitment) has been difficult in live group discussion of videotaped interaction. Often the group remembers only a general impression of specific utterances and cannot remember how they were worded. Asking them to read through a transcript displayed did not work well. Thus, the participants at a live MI workshop may wind up impressed by the relational qualities of MI but still may remain relatively unable to identify how MI is accomplished through specific devices working smoothly in a coordinated sequence. In contrast, e-learning is able to manage an individual learner's focus more easily so that the HCP can see and appreciate how specific features of individual utterances work in sequence to create a safe and caring environment in which the patient can consider new information that invites health behavior change. Instead of relying upon videotaped interaction as the basis for discussion, our approach is as follows:

    a. In each section of each module, brief background information is presented to the learner on specific principles, concepts and skills.
    b. The learner then sees an inappropriate and then an appropriate application of MI concepts. In our approach to e-learning, the learner sees a picture on the screen of a patient and a HCP. Their audiotaped dialogue is played while simultaneously a transcript of the dialogue is being built on the screen. This approach allows the transcript to come alive as the spoken interaction progresses. Now the narrator's (MI expert) audio description of what has happened at various points in the interaction can be reinforced by visually highlighting relevant words, phrases or sentences in the transcript. In the inappropriate example, words and sections of the transcript that cause the interaction to go astray can be highlighted so the learner can "see" how inappropriate responses to the patient create problems in the relationship and behavior change. In the MI example, the narrator points out highlighted words and language on the screen that create rapport and address the patients' issues in order to increase the probability of behavior change. The HCPs who beta tested the e-learning program consistently remarked that they quickly found this approach to be very involving and helpful because it led them to focus on how various aspects of MI worked together to form a smooth and easy flow of interaction.
    c. Next, the learner goes through several assessment questions with feedback to immediately apply what they have just learned.

The following link will take you to an excerpt from our new e-learning program to see how this approach works in exploring how the two dimensions of building rapport and addressing patient sense making account for different styles of interacting with patients:

https://www.youtube.com/watch?v=yX4XXbikpQM

Through the support of the NACDS foundation we were able to create an engaging and interactive e-learning MI course. Joseph Ganci (http://www.elearningjoe.com), a Guild Master in E-learning, did the programming in Captivate. Joe's creative input into the process allowed us to find new and creative ways to make the principles and skills of MI come alive for the learner in a very interactive format.

This e-learning approach addresses all of the problems of live training previously listed. The cost is an affordable $225 per participant for eight hours of CE credit for pharmacists, physicians and nurses. As stated earlier, learners have three months to complete the eight hour course. At any time, learners can stop and then return at a later time to where they left off in the program. Learners are engaged throughout the course by practice questions and multiple audio and

written dialog case studies. Learners must pass each assessment at 70 percent or greater if they want to receive continuing education. Finally, learners may review each module as often as they like to reinforce learning. The e-learning program can be accessed by clicking on the course catalog tab at: http://nacds.learnercommunity.com/

Summary

In this article we reviewed the development of the ground breaking counseling intervention, motivational interviewing. We posited that teaching MI to health care professionals is very different than teaching MI to counseling psychologists because of differences in prior education and training, the amount of time spent with the patient, and understanding how to use the principles of MI. HCPs struggled with the original conceptualization of MI, especially with its acronyms. In order to teach MI more easily to HCPs, we reconceptualized MI to emphasize patient sense making and practical reasoning. More specifically, people are sense makers and reason their way through situations using whatever information and beliefs they have available to them or have constructed. We stressed the synergy of MI that derives from coordinating rapport building with addressing the patient's issues. And we focused on explaining how and when to use MI skills to build the synergy of MI. Finally, in response to a number of issues involving live training, we developed an innovative e-learning approach to MI that makes 8 hours of basic MI training available to HCPs and organizations in a more accessible, affordable and standardized format.

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