***Motivational Interviewing and***

***the Stages of Change***

Very few decisions in life are completely unambiguous. People make decisions and engage in behaviors for multiple reasons, and frequently, there are simultaneous pressures to both engage and not engage in behavior. These pressures can be from both internal and external sources, and often result in ambivalence, or mixed-feelings, about making a decision or engaging in a behavior. The *PATH* intervention has the philosophy that people generally have compelling reasons for the decisions they make, even decisions that may be harmful. This position recognizes the difficulty involved in behavior change, as unhealthy behaviors are frequently driven by strong motivations.

Behavior change that is driven by intrinsic motivation is more successfully achieved and maintained. Motivational interviewing is a method of enhancing motivation to change by addressing an individual’s ambivalence.

Goals of Motivational Interviewing

1. Address participant ambivalence toward behavior change
2. Encourage participants who have not yet initiation action toward behavior change to move toward behavior change
3. Reinforce participants who are engaged in the process of change to help them maintain their behavior change
4. Reinforce participants who have achieved change and help them avoid relapse

Due to the central role of motivation in the intervention, it is essential for counselors to have some knowledge of the transtheoretical model of change and the accompanying stages of change (Prochaska, DiClemente, & Norcross, 1992) and motivational interviewing techniques (Miller & Rollnick, 2002). The *Positive Choices* intervention requires counselors to assess participant readiness to change risk behavior, substance use, and disclosure decision-making, and includes specific exercises to enhance participant motivation. The stages of change include:

* Precontemplation: The participant does not yet have any intention to reduce health risk behavior.
* Contemplation: The participant has begun thinking about reducing health risk behavior, but has not yet acted on these thoughts.
* Preparation: The participant has intentions to reduce health risk behavior, and has started taking preparatory steps (i.e., he has made a doctor’s appointment or purchased condoms).
* Action: The participant has engaged in health promotion behavior (i.e., he has used a condom during intercourse, or has disclosed his status to a sex partner).
* Maintenance: The participant routinely practices health promotion behavior and has maintained this for several months.

Counselors should be able to quickly assess which stage a participant is in, with regards to engagement in care, sexual risk behavior, substance abuse or disclosure (recognizing that participants may have unique motivations for disclosure/nondisclosure with different people). Having some tools available to assist participants at each stage of change will enhance the counselors’ ability to work with the IMB model and successfully implement this health intervention. Assessing and working within each stage of change will be reviewed briefly.

Assessing Stage of Change

1. Is there ambivalence around reducing health risk?
2. Do intentions match behaviors?
3. Are there barriers preventing change?
4. See “Readiness to Change” questionnaire

Precontemplation: This is perhaps the most challenging step, as the participant has no intention of changing. It has been found that an empathic, open, and reflective listening style is the most useful approach at this stage, and that a confrontational style actually leads to an increase in the undesirable behavior. Participant resistance is a sign that the counselor has pushed too hard. The goal at this stage is to get the participant thinking about change. Questions work better than advice, though must be appropriately phrased (“Do you want to die from this?” may be better asked as “What will you do to protect yourself?”). Analyzing the pros and cons of changing may be a useful approach, or asking questions such as “when do you think it will be time to change?” or “what would have to happen for you to want to change?” Some participants may respond to making behavior change more personal (“what qualities in yourself are important to you? How are these qualities related to reducing or not reducing health risk?”)

Contemplation: People can spend years in the contemplation stage. If a participant is ambivalent, or doubts his ability to change, it is useful for counselors to acknowledge the difficulty in changing while instilling hope (“yes, it is difficult. What other difficult things have you accomplished?” or “how have you changed things in the past?”) With disclosure, counselors may want to use “coming out” as an analogy to disclosing HIV status (“how is telling someone you have HIV similar to or different from telling someone you are gay?”). Discussing barriers to change is also useful (“What would keep you from telling a sex partner your status, or from using a condom”), as is discussing strategies for change (“What would help you to tell a sex partner your status, or use a condom?”).

Preparation: Participants in this stage intend to change and are experimenting with new behaviors. Encouragement and discussion of potential barriers and strategies for action are useful. At this stage, shifting the focus from enhancing motivation to developing behavioral skills is useful. Rather than discussing why to disclose HIV status with a sex partner, it is more useful at this stage to discuss how to disclose, and then practice using role-plays.

 Action: At this stage, behavior change is occurring. Counselors should encourage and praise positive behaviors. Skill building and exploring successes and failures are important (“You talked to your partner about being HIV-positive last night. Great! What went right? Is there anything you would change?”)

Maintenance: Participants in this stage benefit from encouragement and could use behavioral skill development, but are exhibiting the desired behavior. One thing that could be useful is a discussion of relapse, as this is common in behavior change. Relapse, if it happens, can be used a learning tool (“so now you know that sex with a new partner while intoxicated makes you less likely to use a condom. What can you do differently now to keep this from happening in the future?”).

Counselors should operate from within the basic principles of motivational interviewing. This method has a background in humanistic, client-centered psychological theory, and as such, respects the agency of the individual and avoids imposing upon this agency. Counselors should strive to enter the participant’s frame of reference (i.e. understand things from their point of view) and support the intrinsic motivation of the participant.

Basic Principles of Motivational Enhancement

1. Expressing empathy
2. Developing discrepancy
3. Avoiding argumentation
4. Rolling with resistance
5. Supporting self-efficacy

Expressing Empathy: As mentioned above, motivational interviewing is a client-centered and humanistic approach to counseling; therefore, the foundation of motivational interviewing counseling is empathic communication. Key to this are acceptance and understanding of the participant’s feelings and perspectives (though this does not necessarily mean agreeing with the participant). Counselors should become skilled *listeners* with the goal of understanding the participant’s situation from the *participant’s point of view*. Ironically, being accepted *as they are* is often an important step in enabling people to change.

Developing Discrepancy: This step departs from traditionally client-centered counseling, which takes a non-directive approach, as motivational interviewing is deliberately directive and aimed at pushing through ambivalence. Thus, a central goal of motivational interviewing is to identify and amplify discrepancies between participant’s current behavior and their values and goals. When a participant’s behavior, such as substance use or sexual transmission risk behavior, is seen as conflicting with his personal goals, such as physical health, or values, such as protecting the safety of others, behavior change is more likely to occur. Finally, change is more likely when it is motivated by intrinsic goals and values than by external goals and values. When participants are responding to external pressures (such as from a doctor, counselor, partner, or court) it feels coercive. Thus, motivational interviewing aims to draw on the personal values of the participant to identify discrepancies between his behavior and his goals to motivate a change in behavior.

Avoiding Argumentation: As motivational interviewing is a deliberately directive counseling approach, which aims to use confrontive techniques to create dissonance between a participant’s goals and values and his behavior, it is important to emphasize the principle of avoiding argumentation. Holding and arguing a perspective counter to the participant’s can put him on the defensive, thereby increasing resistance and possibly reinforcing the behavior that is trying to be changed. It is fine to hold different opinions, beliefs, and values from a participant, but these differences should not be debated or argued. Finally, feelings expressed by a participant are not arguable. Emotions should always be considered real for the participant.

Rolling with Resistance: It is expected that in the presence of ambivalence, participants will express resistance about changing their behavior. As arguing is counterproductive in achieving behavior change, participant resistance is not opposed or directly confronted, but redirected in the service of change. Motivational interviewing incorporates a fundamental respect for the person, thus decision-making is ultimately up to the individual, and it is assumed that a participant’s decisions make sense from his point of view. The counselor should not impose ideas or give directives, but should invite consideration of alternatives. It is not the counselor’s responsibility to provide answers; rather, the counselor should see the participant as a responsible and capable individual, with the ability to come up with his own solutions to problems. In fact, resistance is a signal to the counselor that a shift in approach is needed.

Rolling with resistance is a way to turn resistance back to the participant. Thus, rather than challenging resistance, counselors should see resistance as a signal to back away and adopt a stance of reflective listening and explore reasons for resistance. This will lead to a new understanding of how to address change—for example, it could lead to identification of barriers to change that need to be addressed, or could identify a need to revisit a participant’s values and goals to increase his intrinsic motivation for change.

Supporting Self-Efficacy: Self-efficacy refers to a participant’s belief in his ability to be successful in completing specific tasks. This is an important element in change, as even if a participant can agree that change is important, if he does not feel that it is possible, it is unlikely to happen. Therefore, it is important for counselors to instill a sense of confidence in participants, and to help participants develop the behavioral skills needed to succeed in changing behavior. Collaboratively developing a health promotion plan that a participant believes he can successfully implement, including trouble-shooting the plan to identify potential obstacles and developing strategies for overcoming these obstacles, is an important step in developing participant self-efficacy beliefs around health risk behavior change.











***Before You Begin: Consider Cultural Competency and Cultural Humility***

What is cultural competency? Cultural competence is an approach to delivering health and mental health services that is grounded in the assumption that services are more effective when they are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. Cultural competence among health care providers is important, as research suggests that many ethnic minorities are distrustful of health professionals, and perceive the health care system to be focused on stereotypes associated with minorities, and disinterested in their health needs.

Cultural *humility* is a concept that builds upon the idea of cultural competency. Cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations. Cultural humility is an important characteristic that *PATH* counselors should possess.

Consider the following steps to cultural competency/humility when delivering this intervention. Don’t hesitate to contact a supervisor or member of the research team to discuss and learn more about cultural competency.

Steps to Cultural Competency/Humility

* Start where the client is: take a moment to learn about who you are working with. What is their cultural, sexual, gender identity? What do you know about these identities? What do you need to learn?
* Assess your own cultural beliefs and biases. How might this impact the work you do with this client? What are some ways to overcome these obstacles?
* Tailor the intervention and your work to be responsive to the cultural concerns of your client, including their language, history, traditions, beliefs, and values.