Welcome to Module 3: Stages of Change and Motivational Interviewing.

By the end of this Learning Module, you will be able to describe the stages of change, delineate some of the principles of motivational interviewing or MI, summarize evidence of its effectiveness, and implement some of the approach in practice.
Now, we will discuss Stages of Change.

First we’ll focus on the Stages of Change model, which is also called the Trans-theoretical Model of Behavior Change. Trans-theoretical means these stages apply regardless of what other models of behavior change might be operative.

Prochaska and DiClemente first published research on these stages of change in 1977. They found that individuals engaged in a variety of unhealthy behaviors could be placed in one of their model’s stages. They also found that people progress through various stages over time. They suggested that it can be helpful to understand what stage of change a patient is in, because that understanding can guide our intervention.
Here are the stages of change. Many people are initially in precontemplation about changing their unhealthy behavior. This means they are not thinking about change, or they’ve thought about change but clearly have no intention to change any time soon.

The next stage for many people is contemplation. This stage is characterized by ambivalence, where individuals recognize advantages and disadvantages of change and feel torn about making a change.

Some contemplators regress back to precontemplation, deciding that they’re clearly not ready to make a change now.

People are in the stage of determination when they are determined or fully committed to make a change soon—say, within one month. People in this stage have made a clear decision to change, but have not made a change yet. Another name for this stage is Preparation, because people are preparing to make a change soon.

And just as contemplators can slip back to precontemplation, people in determination can slip back to contemplation with resumption of ambivalence. These three stages are conceptually important, because they demonstrate that a lot must happen in people’s minds before they are ready to make a change.

The next stage is action, where people have made a change and continue to implement change. Now the challenge is to sustain that change.

Quite commonly, people in the stage of action experience relapse—a resumption of the undesired behavior. One of the important contributions of the Stages of Change model has been to teach many clinicians that relapse is very common and is considered a normal part of the change process.
Most people who try to change an unhealthy behavior will relapse at least a few times before sustaining behavior change for a long time.

Think of relapse as an instantaneous stage, consisting of the moment where the undesired behavior resumed. Immediately thereafter, people typically move back into precontemplation where they have no intention to try to continue change, contemplation where they’re ambivalent, or determination where they are committed to ending their relapse and resuming their efforts to change.

Some patients may circle through these stages for months or years. For such patients, our goals might be to help them reduce the severity and the duration of their relapses and to spend more time in action, where they are engaging in healthier behaviors.

Some individuals in action will progress over time to the stage of maintenance. People are in maintenance when the changes they have made are well-learned and well-integrated into new lifestyles. This typically happens after people have spent 6 months or so in action without a relapse. An example would be a formerly homeless individual with a severe opioid use disorder who has been in treatment, continues to take buprenorphine, has stable housing and employment, has stable social relationships with people who do not use drugs, and appreciates all the positive changes in their lives.

Unfortunately, even people in stage of maintenance can experience relapse. Such individuals typically relapse in response to significant stressors or losses—for example, the loss of an important relationship or a job. Part of our job for people in maintenance is to help them consider in advance how they might respond to such stressors or losses so that relapses can be avoided. Examples of such relapse prevention strategies would be to increase attendance at twelve-step meetings and seek more support from twelve-step meeting sponsors and other supportive individuals.

Some people in Maintenance will eventually end up in the stage of Termination. Termination does not refer to ceasing unhealthy behaviors, which may occur in stages of Action or Maintenance. Individuals in the stage of Termination have clearly exited from the possible cycle of relapse and behavior change.

In fact, some people call this stage “exit”. When people are in termination, their new, healthy behaviors and lifestyle are very stable, and their old, unhealthy behaviors have no draw whatsoever and may even disgust them.

Termination may occur after years in Maintenance. Some people in the stage of Maintenance never get to Termination because they continue to experience some attraction to their old, unhealthy behaviors. For those individuals, our goal is to prevent, shorten and minimize impacts of relapses.
It's important to emphasize that there is no typical amount of time that people spend in various stages. Some people may stay in stages for many years, while others may pass through those stages very quickly. Our job is to keep people in action and maintenance as long as possible and, if possible, get them to termination.

Some people appropriately criticize this model, because the differences between some stages may seem quite subjective. It is often not clear when precontemplation becomes contemplation, and when action becomes maintenance.

In this way, the stages of change may be less useful as clinical labels for people and more conceptually helpful in guiding our efforts to help them. A key clinical distinction is whether individuals are or are not committed to change.

If people are not committed to change, our goal is to help them build that commitment. If they are committed to change, our goal is to help them sustain and build on change.
Applying the stages of change to individuals can be a bit tricky. The next few slides will challenge you to identify the stage of change for two tricky situations. Don’t feel bad if you don’t get the stage right the first time. The goal is that you remember these tricky situations and be able to identify stages of change for actual individuals you try to help in the future.

Here’s the first example. Abby, a city bus driver, has been taking 12 oxycodone tablets per day for 3 months, as prescribed by her doctor for her back pain. Asked what she thinks about her oxycodone use, she responds, “I really should get off oxycodone so I can go back to work.” From Abby’s statement, which Stage of Change do you think she is in, or is there insufficient information?

The correct answer is that there is insufficient information. A key word in Abby’s statement is “should.” Individuals may tell us what they believe they should do, but they may or may not intend to do it. For Abby, this is evident in possible ways that she might continue her statement. She might say, “I really should get off oxycodone so I can go back to work, but there’s no way that’s possible with my severe pain.” This would put her in precontemplation.

She might say, “I really should get off oxycodone so I can go back to work, but I’m not sure I can.” This might put her in contemplation, as she is expressing some ambivalence. She might say, “I really should get off oxycodone so I can go back to work, and I’m going to ask my doctor for a different pain pill at my visit next week.” This would put her in determination.

She might say, “I really should get off oxycodone so I can go back to work, and I started tapering down my dose a few days ago.” This would put her in action. So, when patients tell us what they think they should do, we need more information to place them in a stage of change.

In this case, we might get that information from an open-ended follow-up question, such as,
“So, what are you thinking at this point about your oxycodone?”

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<td>For several years, Bob has injected heroin, usually four times a day. He stays with friends or under bridges. He has been to jail and treatment once and didn’t like either. He says, “I’m getting tired of all this. It’s not the life I want. I’m cutting down to twice a day right now.” What stage of change is Bob in?</td>
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https://www.prochange.com/transtheoretical-model-of-behavior-change

Here’s a second challenging case: For several years, Bob has injected heroin, usually 4 times a day. He stays with friends or under bridges. He has been to jail and treatment once and didn’t like either. He says, “I’m getting tired of all this. It’s not the life I want. I’m cutting down to twice a day right now.” What stage of change is Bob in?

This case is challenging, because cutting down on opioid use is rarely a feasible long-term solution for patients with severe opioid use disorders. Abstinence is usually necessary for remission and recovery.

So we might be tempted to say that Bob is in precontemplation. However, Bob does truly seem committed to change, doesn’t he?

The answer is that Bob is in determination about cutting down, and he is probably in precontemplation about abstinence. This case demonstrates that people can be in different stages of change regarding different degrees of change.

To strengthen a partnership with Bob, it would be important to recognize that he truly does want his life to be better and to respond accordingly.

To learn more about stages of change, you can visit the website shown at the bottom of the slide.
Now we’ll focus on motivational interviewing or MI. The first thing to know about MI is that nobody can develop expertise in MI through one brief session. Just like learning to play the piano, learning to do good MI takes a lot of practice, feedback and coaching. In this session you’ll get a brief introduction to some important MI principles, and perhaps you’ll be able to modify your interactions with patients to include some of the MI approach.

Here’s a definition of MI. It’s collaborative, meaning that it involves a partnership between patient and helper. It’s a conversation style—a way of talking to people. And its goal is to strengthen patients’ motivation and commitment to change.
Let’s talk about three possible approaches to helping patients. One would be directing—telling people what to do. When people want information and advice, directing can be very helpful. Unfortunately, life is not that easy, because most of the time, most patients don’t want to be directed. At those times, a directive approach builds walls and alienates patients. The other end of the spectrum is following, where we don’t try at all to influence patients. This is what many helping professionals do after realizing that directing often doesn’t work. Of course, merely following patients is not very helpful. MI embraces a middle-of-the-road approach of guiding patients. We listen to patients and do what they want—directing, following or helping patients consider options.

The overall goal of MI is to help people engage in and sustain healthier behaviors. That typically starts with people helping recognize a problem, such as a particular behavior that might prevent them from enjoying good health or other things in life they want.
Through MI, we help patients weigh the importance of change in light of what’s important to them in their lives. We help them recognize their strengths and abilities to change.

Once patients are committed to change, we can help them design personalized behavior plans and refine those plans over time as necessary to help them make and sustain a change.

These days, we always want to make sure we bring the best science to bear when we’re treating our patients, and lots of research shows that MI is effective at improving a wide variety of health-related behaviors.

For patients with alcohol-related injuries, MI results in greater and longer reductions in drinking than information and advice. When patients receive other kinds of alcohol or drug treatment, one or two sessions of MI before that treatment can enhance the effectiveness of that treatment.
A key concept for motivation interviewers to understand is ambivalence. Most people who engage in unhealthy behaviors, including drug use and unhealthy drinking, are conflicted about their behavior.

They can typically identify some benefits of their behavior that they wish to continue enjoying and some actual or possible harms of their behavior that they wish to avoid. In MI, we help surface this ambivalence, and we try to help patients resolve it in the direction of better health.

One way to help surface this ambivalence is to help patients consider a decisional balance—a list of the likely benefits and possible concerns about changing and a list of the likely benefits and possible concerns about not changing. In MI, we especially help patients focus on the benefits of changing and the concerns about not changing.
A common misconception about most people with serious substance use disorders is that they are in denial about the consequences of their substance use and resistant to consider change. In actuality, people with substance use disorders don’t use denial as a defense mechanism more than those without substance use disorders, and most are not in precontemplation about change.

Often, it’s the way they are spoken to—when a tinge of judgement or impatience is presented—that elicits responses often cited as evidence of denial and resistance. Good motivational interviewers easily surface ambivalence in most patients with substance use disorders.

Good motivational interviewers avoid common pitfalls, which often fall into the category of directing. Those pitfalls often elicit behaviors that are erroneously labeled as evidence of denial and resistance. Most of those behaviors are simply reactions to the interviewer’s style of communication.
Another key concept in MI pertains to people’s levers of change. What perceptions do we attempt to change in people to increase their commitment to change?

The answer is...

...patients’ perceptions of the importance of change and their confidence to change. In order for people to try to change, they must perceive that change is important—that it would serve their interests and their goals. And they must perceive that they can accomplish change if they want it. Otherwise, it wouldn’t make sense to try. When we do MI, we attempt to bolster people’s perceptions of importance and confidence.
So often, various healthcare practitioners make a common error in helping people decide how to change before they are committed to change. This may be a drawback to some alcohol and drug treatment programs, and this is why one or two sessions of MI before such treatment can improve treatment outcomes. Those sessions help people find commitment to change so they will benefit from efforts on how to change.

Another key concept in MI is change talk. Change talk is arguments that patients make in favor of change. Those arguments occur in the realms of importance and confidence.
Studies have shown that the more change talk we hear from patients, the more likely they will try to change and succeed at change. Thus, a key goal of MI is to elicit change talk from patients, and later we will talk about ways to do this.

The opposite of “Change Talk” is Sustain Talk. Sustain Talk is arguments that patients voice against change—also in the realms of importance and confidence. Studies have shown that the more sustain talk we hear from patients, the less likely they will try to change and succeed at change. Therefore, as motivational interviewers, we try to avoid eliciting lots of sustain talk.
If you were in a state-of-the-art MI training program, you might spend a day or more exploring the spirit of MI. This module will talk about the words to use when delivering MI. If these words are the lyrics to a song, then the spirit can be considered the music. If the lyrics are delivered without the music, the song fails. The spirit is that important.

The spirit of MI emphasizes empathy—the accurate understanding and acceptance of the patient’s situation and never any judgment, always respect. It emphasizes a spirit of collaboration and partnership where we are always eliciting from patients their thoughts, feelings, goals and values, while setting aside our own.

A key aspect of spirit is honoring patients’ autonomy—their right to make their own decisions and our role of supporting those decisions, even if we think they might not be optimal. And all of this occurs with a backdrop of positivity and hope for patients and their wishes.
Consistent with the spirit of MI, here are things that we should never do as motivational interviewers. We should never give unwanted information and advice, nor should we attempt to persuade patients using guilt or scare tactics. We should never talk about how to change when patients are not committed to change. All of these actions would show disrespect for patients and dishonor their autonomy. They would tend to build walls and elicit sustain talk.

Now we’ll cover the four processes of MI in sequence—engaging, focusing, elicitation and planning. Each earlier process serves as a platform for a later process.

First and foremost is engaging with patients—establishing their trust and openness. That process continues throughout every interview.
Initially, engaging could include all the items you see on the slide.

For example, “Hi, I’m Joe. I’m a peer coach. Your doctor asked me to come see you and talk, if you’re willing. What we talk about would be as confidential as all of your care here. The only exceptions where other people might have to get involved are if you say anything about possible child abuse or hurting yourself or someone else. For anything we talk about all decisions will be totally up to you. I’m not here to judge you or talk you into doing anything you don’t want to do. Do you have any questions?”

Assuming the patient says no, you might continue, “Is it OK if we start talking a bit?” Assuming the patient says yes, “I’m sorry to see you hooked up to all these tubes and machines. How is it going?”

The next step is focusing—collaborating with the patient to decide specifically what you’ll want to talk about. An important part of focusing is asking the patient permission to talk about a particular topic. If there’s more than one topic you’d like to discuss, you can ask the patient which they’d like to talk about first. As an example, you might say, “My job is to talk to people about how to stay healthy and avoid coming to the hospital again. Your doctor mentioned that your use of heroin might have had something to do with why you’re here, so I wonder if we could talk about that.”

Once the patient agrees to talk about their substance use, the next process is elicitation—gathering lots of information from patients about their lives, their substance use, the impacts of the substance use on their lives, and especially change talk, because our ultimate goal is to try to help patients commit to change. Most of the rest of this presentation will focus on how to conduct elicitation.
Finally, if and only if patients are committed to make a change do we offer to help them plan exactly how they would go about changing. We’ll come back to planning at the end of this presentation.

Now we’ll talk about ways to elicit change talk—how to establish a climate where change talk tends to surface, how to respond to it so that more change talk occurs, and how to actively seek change talk if it doesn’t occur spontaneously.

To establish a climate where change talk frequently surfaces, motivational interviewers practice “OARS.” They ask open questions, deliver affirmations, make reflections and summarize. OARS is an apt metaphor, because they give structure and direction to interviews, just as people use their oars to direct canoes.
Open questions ask for more than a brief response. They ask patients to tell stories and talk about what’s important to them. They usually start with “How”, “What”, or “Tell me more.”

It’s especially helpful to start talking about alcohol and drugs with open questions to get patients talking openly about their substance use and its impacts. An initial open question could be, “How do alcohol and drugs fit in your life?”

You also might ask, “What do you like about alcohol and drugs?” It’s critical that you show acceptance and no judgment about patients’ responses, so that patients will feel comfortable opening up even more. Patients’ responses to this question typically consist of sustain talk—reasons why they might not wish to change.

It’s OK to elicit a little sustain talk in the beginning of the interview to demonstrate your desire to accurately understand your patients and their lives. After patients get comfortable talking with you about the upsides of their drinking and drug use, they will likely give an accurate response to your next question about the downsides they’ve experienced.
When we ask patients to talk to us about their drinking and drug use, we’re asking them to share personal, sensitive and unpleasant information. To help patients feel more comfortable doing so, it’s important to actively show respect for patients. One way to do that is with affirmations—positive statements about patients’ strengths and accomplishments.

When we do this, we want to avoid praise and compliments, which would suggest that our role is to judge patients. Instead, when we deliver affirmations, we point to objective evidence of particular strengths and accomplishments.

Here’s an example of a positive judgment and empty cheerleading. Unless you know this patient very well, the patient is likely to feel that your statement is not genuine.

Here’s an affirmation instead. It points to actual evidence of strengths and accomplishments that can be applied to recovering from the patient’s current drug addiction. This is much less of a positive judgment and much more of an objective observation. A true affirmation usually leaves a patient feeling good about themselves and more confident that they could change.
Here’s another example of a positive judgment that patients may not feel is genuine. And here’s a true affirmation, which gives evidence of an objective and positive observation of a strength.

Affirmation Example 2

*No:* You’re a good parent.

*Yes:* The careful and thorough way you think things through about your kids shows that you really care about them.

More than half of good motivational interviews are usually reflections. Reflection requires that we listen very intently to patients, because reflections are statements that echo back to the patient the meaning of what they just said, usually using at least slightly different words.
Reflections accomplish several important goals in motivational interviewing. They convey empathy—an accurate understanding of the patient’s situation. They help us check our understanding. If a reflection is not accurate, it gives the patient an opportunity to correct our wrong impression. Reflections encourage patients to say more. By choosing to reflect part of what the patient said, we can shape the direction of the conversation. By choosing to reflect change talk, we can often elicit more change talk.

Here’s an example of an interview segment with two reflections.

The patient says: Beer relaxes me and I enjoy the buzz.
The interviewer reflects: You like how beer makes you feel.
The patient responds: Yeah, and it also helps me feel more comfortable in social situations.
The interviewer reflects again: Beer makes it easier for you to talk to other people.
Maybe you can get a sense from these examples of how reflections help patients feel heard and validated.

Summarization is when, after talking about something for a minute or two, the interviewer ties together several reflections of the patient’s previous statements. This is often a helpful way to end one segment of an interview before making a transition to the next segment. For example, “So on one hand you enjoy drinking, how it relaxes you, and how it helps you have a good time with friends. On the other hand, you’re concerned about your drinking’s effects on your marriage, your job and your health. Did I get that right?”
We’ve covered establishing a climate where change talk can surface. We use OARS, and we avoid pitfalls that tend to put distance between us and our patients and often result in sustain talk. Next we’ll focus on responding to change talk in ways that encourage more change talk.

The bottom line is, when you hear change talk, get curious about it. Ask open questions about it. Reflect it. Get patients talking about change, what it would be like to experience it, and how beneficial it would be, so that they hunger for change.

Here’s an example of change talk and how you might respond to elicit more.
When responding to change talk with reflections, it’s useful to consider a couple of special kinds of reflections. One kind of reflection, a double-sided reflection, is relevant when patients express their ambivalence by including change talk and sustain talk in the same sentence. The interviewer responds by reflecting the sustain talk first and the change talk last. You reflect the change talk last, because whatever is reflected last is usually what patients will talk about next, and your goal is to elicit more change talk.

Here’s an example. The patient says, “I enjoy chilling with pot but then I can’t get any writing done.” The interview reflects, “Pot relaxes you and stops you from getting important work done.” Notice that the interviewer reflects first on the sustain talk, about pot being relaxing, then the change talk, about pot interfering with work. Also notice that the interview ties together the sustain and change talk with the word “and,” not “but”, because “but” invalidates whatever comes before it, and we don’t want to invalidate what our patients say.
Here’s another example. The patient talks about a disadvantage and advantage of going out with friends. The interviewer switches the order when reflecting, so the sustain talk, about liking to go to bars with friends, is first, and the change talk, about feeling miserable the next morning, comes last.

Another kind of reflection that’s especially useful in eliciting more change talk is a reflection of emotion. When reflecting change talk, emphasizing unstated emotion can help elicit more and stronger change talk.
Here’s an example. The patient says, “I want to set a good example for my kids, so I really don’t like when they see me drunk.” The interviewer labels the unstated emotion by reflecting, “When you’re drunk in front of your kids you feel guilty.”

Sometimes, even though interviewers have done a good job with OARS, change talk just doesn't happen. So now we'll focus on how to actively elicit change talk.
One way to elicit change talk that doesn’t occur spontaneously is simply to ask for it. Here are some questions that commonly elicit change talk.

The first one we talked about earlier. After asking what people like about their drinking and drug use, ask about the downsides.

Here are other helpful questions: “What would be better in your life if you quit or cut down?” or “What would be the worst things that could happen if you don’t quit or cut down?”

If these questions elicit change talk, get curious and use open questions and reflections to elicit more and deeper change talk. If not, maybe your patient is just not ready for change.

We’ve covered the first three processes—engaging with patients, focusing and elicitation. Now we come to the fourth process: planning.
The goal of planning is to help patients who are ready to change decide how they are going to change. We do planning only with patients who are ready to change. How do we know who is ready to change? People tend to be ready when we’re hearing lots of change talk and little to no sustain talk. If we’re not sure, it’s best to ask.

First, we summarize what we’ve learned about them and their drinking and drug use, especially emphasizing all the change talk we’ve heard. Then we ask a key question about readiness, like “I wonder where does this leave you?” or “So, what might be your next step?”

Notice these are open questions, not leading questions, as we really want to know whether patients are ready or not. If they’re not ready, we accept their decision, thank them for their openness, and invite them to return if they’d like to talk more. If people are ready to change, we offer them help to plan how they will change.

Here’s how the planning process works. In the initial visit, if patients are interested, we help them design their initial change plan. Between that visit and the next, they implement their plan. At the next visit, we review the plan together and the patient decides whether to modify the plan to better meet his or her goals.

Then the patient implements that new plan and comes back to review that plan and consider changes to the plan, and so on. Through this iterative process, patients learn for themselves what they need to do to meet their goals, and the motivational interviewer helps structure and facilitate the process.
Here are possible elements of change plans. In general, more detailed change plans tend to result in more success. As motivational interviewers, we help patients consider various elements of change plans, present menus of options, and give advice only when patients request it. Patients decide on their plans, and our job is to accept and support their decisions. First we help them consider whether to quit entirely or to cut down to certain limits, which they can set on a daily and weekly basis. We help them consider what might trigger them to exceed their limits and how they might avoid or manage those triggers.

We help them consider what activities they might engage in to help them stick to their limits. For example, patients might consider playing basketball rather than going bowling if they wish to quit drinking, since many bowling alleys serve alcohol. We help patients consider environmental changes that eliminate cues to drinking or use drugs, such as having bottles of liquor or drug paraphernalia available in their homes. We help patients consider medications for alcohol or opioid dependence, which ample research has shown improves remission rates. We help patients consider social supports, such as loved ones, friends, self-help groups and various professional resources.

We help them plan what they might do if they are just about to exceed their limits. Typical contingency plans involve talking to family members or friends or activities that remove them from environments with alcohol or drugs, such as going for a walk or taking a bath. Lastly, they consider when they’d like to come back and review their progress with you—typically in 1 to 4 weeks.
In this module, we’ve covered quite a bit. We covered the stages of change model, emphasizing the importance of understanding whether patients are or are not committed to change. For most of the module, we focused on motivational interviewing, an empathic, collaborative approach to promoting change with effectiveness demonstrated by hundreds of studies. We talked about key concepts behind MI, including ambivalence, perceptions of importance and confidence as levers of change, change talk and sustain talk.

We talked about the spirit of MI that must support our words. We talked about the four processes—engaging with patients, focusing in on a topic, eliciting patients’ stories, perceptions, especially change talk, and planning. We talked about using open questions, affirmations, reflections and summaries to create a climate where change talk often surfaces. We talked about how to actively elicit and respond to change talk. Finally, for patients who are committed to change, we talked about how we can help them design change plans and refine them over time to help patients meet their goals.

As we discussed toward the beginning of this module, becoming a competent motivational interviewer requires quite a bit of training, practice and feedback. If this module stimulated you to learn more about MI, additional resources can be found in the Resources tab.