



## MOTIVATIONAL INTERVIEWING (MI) with Survivors of Violence – A Reference Guide

The “Conviction Confidence Model” of mentoring behaviour change can be used to support those who need to make changes in their life.<sup>1</sup> The model was created specifically for clinicians working in the time-limited setting of the medical interview to bring about positive and durable change in lifestyle or behaviour by informing and motivating patients. “Informing” is a frank discussion of risks in order to increase awareness and replace denial with insight. “Motivating” is a guided exploration of factors leading to empowerment with the ability to change. Motivational interviewing (MI) is a skill used to support the discovery of the personal value of change and to build confidence in the ability to accomplish change.

Three steps are used in motivational interviewing:

1. Assess the **stage of readiness** for change – this may require a frank discussion of risk to overcome strong denial.
2. Increase **conviction** (motivation) to change by an objective reflection in order to discover the personal **benefits** of change. As conviction (motivation) grows, the attention can shift to building confidence.
3. Building **confidence** in the ability to change through an exploration of individualized solutions to **barriers** perceived by the individual.

The key questions can be used to guide conversations in the three steps of MI:

The questions:	Will reveal:
Q1 What are your thoughts about _____?	(Stage of readiness to change)
Q2 How would your life be better if _____?	(Awareness of <b>benefits</b> increases conviction/ motivation to change)
Q3 Is anything standing in the way of making this change?	(Addressing <b>barriers</b> increases confidence / empowerment in ability to change)

## STAGING THE PATIENT

### Q1. WHAT ARE YOUR THOUGHTS ABOUT \_\_\_\_\_ E.G., SMOKING, ALCOHOL, YOUR RELATIONSHIP?

The patient's answer provides the stage of readiness for change. Listen carefully to the language in the response.

Stages of change are used to determine readiness of the patient to change (Prochaska's<sup>2,3</sup> model of human behaviour change below and also some of the key stages are superimposed in [Figure 1](#)):

- **Pre-contemplation** (can't conceive of change, denial of any benefit from change)
- **Contemplation** (sees the good and bad, responds with an ambivalent "but" – "I could change but I have reasons to continue this way")
- **Preparation** (desires the change but can't see how, responds with a disempowered "but" – "I would love to change but I can't do it")
- **Action** (empowered with growing confidence, regaining control of life)
- **Maintenance** (change accomplished for > six months)
- **Relapse** (is a normal part of the process and is an opportunity to learn)

The patient's stage of readiness determined by the answer to Q1 will focus the MI conversations that follow. Denial characterizes the **Pre-contemplative** stage of least motivation. Informing about actual risk can help to replace strong denial with increased awareness of the benefits of change. Recognition of personal benefit will transition the patient from pre-contemplation to contemplation. Now the conversation shifts from informing to motivating.

## MOTIVATING THE PATIENT

### Q2. HOW WOULD YOUR LIFE BE BETTER IF \_\_\_\_\_ ?

The answer reflects the benefits of change recognized by the patient.

At the **contemplation** stage, the focus of MI will be on the benefits of change. The interviewer helps to increase conviction (motivation) by guiding the patient from an awareness of general but impersonal benefits (e.g., "It would be better to leave.") to an appreciation of immediate, personal and emotional benefits of change (e.g., "I would love to see my children living without constant fear.")

- Further questioning: "*How would your life be better if by magic there was no fear?*" This will reveal the benefits of change the patient perceives in their life.
- These benefits must be reinforced, made personal, real, immediate, and connected to positive emotion by asking: "*Wouldn't it be wonderful to feel safer? What things in your life would be better if you were safer?*"

- The response might be, “*I want to see my children living in a kind and loving home without constant threats and fear.*” Living without fear –now we know we have connected with a real and immediate personal benefit. This is what motivates (internally) and will need to be reinforced to move forward.
- “***What are your thoughts about...?***” Response “*I’d love to do it **but** I can’t*”. This indicates the high conviction/motivation of preparation stage with a disempowered “but”. The focus can now shift to empowerment by increasing confidence in the ability to change.

## EMPOWERING THE PATIENT

### Q3. WHAT IS STANDING IN THE WAY OF MAKING THIS CHANGE?

The answer reveals the barriers to change

- Overcoming the barriers builds the confidence needed to accomplish the change.
- Further probing can help the patient identify his/her perceived barriers to change “*So you would love to do it. What is standing in the way of making this change?*”
- Once the barriers are identified, the patient begins to think of acceptable solutions. If the patient cannot identify solutions to barriers, the clinician can suggest options that others have tried with success, but don’t tell him/her what to do.

#### PRACTICE POINT

*Not all of this work needs to be done in one or several sessions even though risk has been identified.*

*It is more important to take the time necessary (baby steps if necessary) to successfully move forward enabling durable change.*

*Trying to hasten the process will increase the chance of relapse and reduce confidence in the ability to succeed.*

The model (see [Figure 1](#)) is used to plot the patient on the scale of increasing conviction/motivation as benefits to change are appreciated and then increasing confidence as solutions are found for barriers to change. Prochaska’s stages are superimposed on the diagram and create a focus for the next steps in MI.

Clinicians can tailor interventions to assist the patient visualize the benefits and/or identify barriers to change.

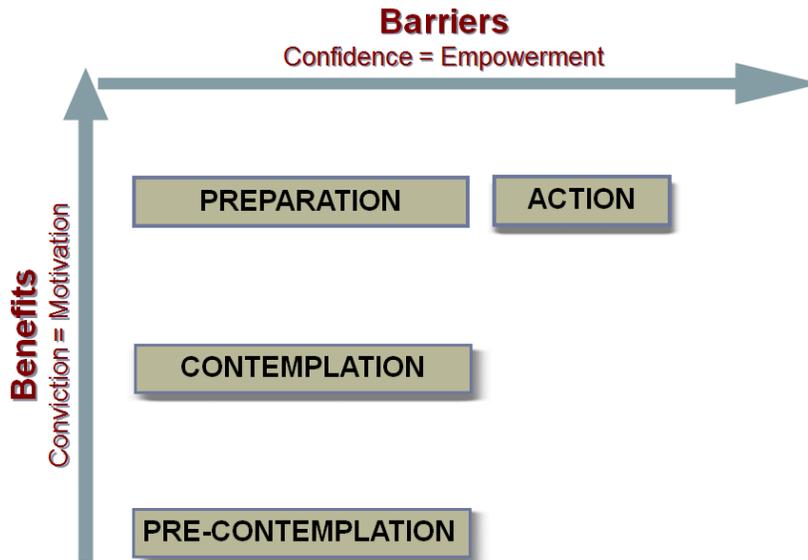


Figure 1: Blueprint for MI conversations leading to lifestyle changes<sup>2,3</sup>

Change does not occur in a straight line of increasing conviction and growing confidence. The path can be forward then backward but should eventually proceed over time as the patient learns from his/her relapses.

## CLINICIAN CHECKLIST TO IMPROVE MI SKILLS<sup>4</sup>

### *DRES* (“SPIRIT OF THE DISCUSSION”) SKILLS

- Develop Discrepancy – between actual and ideal behavior, between behavior and larger values. Informing of facts can replace denial with personal insight of benefits – becoming contemplative.
- Roll with Resistance – never use force to respond to force; avoid the ‘righting reflex.’ Ask don’t tell, and, listen don’t lecture.
- Express Empathy – especially when the patient exhibits strong resistance. Understand their experience and offer ideas and options.
- Support Self-efficacy – actively support and affirm the patient’s strengths and allow maximum freedom, choice and time. Empowerment is a personal journey.

### *AROSE* SKILLS

- Affirmations – support strengths, conveys respect and appreciation, deflect resistance
- Reflective listening – used to explore concerns, convey understanding, reflect respect, elicit change ‘talk’
- Open-ended questioning – to explore concerns, promote collaboration, understand the patient’s perspective

- Summarize – to organize discussion, clarify motivation, build insight
- Elicit change talk – the patient must identify what the main problem is before change can happen

## *REVIEW YOUR MI SKILLS WITH THE FOLLOWING CHECKLIST*

### **ENGAGED WITH MY PATIENT**

- I fully understood the problem and the patient’s perspective before talking about change
- I focused on engagement before moving to change
- I used reflective listening to convey empathy and understanding
- I used affirmations to build a positive relationship with my patient

### **ASSESSED MY PATIENT’S MOTIVATION**

- I identified a target behaviour
- I identified the stage of change
- I used the importance, readiness, confidence ruler
- I differentiated between areas of motivation (e.g., substance use vs mental health; treatment vs change)

### **ADDRESSED AMBIVALENCE**

- I normalized ambivalence for my patient
- I explored the ambivalence with my patient
- I reframed the ambivalence for my patient
- I used a decisional balance with my patient – weighed options
- I avoided direct persuasion when discussing with my patient
- I explored pros and cons of change with my patient

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