Motivational Interviewing

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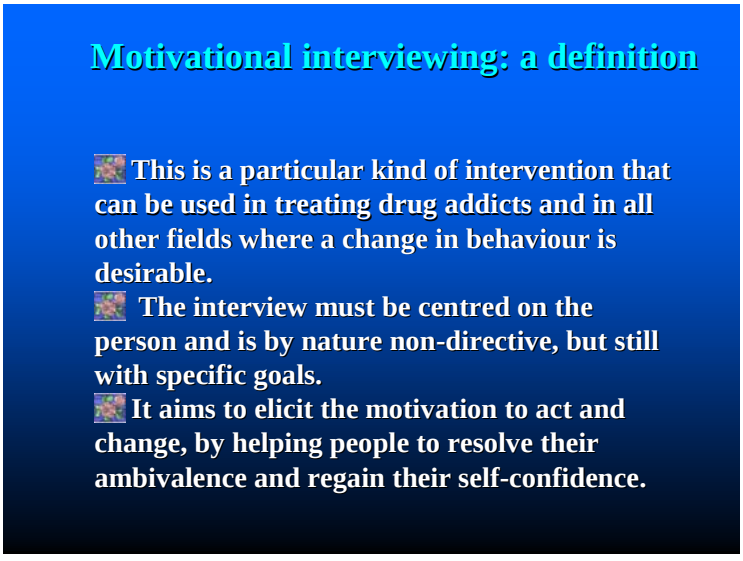
The need for change

When faced with a patient who lacks the motivation to follow his or her[1] treatment or someone whose behaviour reflects an addiction, who among us has not felt overwhelmed by this attitude which appears to us to be both illogical, irresponsible and exasperating? How many of us have never felt tempted to convince, to confront, to make the patient adopt behaviours considered to be better? The diabetic who doesn't follow his treatment, the obstinate smoker, the alcoholic who doesn't want to admit that he drinks – these are all, for us as nurses, significant challenges and hazards in the course of our therapeutic activities.

The habits we have acquired of intervening and our desire to do our jobs well has led us to adopt more or less directives approaches with our clients. So we have come to believe in the need to use "confrontational" methods to overcome the alcoholic's or drug addict's defences of denial. This was the approach of Vernon Johnson, a classic approach in this field, whereby the person has to first recognize his alcoholism or his addiction to some substance or his lack of motivation to follow a treatment, even after dramatic demonstrations of the harm he was doing to himself and to his family or the risks he was taking. Our way of dealing with the diabetic or the recovering cardiac patient by generating fear and the threat of complications is not so different, but it has shown itself to be as ineffective in these cases as with alcoholics and drug addicts.

It would seem therefore logical to explore other ways of convincing people and eliciting their motivation to change. In an approach based in scientific studies, the researchers William Miller and Stephen Rollnick proposed a different approach towards preparing patients for change and new suggestions for interviewing these patients, questioning the directive role of the interviewer and replacing this with a more motivating attitude.



Motivational interviewing

This approach, first used in the context of addiction was subsequently adapted to other areas

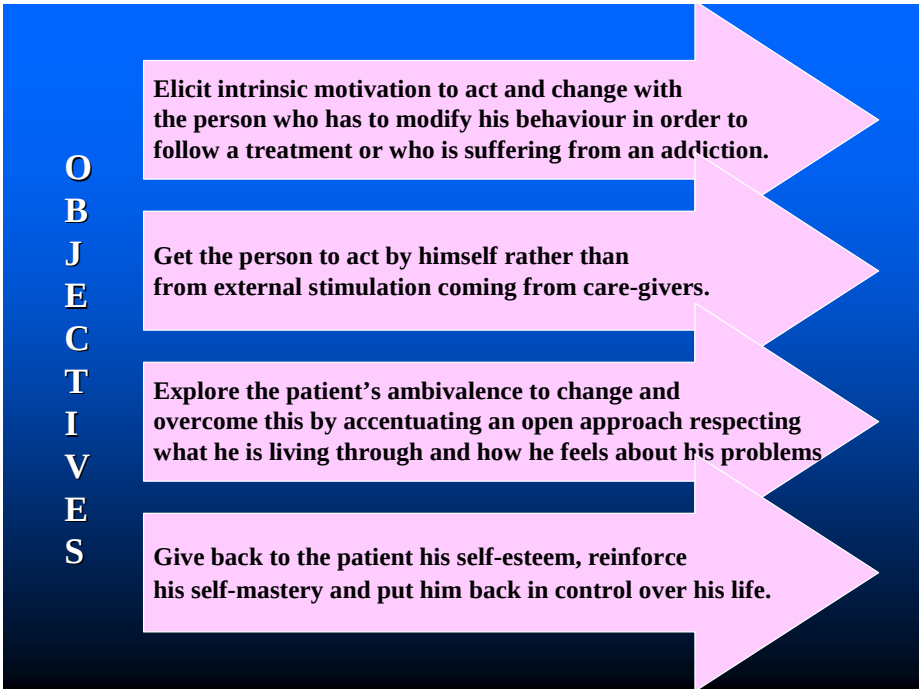
[1] Throughout this text we will be using the masculine when referring to patients or clients, and the feminine to refer to the interviewer or care-giver. This is to make the text more readable and does not suggest that patients are usually men, nor care-givers necessarily women.

of health care where we have to get people to take responsibility for themselves in the face of their treatment or a change in their behaviour. By adopting an approach that is open and respects the patient's own life experiences and how he feels about his problem, it becomes possible to explore the patient's ambivalence to change and to succeed in overcoming this. This approach does not impose anything; it does not use either fear or threats. Throughout the interviews, the measure of the care-giver's effectiveness remains the extent to which the person interviewed is resistant to what is proposed; this shows that the insistence is too strong, and that the intervention is generating an opposing force, through the defence mechanisms of negation and rationalization. The therapeutic influence occurs, then, in a delicate balance between action and reaction.

Motivation is a central factor in these situations of addiction or when a behaviour needs to be modified. In the more traditional approach, for the treatment to be successful it went without saying that the person has to be motivated. You could see this, for example, when the person accepts the label of "alcoholic", when he agrees with the care-givers and faithfully follows their recommendations. Otherwise, the person is judged to be "amotivated" and condemned to failure.

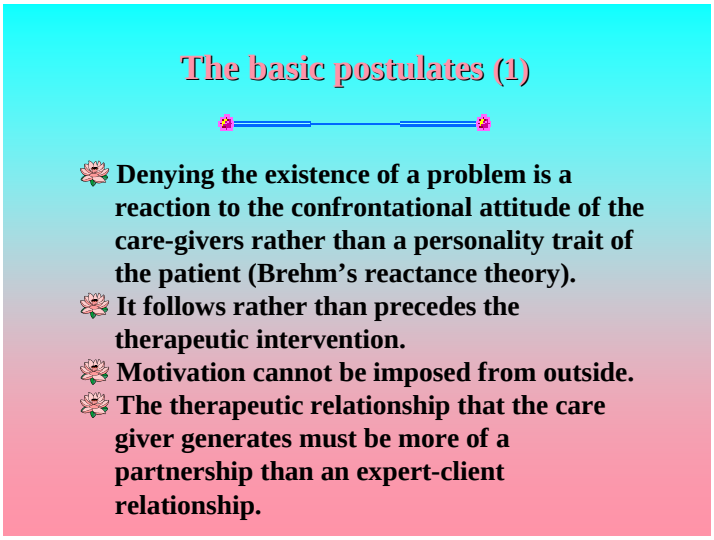
Objectives

Essentially centred on the person, this approach of motivational interviewing has the central objective of generating intrinsic motivation leading to the decision to act rather than extrinsic stimulation coming from the care-givers. We all know how hard it is to change a habit, even a bad habit, such as smoking cigarettes, drinking or taking drugs. We also understand that it is not easy to adopt a new way of living because one is diabetic, obese or asthmatic. This is the drama of these addicted people or of patients who would certainly like to change their behaviour and their life-style, but do not manage to do so, or who, if they succeed in making changes, often only do so after a lot of efforts, repeated attempts and numerous failures.

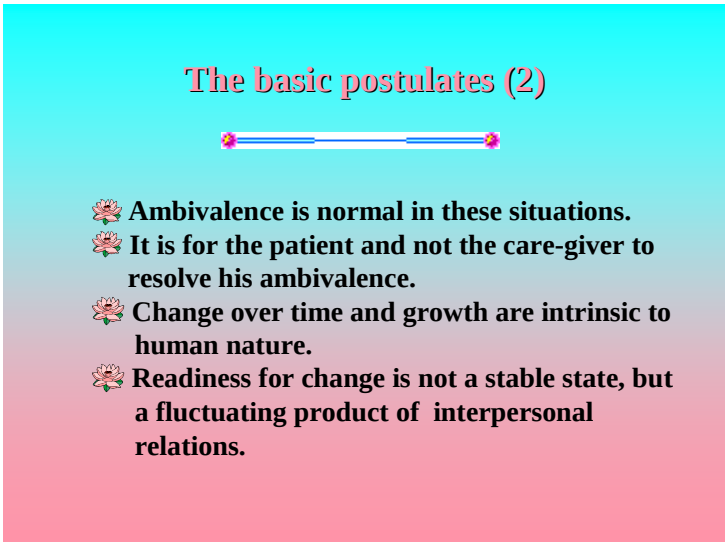


The approach using motivational interviewing is different in the sense that it targets an important change, supported by activating an internal motivation that comes from the person himself and the patient himself, overcomes his ambivalence and denial. The objective can only be attained by creating, right from the start, a partnership in the provision of care, immersed within a relationship of respect and non-coercion.

Especially when the person has an addiction, another objective of this approach, and by no means the least important, is to give him back the self-esteem that the addictive behaviour and the problems inherent in this have taken away. Whether the problem is related to taking medication, alcohol, drugs, gambling or the Internet (blog addiction), this person is not only living through the humiliation of his numerous aborted attempts to stop, but he also has to put up with pressure from his close circle of friends and family and the sense of guilt resulting from this. In fact, the deviations in his behaviour and resulting financial and interpersonal problems are at the origin of conflicts, often destructive, within the family, but, at the same time, devastating at the level of his self-image and self-esteem.



The esteem in which we hold ourselves and that we see reflected in the eyes of others, particularly those who are dear to us, is a powerful source of happiness and energy. It is the miracle of positive regard that Carl Rogers talked about. It nourishes our motivation and action. There is one undeniable fact: if we value ourselves, we feel we are competent. This is why, in this motivational approach, it is important to reinforce the self-image of people in whom we want to bring about changes in order to arrive at giving back to them self-mastery and to putting them back in control over their own lives. Since self-esteem is one of the factors nourishing action, the subject will in this way be able find more easily the means to succeed in bringing about change. And, if we want this change to be truly lasting, we have to get him to convince himself that he can become the captain of his own ship. Otherwise, nothing will be achieved.



The foundations of this approach

Motivational counselling retrieves the principles of the patient's autonomy and of listening, focusing on the person by which empathy, as elaborated by Carl Rogers, creates an open and warm dialogue. These are the major components of the helping relationship so well-known in nursing.

We see here this optimistic belief in human nature: each of us possesses within ourselves the psychological resources that are required to solve problems and to improve our lives. Also relevant here is Rogers' fine comparison with the acorn on an oak-tree which, he said, conceals within itself all it takes to become a big tree, just as each person contains what is needed to evolve and grow. But there is more than this in the principles underlying this approach. Like the plant that, following the laws of nature, germinates and matures, within each human being there is a profound feeling, a vital energy that incites self-fulfillment. This is the tendency towards self-actualization of the Rogers' humanistic approach that one finds repeated in motivational interviewing.

Just as the oak-tree acorn contains within it everything needed to create a tree, so Man has all it takes to improve, to have a greater sense of responsibility, more autonomy and more peace-of-mind.

Carl Rogers

For this force to come to the surface, in an interview for example, the person has to be immersed in a climate of freedom, that Rogers called "non-directivity". This way of conducting the interview, showing respect for the other person, aims to let the subject express himself without interrupting him, nor judging him, nor criticizing his moral, social or religious values, nor trying to impose our own ideas or ways of doing things and without trying to channel what he is saying in a particular direction. Essentially, motivational interviewing tends to allow him to follow his own course. This is an approach reflecting a sense of confidence in other people, an unconditional acceptance of who a person is and what he has within himself as possibilities. As care-givers, we often have to remind ourselves of this comparison with the acorn on the oak tree. It is not only a beautiful image, but also the source of inspiration, particularly when we are finding it hard to accept certain difficult patients, whose values are far from our own. This comparison can also be reminiscent of hope in the face of those whose will-power is slipping and of whom we lose hope that they will ever develop the motivation to change.

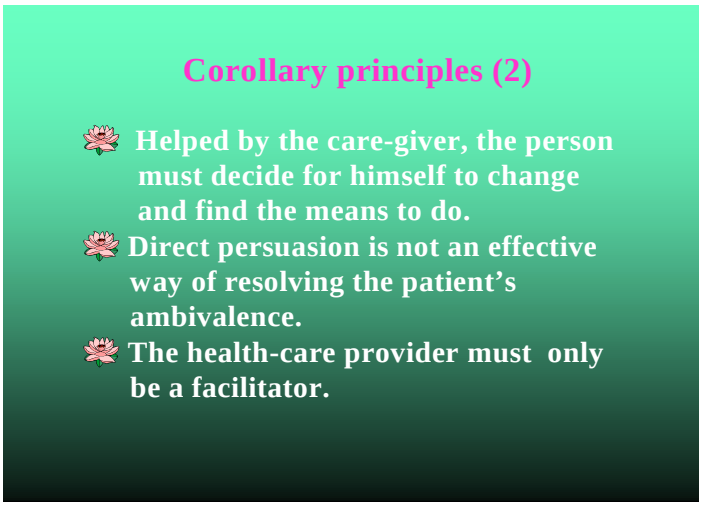
The acceptance that underlies this way of seeing the other person is, in its own way, another "motor" for action. Psychologists tell us in effect that it is from the moment that a person feels accepted and understood, becomes reconciled with himself and regains his dignity, that he feels happier and more open. He no longer needs to seek refuge behind his defences in order to justify his choices and his behaviour; he finds he has the energy that is needed to change.

Corollaries (1)

- **Resistance to change is an indication that an intervention has failed.**
- **Interviewing strategies must be adapted to the patient's stage of motivation.**
- **People who have experienced numerous losses or failures find it difficult to perceive hope as an effective survival mechanism.**

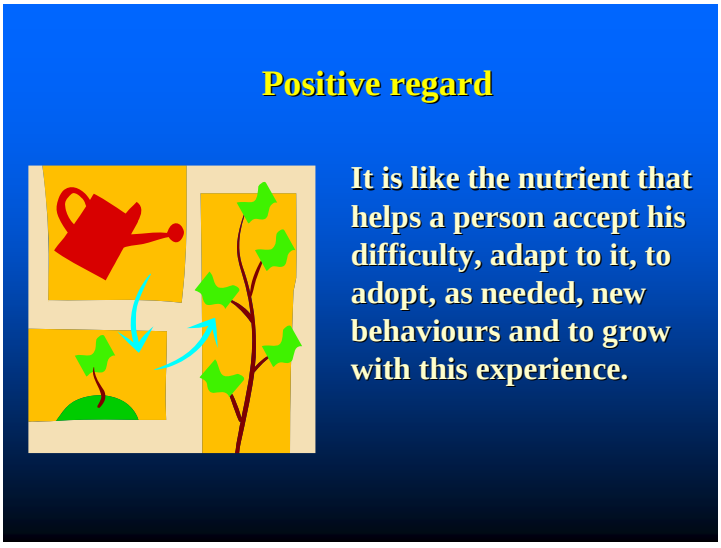
Motivation

In this approach, as its name suggests, motivation is the central factor. In these situations of addiction or behaviours that need to change within a treatment framework, this positive attitude is the basis of everything else. From a more traditional perspective, it is obvious that for a therapeutic intervention to succeed, the person has to be motivated. Nobody can deny this contention. But in motivational interviewing, the way of seeing motivation and eliciting it is diametrically different.



In fact, when we use an interventionist approach, we see the motivated person as having certain particular traits. First, we link his motivation to that fact that he accepts the label of alcoholic. Otherwise, we don't believe he is willing to change and consider he has no chance of doing so. Another condition of this person being considered as "motivated" is that he must agree with the care-givers and accept to follow their recommendations faithfully. Otherwise he is judged to be "amotivated", unworthy and condemned to failure.

In such a perspective, difficult situations take on the character of confrontation, a "low-intensity warfare" in which the recalcitrant patient is seen as a bad patient, sending a message back to the nurses that they are bad care-givers, rather than simply seeing him as a partner in the provision of care caught up with real difficulties. But there is more to this. The whole attitude of the care-provider and the content of what she says are often biased from the start by the conviction that the person will be inevitably obstinate in his stance of lacking the motivation to change and that he is invariably seeking refuge behind his defences. These preconceived ideas about patients - for here we are really talking about prejudices - have consequences that resemble those of the Pygmalion effect (Vincent Rossignol, 1998), as observed in research studies and educational settings. It has been shown many times that our expectations and perception of others modify their behaviours. In schools, for instance, if a teacher thinks that a child is good, there is a good chance that he will rise to the level the teacher expects of him.

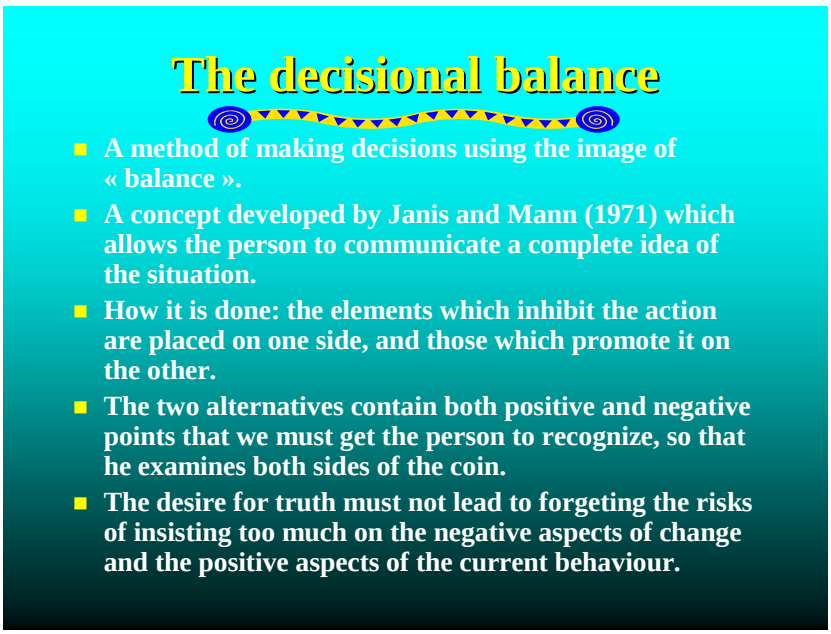


It is the same in nursing. If we see patients in a positive way, as capable of achieving change, they in fact do become capable of this; if, on the contrary, we see them as unmotivated, they equally become unmotivated. It is clear that when, from the start, we lack confidence in the person and our respect for them is limited, it is hard to create a real care-partnership with them.

The relationship between the care-giver and the patient then remains, to a greater or lesser extent, authoritarian and less motivating. As a result, if the nurse puts herself in a relationship of expert-client, if she tries to impose her desires outside of herself, there is little chance of generating a desire for change. However, as Miller has explained very clearly, without a real desire to change, if the person does not see for himself the need to do this, no change will be achieved (Miller, 2000, 89-93). So, in this approach, motivation takes on a different guise which makes us recognize that it cannot be imposed from outside with insistent pressure or threats. We have to understand that our own action, during the course of an interview, has to occur within an approach characterized by respect, consideration and reinforcement of the positive values that are expressed by the patient and of the adaptive behaviours he demonstrates. This must also be directed towards stimulating the person to develop internal motivation, coming essentially from inside himself, in other words, intrinsic motivation. This has to be a lever for action, not a crutch to lean on.

Working on ambivalence and resistances

This motivational approach leads also us to adopt a very different opinion about ambivalence, the negation of the problem and the patient's resistances to change. Originally, these were considered as part of the personality of the subject who was suffering from addiction. But here ambivalence is considered rather as being normal in a situation in which the person receives benefits that are pleasant for him and he is hesitant to drop these for a change which is still unpredictable and that worries him. The decision to break a well-rooted habit, that has become a way of life, is really extremely difficult to do. This addictive behaviour of failure to follow a treatment certainly creates major inconveniences, but it contains also a whole potential for satisfactions that make the decision to stop the behaviour very problematical.

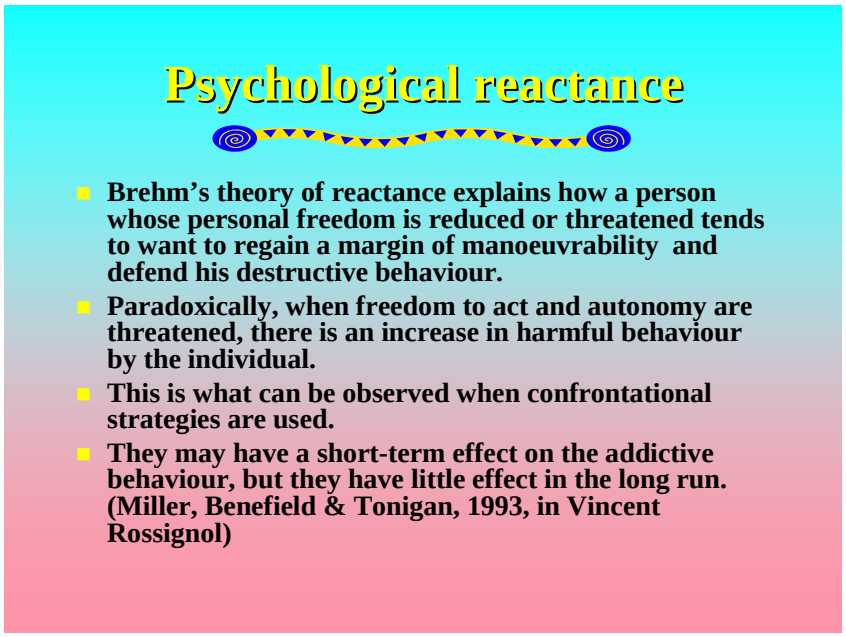


But the ambivalence always remains an important problem in these situations, yet in motivational interviewing, this attitude is considered as coming from the patient himself, and not from the

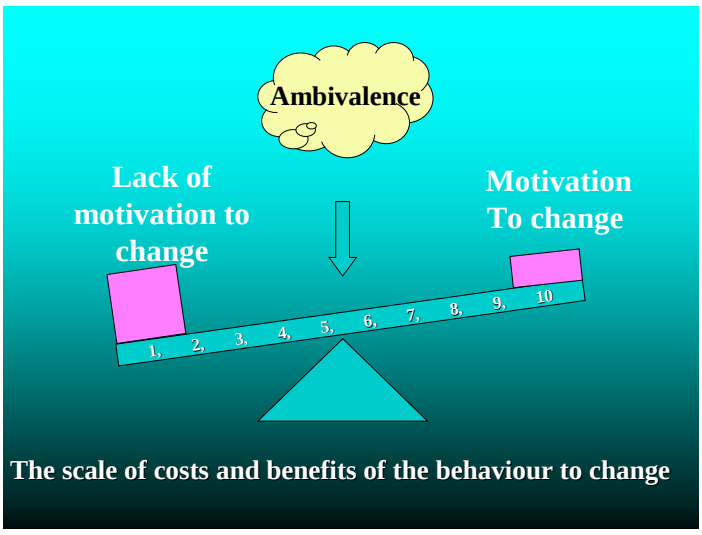
people who are trying to help him. He has to resolve his own ambivalence, but first he has to become aware of it, which is possible with the response-reflection technique. Yet, this idea of leaving it to the patient requires a solid dose of confidence on the part of the care-giver. But, if the intervention is based on the principle that growth is inherent to us as human-beings (as in the case of the acorn and the oak tree), it is normal to hope for and believe in the emergence of this motivation and the development of the willingness to act.

Denial, resistances and psychological reactance

Viewed from a different angle, denial and resistances are seen rather as the patient's reaction to pressures from the care-givers and would be seen like this even after their intervention which had nevertheless been intended to be motivating. The authors Miller and Rollnick explain that herein is precisely the reasoning behind their non-directive mode of intervening. For them, it is a way of avoiding what they refer to as "psychological reactance", in other words, behaviours that contradict the action, triggered by the care-giver's insistence that he changes his behaviour.



It is true that, faced with some forms of pressure, we tend to develop behaviour that is contrary to what our parents and teachers try to impose on us. How many of us have not had the experience of these episodes of obstinacy? Here it is a matter of a defensive reaction in which the subject wants to justify what he does, even if he knows very well, inside himself, that it would be advantageous to change. This stubbornness is not only directed towards others, or, as one might believe, towards the care-givers. It serves also to preserve a certain self-image, which the person is afraid of being seriously damaged.

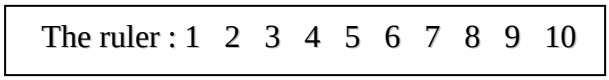


Rather than insisting and the use of coercion, the advocates of the motivational approach, suggest using

different strategies, among them, the ***decisional balance***. Its application is based first on a cognitive evaluation of the situation by the person when the interviewer leads the patients to consider the advantages and disadvantages of his behaviour, as well as the advantages and disadvantages of changing, which he is trying to become motivated to do. This is not necessarily easy, since the patient usually tends to see only the inconveniences of change and the advantages of his addictive behaviour or his failure to follow the treatment. The nurse has to see how to maintain an equilibrium between these two realities, in order to ensure that the patient does not see his convictions as deeply rooted, and thus the elimination of destructive habit in a positive light.

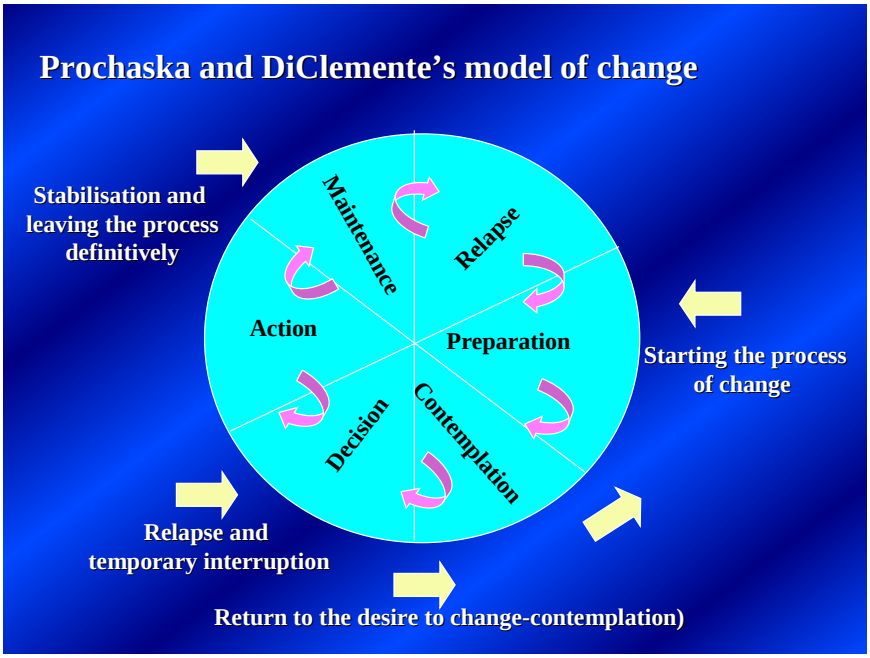
Through its logic, objectivity and clarity, this strategy often helps the patient to see the situation in an unbiased light and motivate himself to change and so give himself the energy to do this. So it is not with threats or by eliciting fear that motivational interviewing achieves its results. It is rather through reflection on the inconveniences that his behaviour causes to himself and the eventual benefits of changing his behaviour that the patient finds within himself the strength to take his own life in hand. It is true that human-beings are usually intelligent enough to understand where their interests lie and should not need this help, but, like in some people the feeling of pride, the strength of a habit or inertia carry the day, so strategies have to be adapted to this reality.

Another method complements the one we have just described. It allows the care-giver to lead the person to see the situation more tangibly and to commit himself to a process of reflection. This is the concrete measure of his readiness for change. To do this one has to use a ruler with a scale of 1 to 10. This must be presented within a stress-free dialogue that encourages exchanges between the care-giver and the patient on the need for the patient to be sincere about his self-evaluation and on the reasons behind, for example, a score of 3 rather than 5, or the contrary. Low motivation can be emphasized in an objective way, but must not give rise to any criticism. It is often necessary to repeat this technique and to make comparisons with the preceding scores and to provide positive reinforcements for any progress.



It is also important to ask the patient what is, for him, the biggest obstacle to change. (National Institute on alcohol abuse and alcoholism : http://www.niaaa.nih.gov/).

Each person experiences his difficulties in his own particular way, and, to help him, one has to understand the situation, to know, among other things, what alcohol, gambling or drugs allow the patient to forget or to hide from himself: his unrealized dreams, his job failures, his family conflicts, his lack of self-esteem. What sort of “life-crutch” does this habit provide him?



Change

This motivational approach targeting change, the principles underlying it and types of action, takes into account all the factors that can influence it. In fact, this process is complex: it has to be carefully studied and well prepared to be effective. It draws here on the model proposed by Prochaska and DiClemente, who defined very clearly the stages through which the subject who wants to change his behaviour passes, either in the context of a treatment, or to end an addiction of any kind, whether alcohol, gambling or drugs.

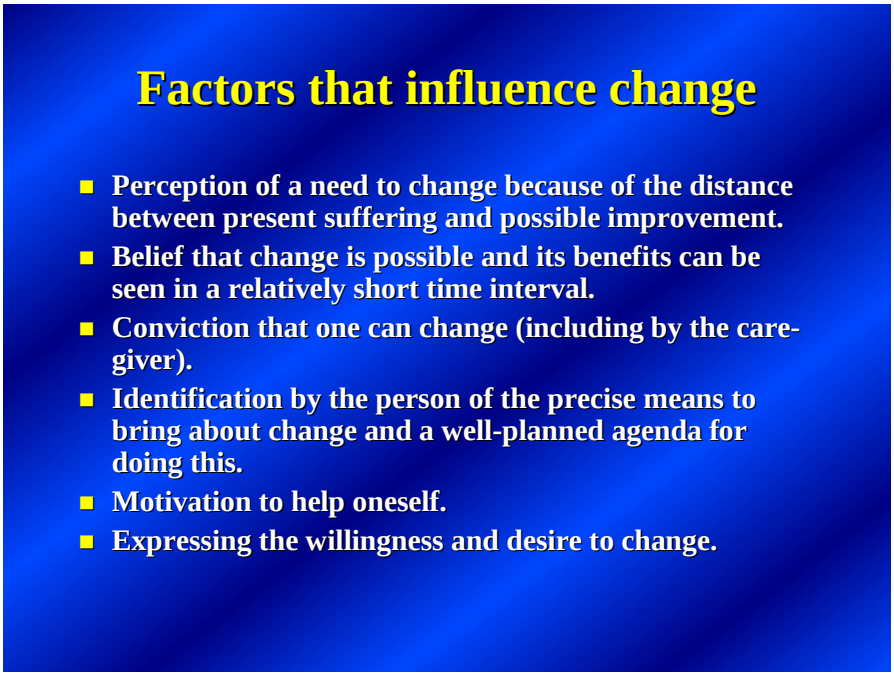
The stages are well defined in the accompanying sidebars. They show eloquently that the person passes through ascending periods of motivation, of success and of new adaptive behaviours. But equally, they show that the subject can also pass through negative periods of relapse. This is not, however, hopeless, since it is recognized in the model that it is possible for the stages of success to be followed by stages of relapsing to the point of departure and to restart the path towards change. These relapses are not inevitable, but we know that they happen frequently. It is, then, more realistic to anticipate them and accept them, not as a sign that the care and relationship with the patient has failed, but rather as an additional hurdle to overcome. Faced with such an eventuality, it is easy to blame ourselves in thinking that we should have done things otherwise or have done more. This "self-whipping" never adds anything. Moreover, within this approach, change depends on the patient and motivational interviewing aims precisely at him becoming responsible for himself so that he can become the manager of his own life, rather than handing the control over to care-givers.

The stages of change: Prochaska and DiClemente's model

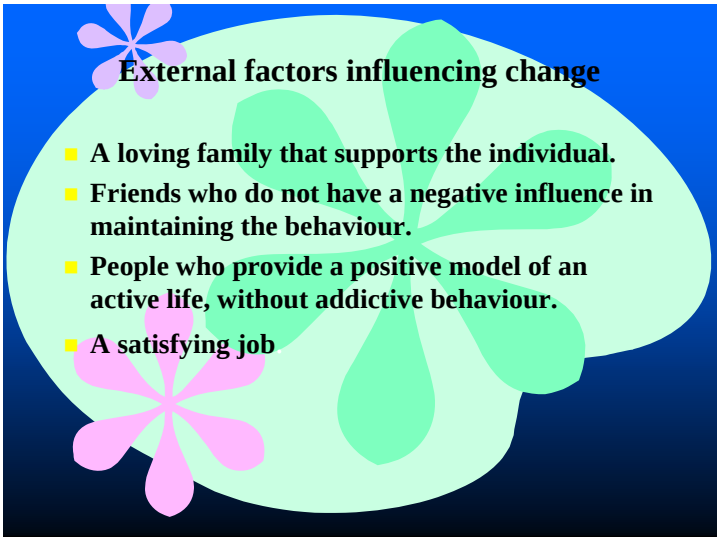
- 1- **Precontemplation:** phase preceding the idea of changing in which the person sees no need to change his behaviour.
- 2- **Contemplation:** phase of becoming aware of the problem, which coincides with developing a feeling of ambivalence about change.
- 3- **Determination to change:** phase of orientation towards the reduction of ambivalence and the desire to change.
- 4- **Action:** phase of adopting the means to change.
- 5- **Maintenance:** phase in which the person perseveres in his desire to change and to adopt measures necessary for a long-term action.
- 6- **Possible relapse:** phase of regressing to previous habits and the person has to re-start the change process.

In providing care, we often finds addicts or patients who have to modify their behaviour when it is not changing their whole life and who imagine that they can remain passive. They then think that the nurse, the doctor or the social worker are going to sort everything out. But we know very well that this does not work, and herein lies the strength of motivational interviewing, which leave the whole of the front-stage for the person most involved, the patient.

Prochaska and DiClemente's model that this approach proposes also has the advantage not only of being clear, but also of showing us that there being a period of time preceding the decision to change, that is the very time of ambivalence and its procession of projections and denial, is normal and perhaps even desirable. This is what these authors call the moment of contemplation of change, the time when the person weighs up the "pros" and "cons", the moment when he is oscillating between deciding to change and refusing to change. It is a bit like a time of "ripening" of the decision. So the ambivalence is not seen as a major disaster, but rather as stage in the process of change



This model also incorporates failure as an integral part of this movement towards other habits, which makes this a pragmatic approach, clearly in touch with reality. In fact, we must not think that it is enough to set in motion a process of personal development with the patient so that, with the wave of a magic wand, change will begin and be adopted. Unfortunately, it is more of a struggle that the person pursues, winning some battles, but also, and predictably, losing others.



But these are not the only factors to consider in the process of change. The whole unwinding of this complex mechanism has to be examined very carefully, taking into account the internal factors, but also the external factors, that influence the process of recognizing the obstacles and drawing the best lessons possible and avoiding

certain traps. The sidebar alongside illustrates how change is related, as we have already seen, to factors concerning how the subject sees himself and his capacities, but also setting in motion a precise and voluntary process, in which the person clearly expresses his willingness to change, decides the means for doing this, establishes a calendar to follow and, one might add, sticks to the calendar

External factors

Internal factors are of course primary for the successfully passing through these stages. But one must not completely put aside external factors which facilitate it and maintain change over time. Among these, the influence of the family is primary as well as others close to the person, other family members, friends, work-colleagues. They can as easily contribute to its success or failure. It often happens that the subject's fluctuating motivation, even when he wants to improve, is supported by those around him. But all it takes is negative attitudes, expressing doubts, judgmental comments, expectations that are excessive, or too hasty, of people in his social environment for the person to lose confidence in his possibilities and his motivation. From this emerges the need for the care-giver to make the family an ally, to forge a partnership with them in the care process, of equal importance as the patient himself.

A combined approach

Attitudes to be encouraged (1)

- **Adopt an open, person-centered approach towards the other.**
- **Respect his freedom of choice and autonomy.**
- **Demonstrate unconditional acceptance of his ambivalence, his denial and his resistances.**
- **Show empathy.**
- **See the person as a health care partner and not as an adversary to be conquered.**
- **Avoid all judment, arguing, confrontation or pressure, that risk leading the person to defend what he is doing. (Brehm's psychological reactance)**

This approach using motivational interviewing brings together a number of characteristics that are unique, but also others coming from various schools of thought in the behavioural sciences. It is an eclectic approach. In fact, as well as its roots in Rogers' non-directive, non-judgmental, empathic, positive regard perspective, motivational interviewing adopts elements from numerous highly varied interventions, some of which are borrowed from approaches such as those of Egan with the focus on problem-solving capacity, that of Neuro-Linguistic Programming (NLP) with its way of seeing failure more as feed-back, providing information about action, rather than a sign of failure; the ideas of Festinger, known in the field of education especially for his concept of "cognitive dissonance", placing the person in a state of mental insecurity when he finds himself between a known situation and another which he anticipates, but is not yet familiar with. It is in this case a situation in which ambivalent people are caught between the decision to change and refusing to change; there is also

behaviourism, with the positive reinforcement of the person's qualities and behaviours that are adapted and with the whole concrete, rational aspect of its theoretical elements, as well as setting into motion the practical means for change. But we must also not forget the influence of Gordon with his "no win-no lose" communicative strategy. In this way of looking at motivational interviewing and the therapeutic interventions that accompany it, the person is free to change and does not have to accept the triumphalist authoritarianism of those who are treating them. Both care-givers and patients are on the same footing. This eclectic way of considering the intervener's actions during the interview adapts well to nursing care, where we look on the patients as being autonomous. Moreover, the notion of *empowerment*, which is becoming increasingly popular and tends to re-establish the care-giver/patient equilibrium and give power back to the patient, here finds a highly appropriate application.

The strengths and difficulties of some of the interview strategies

Attitudes to be encouraged (2)

- **Try to understand his frame-of-reference. An undesirable behaviour does not exist except in its context.**
- **Evaluate the situation objectively.**
- **Provide positive reinforcement for the person's competence in taking his own destiny in hand and resolving his problems (positive regard).**
- **Point out the cognitive dissonance (contradiction) between his aspirations, his values and his actions through a gentle confrontation which draws out the unrealistic nature of his conduct (particularly at a more advanced motivational stage)**
- **Elicit positive comments about change from the client himself.**

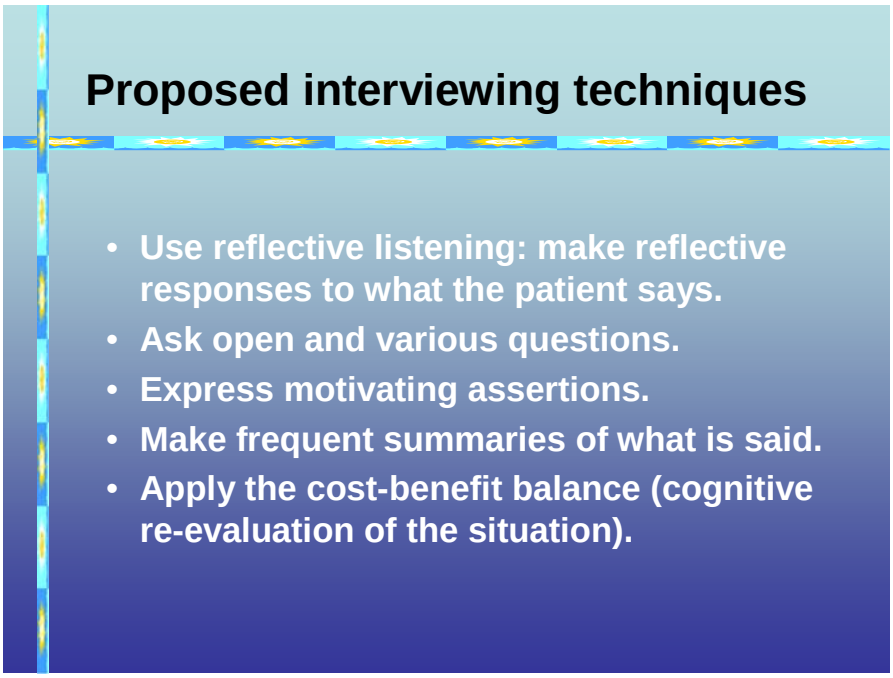
To obtain the expected results, the course of the interview requires choosing facilitating techniques and strategies so that its principles can be applied. This is shown in the three accompanying sidebars. Some of these strategies are more widely used and easier to apply, others are harder to put into practice. For instance, one of them is the unconditional acceptance of a person whose values and even manners are very different from our own or someone who clearly tells us that he is not in the slightest interested in what we are saying and even less in changing. We then find ourselves feeling non-acceptance, if not outright rejection by such a person. Yet acceptance is the key to success and the only key. Without that, the relationship breaks down and our power to intervene disappears. To help us open up to such patients and give ourselves the motivation to help them, we can think about what they used to be like, before their difficulties of addiction and about what they can become through a well-conducted intervention. We can also think of them as having dignity as human beings. A dignity that is always there despite the apparent lapse. It is not a magic formula, but it can help.

Another problem in applying this strategy of motivational interviewing is the individual's use of ***psychological reactance***. This may appear to be simple, but it is not however so easy to avoid all forms of oppositional behaviour to what the patient says and does, that is to say, to "roll along with all his objections" and, whatever happens, to never become the patient's enemy. Whether it

is being confronted by his apathy, his facial expression of rejection, of disgust, of resentment or his sometimes stinging language, we must set aside our own reaction of frustration and even of anger, adopting a flexible attitude and remaining, despite everything, open and ready to continue the interview. This demands substantial self-control and a strong conviction that maintaining contact with the patient remains the best way of achieving success.

Another sometimes high-risk strategy is ***decisional balance*** where we have to first consider the positive and negative sides of the problem, just as much as the positive and negative sides of change, without however reinforcing the attractive aspects of addiction or the unpleasant aspects involved in modifying the behaviour. This is not necessarily easy and demands solid experience in using this strategy. We have to remain vigilant, for the patient can be smart enough to find faults in our arguments and take advantage of us by opposing whatever we say and convincing themselves that the contrary is true.

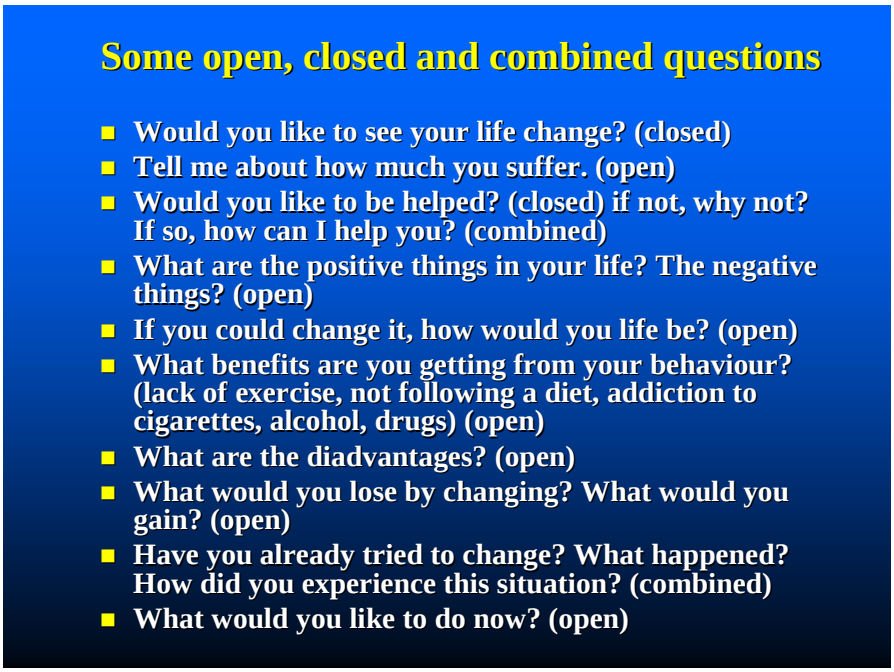
Recommended interviewing techniques



Interviewing is an art that nurses have to master. It is a professional act with interpersonal, organizational and even legal requirements. Motivational interviewing has additional imperatives, which are different from other forms of interviewing. The sidebars provide a list of interpersonal interventions to be encouraged when using this method, and getting the subject to see himself as capable of changing and deciding to do so.

One of these strategies, among the others, involves compiling with the person a ***list of his previous accomplishments,*** for example receiving a prestigious degree of diploma, having an interesting job, putting together any sort of project and developing rewarding relationships with others. This is, once again, a way of recognizing the value of the person, of getting him to see himself positively and building his self-esteem. But this strategy goes further, since you then have to draw out with him the feeling of satisfaction and of having succeeded that came out of these experiences, and use this to convince him that he has already succeeded in some things, on some occasions, in his life, so he can still do so by modifying his behaviour.

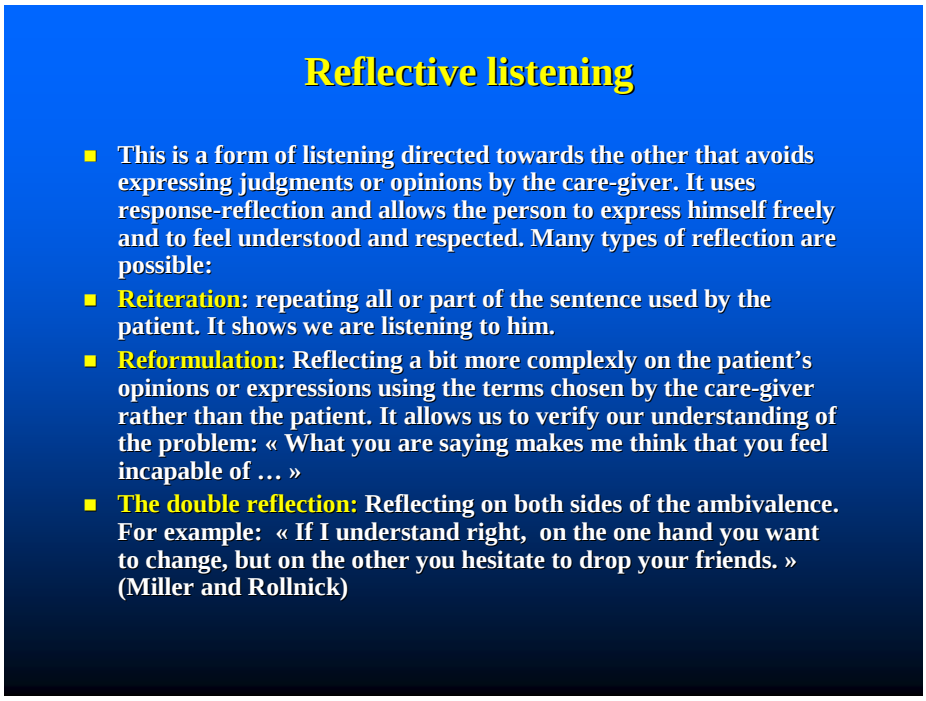
Another strategy that should merits use is asking open questions. In nursing, we regularly collect information from patients, but unfortunately we often ask closed questions, leading to "yes" or "no" answers, or else answers in just a few words. This is in itself a directive strategy that limits the patient's reply to a narrow range of expressions and does not allow him to really describe his emotions and feelings. Asking questions that are principally open is a habit that you have to develop, allowing the person to reveal what he is thinking and feeling. An interpersonal intervention like this one assumes substantial freedom of expression. Asking open questions can greatly encourage this.



Closed questions are certainly still useful to collect very precise information of the kind: "How many children do you have?" or "How long have you been in hospital?" The answer is not always a simple "yes" or "no", but this does not lead to the patient elaborating on his answers and is poorly adapted to expressing feelings. Altogether, it is the good balance between pragmatic closed questions when these are necessary and open questions that are much more productive that constitutes the quality of an interview. Closed questions provide information, but open questions create as well as information a climate of freedom and respect that benefits the relationship.

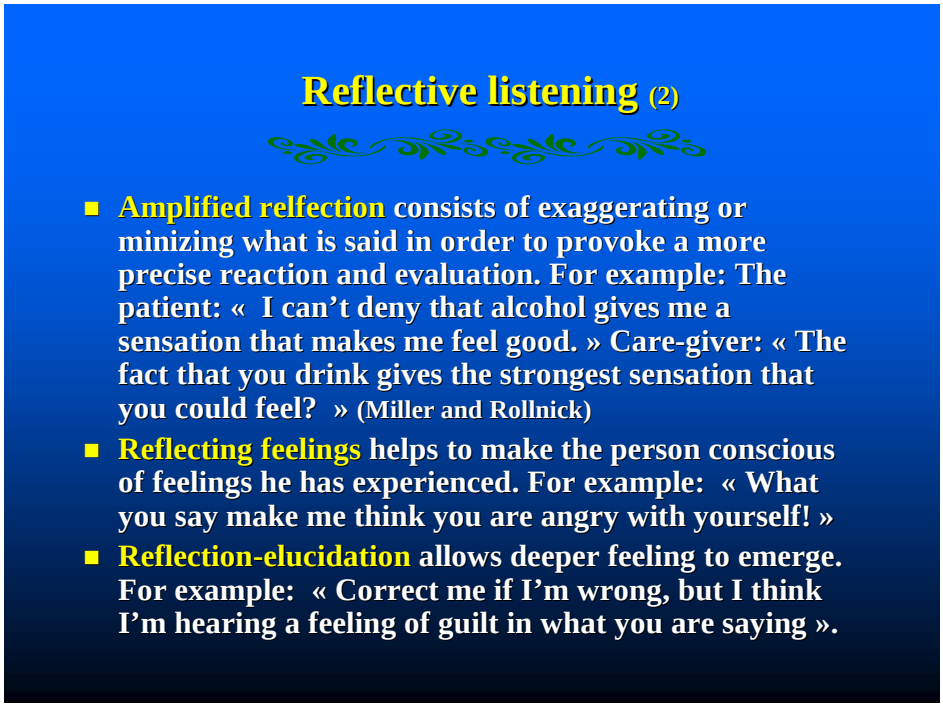
Using open questions requires a degree of mental gymnastics that is quite easy to master. Questions that begin with "How...", "Tell me …", "Describe to me …", "What do you think of …?" are open questions. But when the pronoun of the verb is inverted, as in "Have you slept well?" or "Is your wife aware of this?" the questions are potentially closed since the person can, if he wants, simply reply with a "yes" or a "no". Some questions are, however, combined, that is, they start with a closed question and lead on to an open question.

Reflective listening



But the preferred tool in social exchanges within this non-directive approach is ***reflective listening***. Just as in any helping relationship, this provides, through "reflective-answer", a mirror to the patient of all he communicates about his thoughts, his opinions, his fears, his feelings. In this way, the person can express himself completely freely and at the same time receive an image of what he is with his failures to understand, his blockages, his ambivalent reactions, just as with his possibilities and his strengths. So reflective listening is a strategy that encourages self-knowledge and reflecting on the self, both of which are likely to lead the person towards self-criticism and the desire to change.

These powerful non-directive listening tools and when you open yourself up towards the other person can in some cases be enough to prepare the person and motivate him to change. It is noticeably effective, for instance, in inciting diabetics to follow their treatment or someone dependent on alcohol to modify his behaviour. However, reflective listening goes a bit further than simple passive listening: it becomes in and of itself a form of intervention.

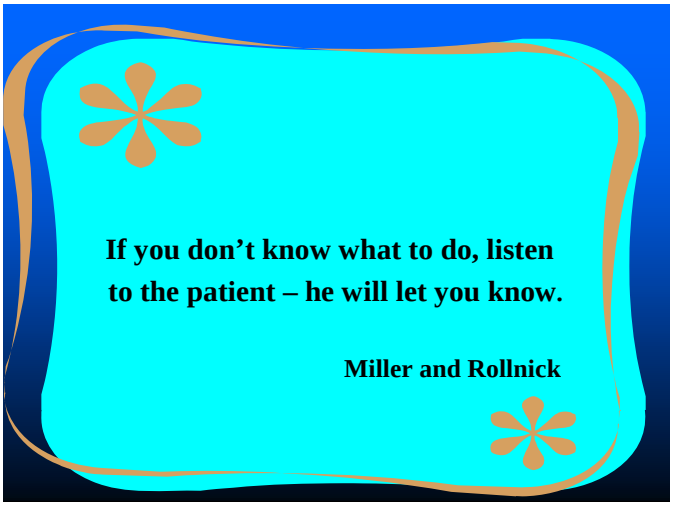


In this motivational approach, this form of listening takes on a somewhat different form. It includes the

same levels as reflective listening as in the context of a helping relationship, but two additional levels are added. There is first the double reflection which completes the ***decisional balance of behaviour*** by reflecting the positive and negative sides of the situation, and also ***amplified reflection*** which gives increased attention or less attention to a behaviour or a situation. It aims to provoke a reaction by the person.

These strategies of reflective listening are not always easy to use, but appropriate training can remedy the difficulties. They are effective techniques to use during the course of an interview with a patient whom you want to motivate to follow his treatment or change his behaviour.

In any case, attentive listening is always at the core of any interpersonal intervention with a patient. Motivational interviewing is no exception. And the precept that if you do not know what to do in an interpersonal situation, whether a relationship aiming to help a person or another approach, you just have to listen to the patient and what you hear and observe will help you to understand the situation and get a better idea of the intervention to adopt



Traps to avoid

Any intervention with patients involving human relations, inducing a change in behaviour or following a treatment contains risks of clumsiness or of being directive. These are not always obvious, but nevertheless they are certainly present. The following sidebar resumes these problems. Several of these traps have already been discussed in article, but other merits specific consideration.

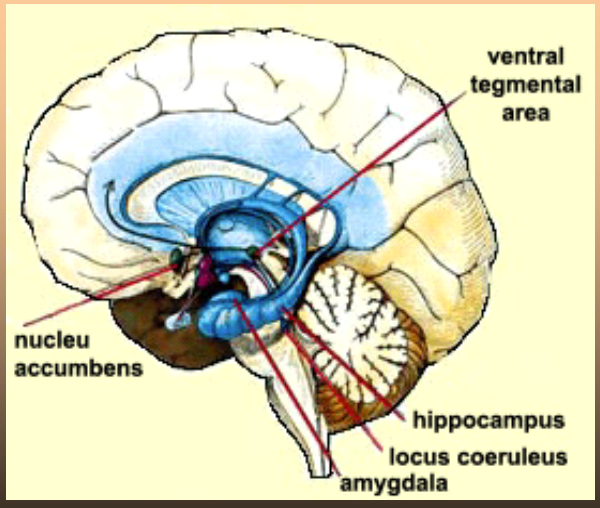
For instance, when the person interviewed raises objections, it is tempting to confront him directly with his lack of logic or his lack of awareness. We have just seen how this attitude is not really constructive and can even be detrimental to the relationship and the partnership with the patient; it should be avoided in using this approach. But a gentle confrontation can in some circumstances reveal itself to be useful. If this is done in the true interest of the patient, if it clearly rooted in empathy and particularly if the interviewer uses humour, it can certainly be adapted to this kind of interviewing. But its use should particularly be limited to the time at which the person is manifesting positive motivation. However, whatever the circumstances, we have to recall that confrontation must always be done tactfully.

Traps to avoid

- Adopt the attitude of an expert.
- Ask a lot of closed questions.
- Be directly confrontational.
- Consider ambivalence as a fundamental trait of the addicted person.
- Focus exclusively on his problem.
- Make judgments, attach labels: « You are addicted to … », « You lack will-power ».
- Propose ready-made solutions, give orders: « You've got to change! ».
- Make threats : « If you continue, you'll lose your job, your wife … ». He already knows this.

Another element to avoid is focusing uniquely on the problem of the failure to follow treatment or any form of addiction to a substance or to gambling. For example, some interventions with alcoholics are a clear illustration of the attitude by which, at each meeting, the practitioner is asked to enquire whether the patient has drunk any alcohol since the last interview, how much he has drunk, and if he is aware of the effects of his behaviour on his own health and on his family. These points are certainly important, but they must not turn into a sort of chorus, repeated over and over again. By dint of hearing it, the patient retreats behind a wall completely unmotivated, he closes in on himself and refuses to express himself or commit himself. His opinions, thoughts, insights about himself, aspirations or dreams are ignored. His whole world just turns round in a closed loop. It can happen then that this person gets stuck instead of moving on. There is nothing convivial about these meetings and they are nothing like interviews between health-care partners.

They are intended to provoke awareness in the person, but rather they cause discouragement and resistance. We have to remember that the human-being is more than his or her behaviours, however harmful they may be, that people are more than their problems and that their addictions are only one part of who they are. This hides many other riches that can be used to advantage.



The Brain from Top to Bottom:
http://thebrain.mcgill.ca/flash/i/i_03/i_03_cr/i_03_cr_par/i_03_cr_par.html

One of the conditions of success of motivational interviewing is that they are pleasant experiences and immersed in a climate of gentleness, of interest in the person and conducive to

reflection and self-evaluation. You don't attract flies with poison, but rather with honey. It is also true in human relations and particularly when you want to motivate the person to make decisions as committed and difficult as those of stopping to drink, taking drugs, turning to gambling or using computers in a compulsive way (blog addicts) or adopting a treatment that is hard to accept.

It is perhaps worth underling that recent research has shown that addiction habits and indeed many of our behaviours – without us being aware of this – are linked to activity in our brains, in the acumbens nucleus, the pleasure-crossroads for human beings. This has led some philosophers to say that Man is a pleasure-seeking animal. The nucleus reacts by releasing dopamine that provokes a delightful state and a strong attraction to seeking it out and repeating it. This would also be the centre for addictions. It is stimulated by pleasure and novelty. Without claiming to be specialists in neurology, we could certainly consider that if we want to oppose certain addictive behaviours or failure to follow treatment, it would perhaps be logical to go along the same pathways, that is to say, by creating a climate of acceptance and pleasure.

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