Motivational Interviewing: Core Skills Training

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Goals of MI Training:

- Build rapport and create authentic engagement with different diverse groups.
- Use direct, empathetic communication to create an effective relationship
- Negotiate goal setting with patients.
- Provide advice and information collaboratively.

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“Motivational interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change.”

Miller and Rollnick
**MI Preparation Prayer**

Guide me to be a patient companion  
To listen with a heart as open as the sky  
Grant me vision to see through her eyes  
And eager ears to hear her story  

Create a safe and open mesa on which we may walk together  
Make me a clear pool in which she may reflect  
Guide me to find in her your beauty and wisdom  
Knowing your desire for her to be in harmony – healthy, loving, strong  

Let me honor and respect her choosing of her own path  
And bless her to walk it freely  
May I know once again that although she and I are different  
Yet there is a peaceful place where we are one

- Bill Miller

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**Intrinsic motivation for change arises in an accepting, empowering atmosphere that makes it safe for the person to explore the possibly painful present in relation to what is wanted and valued. People often get stuck, not because they fail to appreciate the down side of their situation, but because they feel at least two ways about it. The way out of that forest has to do with exploring and following what the person is experiencing and what, from their perspective, truly matters.**

- Miller and Rollnick, 2002
1. What is Motivational Interviewing - MI?

The founders of motivational interviewing, Dr’s. William R. Miller & Stephen Rollnick, state that “Motivational interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change”. Motivational interviewing addresses many different areas of change. Motivational interviewing evolved from the addiction field. Now it applies to numerous behavior change areas: mental health; co-occurring disorders/dual diagnosis; primary health care - includes diabetes, weight change, nutrition, medication adherence, HIV; gambling; smoking; substance abuse disorders; criminal justice patients, etc. It is practiced with adults and adolescents.

Definition ~ Motivational interviewing is a person-centered, evidence-based, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence with the individual.

Spirit ~ Collaboration; evocation; autonomy; respect; compassion

Which means what?

- **Patient-centered** refers to a fundamental collaborative approach to the practitioner/Patient relationship. Patient-centered specifically refers to Carl Rogers (1946) reflective listening which is a central skill for a motivational interviewing practitioner. The practitioner follows the patient’s thoughts, feelings and perceptions and responds with reflective statements. Reflective statements include degrees of complexity such as possible meaning behind the patient’s statement and reflection of possible patient feelings.

- **Evidence-based** includes practices that are shown to be successful through research. Models that have shown the greatest levels of effectiveness have the ability to replicate successful outcome with different populations, over time.

- **Person-centered:** Person-centered is a transition of the term patient-centered. It is advocated for use by those who believe it is less clinical, less role defining, more equalizing and more personable than the term patient-centered. The term person-centered also serves to broaden MI’s relevance beyond the clinical setting.

- **Directive:** MI is both patient-centered meaning it follows the patient’s thoughts, feelings and perceptions, and directive. Directive refers to the use of specific strategies and interventions that may facilitate the patient’s movement toward exploration, change talk, problem recognition (resolving ambivalence) or the decision to change. The practitioner guides the discussion towards the possibility of change.

- **Intrinsic Motivation:** The motivation that comes from the patient. It’s in there somewhere, and it’s the practitioner’s job to find out what it is and amplify it, reflect it back.
**Ambivalence:** This refers to the patient’s experience of conflicting thoughts and feelings about a particular behavior or change – advantages and disadvantages. The MI practitioner listens for and evokes the Patient’s reasons for concern and arguments for change (change talk), while also accepting and reflecting perceived disadvantages of change (sustain talk). The practitioner reflects both sides, sometimes in the form of a double sided reflection. The recognition of ambivalence may add clarity where the patient has not been ready to move forward or reach a decision. The MI practitioner listens for and evokes the patient’s own arguments for change and assists the patient to keep moving in the direction of change.

**MI Spirit**

**Collaboration:** The practitioner elicits and conveys respect for the patient’s ideas, opinions and autonomy. Collaboration is non-authoritarian, ever present, supportive and exploratory.

**Evocation:** The practitioner works to evoke the ideas, opinions, reasons to change, and patient confidence that change is possible. The practitioner is invested in facilitating intrinsic change pursued with the Patient’s own reasons and motivation.

**Autonomy:** The practitioner evokes and fosters the patient’s experience of choice and control and respects the patient’s decisions. “You are really getting serious about this now.” These amount to “a way of being with people” (Rogers, 1980) and embody the spirit of MI.

**Acceptance:** The practitioner maintains an attitude of acceptance and respect for the patient, no matter what the patient is saying or doing, and expresses it through words and deeds.

**Compassion:** The practitioner maintains and expresses compassion for the patient’s plight. Lets the patient know that he/she understands through the reflections used.

Motivational Interviewing:
- Assumes motivation is fluid and can be influenced
- Motivation influenced in the context of a relationship
- Principle tasks – to work with ambivalence and resistance
- Goal – to influence change *in the direction of* health
The Four Fundamental Processes

**Engaging**

**Focusing**

**Evoking**

**Planning**

The four principles of motivational interviewing:

*Express empathy:* Refers to the practitioner making a genuine effort to understand the patient’s perspective and an equally genuine effort to convey that understanding to the patient. This is an inherent element of reflective listening. It embodies the spirit of MI. Rogers (1962) “…as I see it is that the practitioner is experiencing an accurate empathic understanding of his patient’s private world, and is able to communicate some of the significant fragments of that understanding.” “When the patient’s world is clear to the practitioner…he can also voice meanings in the patient’s experience of which the patient is scarcely aware…” He referred to this “highly sensitive” empathy as important for making it possible for a person to get close to himself and to learn, to change and develop.

*Develop discrepancy:* This is to listen for or employ strategies that facilitate the patient’s identification of discrepant elements of a particular behavior or situation. Example, values versus behaviors: It is important to the patient to be a responsible parent; the patient is having difficulty averting heroin addiction. Discrepancy may result in the patient’s experience of ambivalence. Areas of discrepancy may include: past versus present; behaviors versus goals. Evoking change talk is one way to develop discrepancy.

*Dancing with Discord – avoid argumentation:* This refers to the practitioner’s ability to side step or diminish resistance and proceed to connect with the patient and move in the same direction. It also refers to avoiding argument, expressing empathy. Understanding why a patient has a particular belief might be the intervention. Shifting focus might be another.
Support self-efficacy: This is the practitioner’s ability to support the patient’s hopefulness that change or improvement is possible. Identifying and building upon a patient’s strengths, previous successes, efforts and concerns. These are some areas that may open the process of addressing and supporting the patient’s hope and confidence.
2. Learning Person-Centered Counseling Skills: OARS

What Good Listening Is Not (Roadblocks: Thomas Gordon)

- Asking questions
- Agreeing, approving, or praising
- Advising, suggesting, providing solutions
- Arguing, persuading with logic, lecturing
- Analyzing or interpreting
- Assuring, sympathizing, or consoling
- Ordering, directing, or commanding
- Warning, cautioning, or threatening
- Moralizing, telling what they “should” do
- Disagreeing, judging, criticizing, or blaming
- Shaming, ridiculing, or labeling
- Withdrawing, distracting, humoring, or changing the subject

Why are these “roadblocks”?

- They get in the speaker’s way. In order to keep moving, the speaker has to go around them
- They have the effect of blocking, stopping, diverting, or changing direction
- They insert the listener’s “stuff”
- They communicate:
  - One-up role: Listen to me! I’m the expert.
  - Put-down (subtle, or not-so-subtle)

Human Reactions to Confrontation

- Angry, agitated
- Oppositional
- Discounting
- Defensive
- Justifying
- Not understood
- Not heard
- Procrastinate
- Afraid
- Helpless, overwhelmed
- Ashamed
- Trapped
- Disengaged
- Don’t come back – avoid
- Uncomfortable
- Resistant

Human Reactions to Being Listened To

- Understood
- Want to talk more
- Liking the practitioner
- Open
- Accepted
- Respected
- Engaged
- Able to change
- Safe
- Empowered
- Hopeful
- Comfortable
- Interested
- Want to come back
- Cooperative
Therapeutic Empathy

“...being empathic is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto ... it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them...” - Carl Rogers

Empathy is not:

- Having had the same experience or problem
- Identification with the patient
- Let me tell you my story

Empathy is:

- The ability to accurately understand the patient’s meaning
- The ability to reflect that accurate understanding back to the patient

O.A.R.S. + I

Five Strategies used throughout Motivational Interviewing:

Open ended questions: Open ended questions facilitate a patient’s response to questions from his or her own perspective and from the area(s) that are deemed important or relevant. This provides the opportunity for patients to express their point of view, and for practitioners to discover and follow the patient’s perspective. This is in contrast to closed questions that are leading; they target specific information and give the patient very little room to move. Example open question: “What makes you think you should make a change?” (Following). Example closed question: “Don’t you think you drink too much?” (Leading). Another distinction between open and closed questions is that open questions elicit fuller responses where closed questions can often be given a yes or no response.

- Closed Questions:
  - Have a short answer (like Yes/No)
    - Did you drink this week?
  - Ask for specific information
    - What is your address?
  - Might be multiple choice
    - What do you plan to do: Quit, cut down, or keep on smoking?
  - They limit the patient’s answer options
Open Questions:
- Open the door, encourage the patient to talk
  - How have you managed in prior situations?
- Do not invite a short answer
  - What can you tell me about...?
- Leave broad latitude for how to respond

Affirmations: Affirming means to actively listen for the patient’s strengths, values, aspirations and positive qualities and to reflect those to the patient in an affirming manner. Example: patient discusses many previous efforts to change a particular behavior from the position of feeling like a failure or hopelessness. Practitioner reframes (from a negative to positive perspective) and affirms. “What I am hearing is that it is very important to you to change this behavior. You have made numerous efforts over a long period of time. It seems that you have not found the way that works for you.” This reframe accomplishes both affirming the patient for his or her efforts and perseverance and provides a framework for the patient and practitioner that entails finding a solution that will work for the patient. This is in keeping with collaborative change plans that are used in motivational interviewing.

Affirmations:
- Emphasize a strength
- Notice and appreciate a positive action
- Should be genuine
- Express positive regard and caring
- Strengthen therapeutic relationship

Affirmations include:
- Commenting positively on an attribute
  - You’re a strong person, a real survivor.
  - A statement of appreciation
  - I appreciate your openness and honesty today.
  - Catch the person doing something right
  - Thanks for coming in today!
  - A compliment
  - I like the way you said that.
  - An expression of hope, caring, or support
  - I hope this weekend goes well for you!
Reflections: Reflective listening entails a skillful manner of responding to what a patient says. In MI one responds to patients with more reflective statements than questions. Reflections vary in complexity from simply repeating, to reflecting implicit meaning or reflecting feelings. The practitioner follows the patient’s ideas, perceptions and feelings making every effort to convey understanding; the patient explores, defines or discovers what the behavior or lack of action may be about. Rogers noted that if the patient perceives the practitioner as “trying” he may be inclined to communicate more of himself. Reflective listening facilitates the patient’s focus on his or her knowledge and resources. Reflections are always collaborative and non-judgmental. By many accounts when practiced skillfully reflective listening is a powerful and empowering response.

**Levels of Reflection**
- **Repeat**(restate what Patient has said)
- **Rephrase**(synonym)
- **Paraphrase**(infer meaning)amplify concepts & values, double-sided, continue paragraph, metaphor, understate feelings, reframe
- **Summarize**(gather Patient utterances)

**Reflections:**
- Are statements rather than questions
- Make a guess about the patient’s meaning (rather than asking)
- Yield more information and better understanding
- Often a question can be turned into a reflection
- A reflection states an hypothesis, makes a guess about what the person means

**Form a statement, not a question**
- Think of your question: Do you mean that you . . . ?
- Cut the question words  Do you mean that you ....
- Inflect your voice down at the end
- There’s no penalty for missing
- In general, a reflection should not be longer than the patient’s statement.

**Types of Reflections:**
- **Simple/Repeating** - Reflect what is said
- **Simple/Rephrasing** – Slightly alter
- **Amplified** - Add intensity to idea/values
- **Double Sided** - Reflect ambivalence
- **Metaphor** - Create a picture
- **Shifting Focus** - Change the focus
- **Reframing** - Offer new meaning
- **Emphasize personal choice**
- **Siding with the negative (paradoxical)**
Summaries: Summarizing is an important element of MI methodology. Conversations are ended with a strategic, collaborative summary. Interim summaries are used throughout. Summarizing includes directive elements. The provider may reinforce the patient’s change talk; or highlight realizations; or identify transitions or progress (affirm); or identify themes. An interim summary has additional applications such as reviewing the direction of the conversation or changing focus; slowing down and addressing patient’ statements; or clarifying what has been discussed so far.

- **Summaries:**
  - **Collect material that has been offered:**
    “So far you’ve expressed concern about your diabetes, getting your weight down, and finding a medication that works.”
  - **Link something just said with something discussed earlier:**
    “That sounds a bit like what you told me about the fear you feel when you get out of breath”
  - **Draw together what has happened and transition to a new task:**
    “Before I ask you the questions I mentioned earlier, let me summarize what you’ve told me so far, and see if I’ve missed anything important. You came in because you were feeling really sick, and it scared you.”

The four preceding strategies make up the acronym OARS. This acronym may serve as a reminder for practitioners to use these interventions regularly in their conversations.

**Information:** Giving information, with permission, and when appropriate, is an integral component of MI. There are three general applications of information giving:
- If the client asks for it
- If the clinician asks if it is wanted
- If it is given to emphasize client autonomy
3. Recognizing Change Talk and Sustain Talk

**Change talk:** Any speech that favors movement toward change

**Distinctive Role in MI: Preparatory Change Talk:**

- **Desire** to change (want, like, wish . . )
- **Ability** to change (can, could . . )
- **Reasons** to change (if . . then)
- **Need** to change (need, have to, got to . . )

❖ **Change Talk**
  - I think I could quit
  - I’ve got to do something about my drinking
  - I’m probably gonna quit
  - I want to get my kids back, and I can’t do that unless I quit drinking
  - I’d like to have better control of my drinking

❖ **Sustain Talk**
  - I really like marijuana
  - I don’t see how I could give up pot
  - I need to smoke to be creative
  - I intend to keep smoking and no one can stop me
  - I don’t think I have to quit

**Distinctive Role in MI: Implementing change talk:**

- **Commitment:** (I intend to... I will... I plan to...)
- **Activation:** (I’m doing this today...)
- **Taking Steps:** (I went to my first group...)

**Change talk:** From its inception a guiding principle of MI was to have the patient, rather than the practitioner, voice the arguments for change (Miller & Rose, 2009). Change talk refers to patient’s statements that indicate an inclination or a reason for change. The MI practitioner actively listens for change talk in its various strengths (from weak to strong or committed). One strategy is to reinforce it and carry it forward so that it is recognizable in future dialogue. Examples: asking for elaboration or including it in a summary. Another strategy is to facilitate strengthening change talk from weak to strong. Example: “I wish things were different” versus “I will change this.” Commitment talk has been shown to correlate with actual behavior change. Other motivational modifiers include preparatory change talk – DARN, Statements of Desire, Ability, Reasons and Need for change; and mobilizing change talk -CAT, Commitment, Activation and Taking steps to change.
4. Evoking and Responding to Change Talk

This is the point at which the guiding aspect of MI is introduced. MI is done in relation to a clear change goal. The MI practitioner uses specific strategic method to elicit and strengthen change talk. This is a defining aspect of MI that differentiates it from general counseling.

Elicit Change Talk– self motivational statements: In addition to responding to change talk that is offered by the patient the provider uses strategies that elicit change talk. Some examples: *Evocative open questions - here the practitioner asks open questions that are targeted to change talk areas.

Examples: “In what ways does this concern you” or “What do you see as a problem?” If the patient responds, change talk has been elicited. *Looking ahead can be a written exercise or a verbal dialogue. “What might your life look like in five (1, 2, 3) years if very little changes?” What might your life look like in five years if a good deal of change takes place?” Responses to these questions may include patient change talk. Example: “If very little change takes place I’ll probably get very sick and may even die.” Negative consequences. “If a good deal of change takes place I will no longer need so much medical attention, I will be around more for my children, and I may even have a job.”
Snatching Change Talk from the Jaws of Ambivalence

Please underline the words and/or phrases that are “change talk” and quickly write your response under the sentence(s):

1. I don’t drink any more than most people I know. Sure, I sometimes feel a little foggy the next day, but it wears off quick. It’s no big deal.

2. Sure I want my kids back and I want to be a good mother, but the court’s making it impossible. There’s no way I can do all those things they’re making me do.

3. I wasn’t doing anything wrong! I just went along for the ride, and I didn’t know they were going to grab that lady’s purse. Now they’re saying I violated my probation. I guess it’s not smart to be cruising around at 2 in the morning, but it happened so fast, there was nothing I could do. I didn’t break any laws, and I’m not going back to jail for this.

4. It’s such a hassle to take those pills. I’m supposed to remember to take them four times a day, and half the time I don’t even have them with me. I guess there’s a good reason for it, but it’s just not possible for me.

5. Last time I tried to quit smoking I was really bad to be around for five days. I was just blowing up on everybody. And then after five days I was pretty cool, and after two weeks I was really cool. But those five days, I mean, what if a patient calls me up then, what am I going to do?

6. I have no time to go for therapy. I really hate that I’m so much more impatient with my kids than I used to be because I’m so miserable. But I can’t leave them alone and I don’t trust anyone else to take care of them the way I do.

7. When you take that first hit, man, there’s no feeling like it. At that moment you just don’t care about all the terrible things the drug does to your life, it’s just this amazing rush and nothing else matters.

8. I used to exercise every day, and I have to admit I felt better when I did. But it got to be too hard to find the time, and other things were just more important to deal with. I really do miss it, though.
Interventions to Evoke Change Dialogue

- Elaborating. Continuing a paragraph
- Using the importance, confidence rulers
- Exploring the decisional balance
- Asking wonder-evocative questions
- Querying extremes
- Looking back, looking forward
- Exploring goals, values, hopes and dreams

*Listen deeply for a desire...ability...reason...need = commitment language.*
5. Responding to Sustain Talk and Discord

**Sustain talk** refers to the patient’s stated reasons not to make a change or to sustain the status quo. Sustain talk is noted to counter change talk, but it is not patient’ resistance. Where techniques such as the pros and cons and the decision balance elicit sustain talk, this is now seen as potentially contraindicated to MI in practice (unless it serves some specific purpose). One is cautioned in general not to elicit and thereby risk reinforcing sustain talk and to shift the focus to change talk, if possible, when sustain talk emerges. The objective is to facilitate high levels of change talk and low levels of sustain talk.

**Discord/Resistance:** Discord may be a result of a patient-practitioner relationship that lacks agreement, collaboration, empathy or patient autonomy. The patient and provider are not moving together toward a mutually agreed upon goal. Patient’ resistance may be expressed by arguing, ignoring, interrupting, etc. A MI practitioner seeks to identify the source of dissonance in the relationship, and works to join with the patient. A MI practitioner recognizes discord and handles it strategically. One does not confront resistance or push up against it. There are a variety of MI strategies and skills used to diminish or side step resistance. The goal is to join with the patient in moving together.

**DECISIONAL BALANCE**

**Pros and Cons** refer to a strategic intervention that facilitates the exploration of the positive and negative experiences a patient may have regarding a particular behavior. It also serves to elicit change talk when a patient may not have identified any disadvantages voluntarily. One begins with an exploration of the positive experiences the patient may have –sustain talk; reaches a level of comfort in this discussion; and then moves on to what is “not so good” about the behavior. A patient who is comfortable may begin to identify some elements of concern either for the first time or in a way that is not resistant or guarded. Within the new MI definition there is more emphasis on guiding the patient to change talk with less emphasis on sustain talk. As noted eliciting sustain talk may be counterintuitive to MI, sustain talk may be reinforced or it may deflect from change talk.

The decisional balance is a form of identifying pros and cons This technique is seen as potentially useful when the patient is in early readiness for change; or offers very little in the form of change talk; and when providers do not want to influence patient’ choice.
**Decisional Balance Worksheet**

When we think about making changes, most of us don’t really consider all “sides” in a complete way. Instead, we often do what we think we “should” do, avoid doing things we don’t feel like doing, or just feel confused or overwhelmed and give up thinking about it at all. Thinking through the pros and cons of both changing and not making a change is one way to help us make sure we have fully considered a possible change. This can help us to “hang on” to our plan in times of stress or temptation.

**DIRECTIONS:** Below, write in the reasons that you can think of in each of the boxes. For most people, “making a change” will probably mean quitting alcohol and drugs, but it is important that you consider what specific change you might want to make, which may be something else.

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Not-so-good</th>
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<tbody>
<tr>
<td><strong>CHANGING</strong></td>
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<tr>
<td><strong>NOT CHANGING</strong></td>
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6. Negotiating a Change Plan

- **Signs of readiness to change:**
  - Increased questions about change: asks what they could do about the problem.
  - Envisioning: begins to talk about how life might be after a change.
  - Experimenting: begun by experimenting with possible change approaches (e.g., going to a support group, going without for a few days, reading/looking up information on the internet).

- **Negotiate a plan of action:**
  - Invite active participation by the patient
  - Patient determines goals & priorities

- **Patient weighs options**
  - Together, work out details of the plan
  - Explore (ask/elicit) – find out what the patient already knows or has done about the issue
  - Offer (provide) – ask permission and make suggestions, use a menu of options when possible
  - Explore (ask/elicit) – find out which, if any, of the ideas the patient is willing to consider.

### Giving information and advice

**Menu of options:** refers to a number of actions that a patient and provider collaboratively identify and agree to include in a behavior change plan. Menu specifically refers to the identification of at least several (six, seven, etc.) actions versus one or two. Emphasis is placed upon the patient’s willingness to pursue an identified action. Only actions that a patient wants to pursue are included in a plan. The plan is fluid and can be changed. This menu and flexibility are noted to be directed toward confidence building (each action is prioritized via potential for success) and to convey hope that change can be attained.

**Ask permission to give advice or information:** In contrast to giving direct advice – “Losing 20lbs would be good for you.” a MI practitioner asks permission first. “Would you be interested in hearing my ideas about what might be useful?” If the patient says yes, the practitioner might make a recommendation or a suggestion. One also provides an opportunity for the patient to reject the suggestions. “How do you think this might work for you?” The patient pursues action only in areas agreed upon. Also, ask permission to provide education. “Would you be interested in learning more about this medication?” If yes, some written materials might be provided. Discussion and feedback would follow.
Examples

- Always ask for permission: “Other clients have found ___ to be of help. Are you interested in knowing about that or is there something we should discuss first?”
- Offer alternatives (menu of options): “We could find you a recommended diet or set up a session with a nutritionist.”
- Provide more information according to the interest of the patient: “Would you like to know more about specific exercises?”
- Express concern when indicated: “Would it be all right if I tell you one concern I have about this plan?”
Importance, Confidence, Readiness Rulers:

Questions to Ask:

❖ What does that number mean to you?
❖ Why are you at $x$ and not $(x - 2)$? (always start with the higher number)
❖ (If 9 or 10) That’s great. I’m curious why it is that important.
❖ Where would you like to be on the scale?
❖ What would need to change to move up from $x$ to $(x + 2)$?
## Strength of Commitment Language

### High
- I will / I promise / I swear / I guarantee
- I intend to / I agree to / I am ready to
- I plan / I expect / I resolve / I aim to
- I hope to / I will try to / I will see about / I guess / I think / I suppose I will

### Low

- **Review the commitment**
- **Review the plan**
- **Set up a new time to discuss progress**
- **Express encouragement**
Conversation Flow

Open the conversation
- Name
- Role
- Time
- Ask permission

Ask open-ended questions
- Invites patient to do most of the talking
- Focus on strengths & successes

Negotiate the agenda
- Supports autonomy and choice
- Facilitates conversation
- Less is more!

Assess readiness to change
- Supports tailoring
- Invites “change talk”

Explore ambivalence
- Most common stage of change
- Needs to be addressed for sustained change
- Invites “change talk”

Ask about “next step”
- Assesses impact of conversation
- Perspective often shifts in the process!

Close the conversation
- Show appreciation
- If appropriate, offer recommendation(s)
- Voice Confidence

Ask
Listen
Summarize
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<th>Importance:</th>
<th>Confidence:</th>
<th>Readiness:</th>
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<th>ALCOHOL</th>
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Adapted from Berg-Smith Consulting