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3 Motivational Interviewing and Health Behavior Change Counseling

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3.1 INTRODUCTION

The purpose of this chapter is to introduce Motivational Interviewing (MI), an evidence-based style of health behavior change consultation, and to discuss the implications of MI for the challenges faced in treating the obese patient. Our goal is to provide readers with a set of ideas to stimulate creative thought about health behavior change and a toolkit of techniques that may be readily integrated into professional practice.

3.2 SETTING THE STAGE

We are at the beginning of a new era with respect to the assessment and treatment of obesity. Training in obesity treatment is finally available for generalist and specialist practitioners through many venues, and as body mass index (BMI) becomes a basic vital sign, screening for overweight will quickly become standard practice. Overweight or obese patients will be identified with greater frequency, as will the correlated risks associated with increased weight; but how will the subject of obesity and lifestyle change be effectively addressed by the clinician?

Obesity and weight are inherently difficult topics to discuss. Patients are often reluctant to broach the subject because of previous failures of weight management, misinformation, fear, guilt, embarrassment, or concern about the costs of treatment [1]. Practitioners are equally reluctant to raise the topic. Less than half of obese adults report being advised to lose weight by health care professionals [2]. Primary care practitioners report confusion regarding clinical guidelines and treatment tools. Few receive training in behavior change counseling strategies, and many report an acute lack of consultation time [3]. Practitioners are also reluctant to raise the topic without being able to offer a quick solution or a simple prescriptive approach to weight loss. Unlike smoking cessation or seatbelt use, where the messages are simple, with obesity, the means (lifestyle changes) to achieving the desired outcome (weight loss) are complex.

Even when obesity and weight are addressed, the communication is often problematic. The usual practice of asking questions and providing directives regarding change leaves patients passive, confused, and disengaged. Furthermore, according to a recent report from the Institute of Medicine, “90 million adult Americans have difficulty understanding the health information they get from their doctors” [4]. Attempts to increase motivation through exhortation, explanation, and coercion generally fail. All too often, the outcome of these consultations is frustration and demoralization for both patient and practitioner.

There is a clear need for increased competence in **communication skills**. Practitioners need to learn how to communicate more effectively to foster change. Only through skillful communication will they be able to effectively raise concern and direct patients on a reasonable course of treatment. The Accreditation Council for Graduate Medical Education has acknowledged this need and now recommends that physicians demonstrate competence in five key communication skills: listening effectively; eliciting information through questioning skills; providing information via explanatory skills; counseling and educating patients; and making informed decisions on the basis of patient information and preference [5].

MI holds promise as a means to meet the need for increased effectiveness of practitioner–patient communication. With demonstrated effectiveness in the treatment of addictive disorders [6], there is a growing body of evidence that supports the efficacy of MI in consultations addressing weight management and dietary modification and obesity-related diseases such as diabetes [7,8].

3.3 HISTORY AND DEFINITION

Evolving from the earlier work of William R. Miller [9] and Stephen Rollnick [10], the 1991 seminal volume, *Motivational Interviewing: Helping Clients Change Addictive Behavior* [11] introduced MI to an international audience as a “client centered yet directive” interviewing style that promoted behavior change through the “analysis and resolution of ambivalence.” With the 2002 publication of the 2nd edition of the MI text [12], we saw a broadening of the application of MI to behavior change in general including preventative medicine and chronic medical illnesses. These then are the two key features of MI: directed listening and the resolution of patient ambivalence to change. A central premise of MI is that, prior to the initiation of change, the practitioner must understand and appreciate the idiosyncrasies of the patient’s often conflicting ideas, attitudes, and feelings about the targeted health behaviors. Through a process of directed or strategic listening, the practitioner promotes the resolution of the ambivalence in a manner that increases the patient’s commitment to changing his/her behaviors toward healthier options.

Four key elements of MI address both what one discusses with the patient and how one discusses this: express empathy, roll with resistance, develop discrepancy, and support self-efficacy. The first two elements, *express empathy* and *roll with resistance*, pertain to the practitioner–patient relationship. Empathic listening (accurately understanding the patient’s story) is fundamental to MI as it provides the vehicle for both understanding the patient’s unique connection to the targeted health behavior and is the venue through which rapport is developed and maintained. *Roll with resistance* is a particular manifestation of empathy, wherein argumentation is avoided and attempts are made to thoroughly understand the patient’s reluctance to change. Furthermore, unsolicited advice-giving is avoided in an attempt to maintain the collaborative spirit of MI.

Develop a discrepancy refers to the engine of change. MI is a self-advocacy model of behavior change. The focus is on increasing intrinsic motivation, changing “because I want to,” by helping patients become aware of the discrepancy between current behavior and highly cherished personal values and goals.

The fourth element, *support self-efficacy*, simply asserts that wanting to change is only half of the behavior change battle. Patients need to also believe that change is possible, that there is a way to succeed, to persist with health behavior change. Empowerment and offering choice are critical to the development of patient self-efficacy.

MI, then, is an approach to health behavior change consultation that employs high-quality listening to discuss the “whys” and “hows” of change, with goal of increasing patients’ readiness for, and commitment to, the adoption of a healthier lifestyle.

3.4 THREE STYLES: TOWARD INTEGRATION

Before further pursuing the discussion of MI, let us look at where this consultation fits into the world of the health care practitioner. Rose et al. [13] have proposed that practitioners adopt one of three styles in their patient consultations: *Instruct*, *Guide*, and *Listen*. They further propose that each of these styles is critical to communication,



FIGURE 3.1 The three styles of motivational interviewing.

and that to be effective, the practitioner needs to be flexible, adaptable, and competent in the delivery of all three styles (Figure 3.1).

The three styles are defined as follows:

1. **Instruct:** *Give information or advice.* Other activities associated with this style include directing, informing, leading, educating, telling and using one's expertise. These are used when there is specific information that one wants to provide, hopefully which the person wants to receive.
2. **Listen:** *Understand the person's experience.* Other activities used include gathering information, following, eliciting, attending and empathizing. These are used when one wishes to understand how the person feels or what has happened to him or her.
3. **Guide:** *Encourage person to set his/her own goals and find ways of achieving them.* Other activities associated with this style include coaching, negotiating, mobilizing and motivating. These are used when the person is facing change, having to make decisions and to act upon them.

The guiding style is best understood as a higher-order style of communication that integrates elements of both instruction and listening, but differs fundamentally from these other two styles. Critical to effective guiding are activities such as collaboration, empowerment, affirmation, and the entertaining of alternatives.

Our model does not suggest that any one style is *a priori* more effective. Rather, we propose that each style has a place in the armamentarium of the health care practitioner, and the challenge is one of matching the consultation style to a specific clinical context and the expectations of the patient. **The guiding style is particularly effective when addressing health behavior change.** This is due to the nature of the desired change, which is almost completely under the control of the patient and entails the patient learning to integrate changes with day-to-day habitual activities in the face of competing nonhealth interests.

MI is essentially a sophisticated, evidence-based example of the guiding style of consultation. To the extent that guiding is appropriate, MI serves as a model of effective practice.

As we shall see later, however, MI is not just a form of guiding. Rather, the style also includes elements of collaborative instruction and purposeful listening.

3.5 LEARNING MI

The representation of the MI learning process as a pyramid (see Figure 3.2) has proven to be an effective heuristic vehicle. MI as a style of health behavior change consultation is built upon a theoretical/attitudinal foundation called the *Spirit of MI* [14].

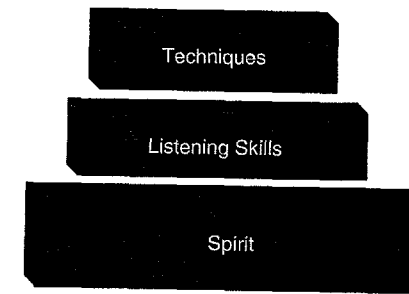


FIGURE 3.2 MI learning pyramid.

Sophisticated listening skills serve to operationalize the spirit, and structured techniques offer opportunities for productive behavior change conversations between practitioner and patient. We will discuss each of these levels of the MI pyramid in turn (Figure 3.2).

3.5.1 SPIRIT OF MI: THE PRINCIPLES OF GUIDING

There is strong anecdotal evidence that the attitudes comprising the spirit of MI are critical variables in the effective implementation of this consultation style. Embracing the spirit of MI often yields significant changes in the manner that practitioners engage their patients. Conversely, implementation of the techniques without the context of these attitudes generally misses the mark and results in ineffectual MI at best. The Spirit of MI can be described as follows: collaborate and empower, appreciate ambivalence, and elicit intrinsic motivation — a desire to change grounded in personal goals and values.

3.5.1.1 Collaboration

Consistent with the patient-centered method in medicine [15], MI promotes practitioner–patient collaboration and the sharing of power [14]. Traditional health care consultation is “top-down,” with a power differential in the favor of the “expert practitioner.” Consider the following depiction of traditional health education:

Collect data, to...
 Assess health status, to...
 Make decisions, to...
 Deliver information, to...
 Improve health!

The active practitioner–passive patient relationship is a wonderful example of the “instructional” style and is perfectly adapted to the demands of acute and emergency medicine and surgery. One cannot imagine, for example, that while being wheeled into the surgical ward, the surgeon offers his patient choices regarding procedures to repair a cranial injury. However, there are serious limitations with this “expert”

consultation style when the goal is to encourage the lifestyle change that often is needed for preventative medicine and chronic illness management. It is important to consider the nature of the requested change and the factors associated with enduring health behavior change. When we ask patients to modify health behavior, we are invariably asking them to both initiate and persist with change. Initiation of change may not be particularly difficult, especially if reward strategies are in place. It is the nonpersistence of new behaviors that can cause problems. Ask any smoker how many times he or she has initiated smoking cessation or any dieter how many “successful” diets he or she has experienced. The challenge with regard to persistence of change has to do with the need to integrate the healthier behavior into everyday life and competing nonhealth-related priorities. Factors that result in successful integration include a sense of empowerment or personal self-efficacy [16] and compatibility between the new behavior and daily life. From an MI perspective, the collaborative relationship provides access to both of these factors. Shared decision making empowers the patient and allows selection of a change plan consistent with the patient’s style of initiating and maintaining change. Rather than a “*practitioner knows best*” relationship, in the spirit of MI, we suggest entertaining the concept of “*dual expertise*” [17]. The practitioner is an expert in medical science and health; the patient provides expertise in self-change [18] and in the whys and hows of health behavior change. Only the patient has the depth of understanding as to what might work and what might not, given his or her lifestyle and priorities; therefore, it is critical that the patient’s own life is understood and integrated into the treatment plan.

One perceived barrier to the adoption of a dual expertise relationship is time. The busy, time-constrained practitioner often fears that collaboration and empowerment just takes too much time. The top-down expert relationship may not always work, but there is a comfort in the perceived ability to “get things done quickly.” Furthermore, there is a pervasive fear among health care practitioners that to ask an open-ended question is to initiate a runaway conversation or a “Pandora’s box” of problems. However, the typical patient only needs 3 to 4 minutes of good active listening to thoroughly inform the practitioner, and this information correlates with effectiveness and efficiency of health care [19].

To anticipate our discussion of listening, we would suggest that an attitude of empowerment accompanied by a few key words and phrases will set the stage for shared decision making. For example, the phrases “Let’s put our heads together and review the options,” and “I can offer an opinion but you’ll need to tell me what will work best in your daily life,” clearly elicit dual expertise in a timely manner.

3.5.1.2 Appreciate Ambivalence

Ask any health care practitioner what proportion of patients have mixed feelings toward change and they will say the majority. Ambivalence is thus a normal aspect of the behavior change quandary. From the MI perspective, the goal is to understand and use ambivalence in the service of change rather than in the service of staying the same. We will now elaborate on this goal.

The decisional matrix [20] provides a visual tool for understanding the concept of ambivalence as it pertains to health behavior change. One might assert that the

	Eat Whatever I Desire	Healthier Eating Habits
BENEFITS	I like the taste It's cheaper and more convenient I feel fine At least I don't smoke I'm not that bad	Stay healthy Less medications Control sugars Good role model In control of my life I don't want to die!
COSTS	My Doc lectures me I've gained another 20 Out of control sugars I don't want insulin I feel guilty	Too expensive No recipes We hate veggies!! Dining out? No time!

FIGURE 3.3 A decisional matrix.

matrix presents both sides of the change–no change argument in the debate about health behavior change. With respect to the argument for the status quo, the decisional matrix illustrates common losses and barriers associated with adopting a healthier lifestyle. Figure 3.3 presents data regarding the adoption of healthier eating habits. The upper left quadrant (benefits of current behavior) describes, from the patient’s point of view, positive attributes of the current “unhealthy” eating style. Included here are attributes associated with taste, convenience, sociability, culture, and psychological coping strategies, to name a few. The lower right quadrant (*costs of change*) likewise describes perceived barriers to adopting healthier eating behavior. Here we observe attributes including cost, inconvenience, fear of failure, disruption of daily habits, and cultural discordance. These factors comprise what we call the *Status Quo* side of ambivalence, which perhaps can be referred to as, “I like my life/your plan won’t work for me!” The remaining two cells of the matrix present the arguments in favor of change, otherwise known as *Change Talk*; Concerns about current behavior and benefits anticipated from change can be referred to as, “I’ve got problems /Life could be better.”

A moment’s reflection yields the observation that both sides of the ambivalence have credibility. Patient-identified barriers and anticipated losses associated with change have credibility in at least the short term, as do mitigations of risk associated with likely health deterioration. It is our contention that traditional approaches to health behavior change have generally ignored these aspects of ambivalence, in favor of the items listed in the remaining two quadrants of the matrix: the problems, costs, and risk factors associated with current behavior, and the potential or predictable benefits that accrue upon implementation of change. This bias causes problems for the conscientious health care practitioner in a number of ways. First, consider how ambivalence operates in normal daily social interactions. If one is ambivalent about a certain matter, such as work, personal relationships, etc., and one is conversing with somebody who strongly supports one side of the ambivalence, there is a strong tendency to defend the other side, e.g. “Why don’t you quit that job! You work long hours for short pay. There’s no chance for promotion, and

your boss is always breathing down your neck!" "But I like the people I work with; I've been there long enough to get a nice corner office, and I feel good about the work we do here!" This wrestling match in the form of point-counterpoint is all too familiar to parents of teenagers, spouses, etc. When it occurs in the health care setting, it is what we call the *Righting Reflex* [12]. The harder the practitioner argues for change, the harder the patient talks about, and thinks about, the benefits of staying the same. "You need to lose weight" — "I feel fine" "You can do it" — "I've tried before and I always fail." "You're going to have a heart attack at this rate!" — "Everybody is fat in my family. This is just how we are built, and, besides, we all live to be 90!"

Not only does the wrestling match of the righting reflex result in apathy and a loss of rapport between practitioner and patient, but it leads to a second, equally enduring problem. Social psychology informs us that **people are more likely to remember what they say aloud (or say with their internal voice)** than that which is simply told to them by others. Every parent and teacher who asks the demure child, "Repeat what I said so I know that you heard it correctly," implicitly understands this principle. Furthermore, self-perception theory [21] suggests that what people hear themselves say influences what they believe. Accordingly, this righting reflex generates a double whammy. Ambivalent patients verbalize their reasons for wanting to maintain the status quo and their concerns about our change plans; these words that they hear themselves utter actually reinforce their commitment to *staying the same!* Simply put, when we are dealing with highly ambivalent patients, the righting reflex becomes a powerful means for demotivating patients. The harder the practitioner tries to persuade the patient to change by differentially asserting current health risks and future gains, the more committed the patient becomes to maintaining the status quo. In the practice of MI, we try to reverse the righting reflex. Using the guiding style, we provide patients with opportunities to verbalize change talk. For it is through the verbalization of change talk in all its variations that people increase their readiness for change [12].

In MI, the goal is to appreciate ambivalence regarding change, to allow the patient to give voice to the status quo, to roll with any resistance. Listening then substitutes for arguing, guiding for debate. Key questions are used strategically to demonstrate an openness to understand both sides of the change-status quo debate, such as this dialog between general practitioner and patient, "I can smell a bit of smoke about you, so I'll shortly have to give you advice and some options for quitting. But, before I do, I'd like to ask, what do you still like about smoking? What will make it difficult to quit?" Rather than fall into a confrontation-denial trap, the MI practitioner rolls with resistance [11].

Curiosity about status quo yields at least three positive products: first, one identifies often personal and highly idiosyncratic positive reinforcers and barriers to change; second, the patient is delivered a message loud and clear, that, "I am not simply going to tell you what to do. Instead, I would like to discuss your mixed feelings here." Thirdly, by avoiding falling into the righting reflex, the practitioner allows the patient freedom to safely discuss concerns about the present and hopes for the future. These utterances then subtly shift the motivation toward, rather than away from, change.

3.5.1.3 Elicit Intrinsic Motivation

"I do everything I can to motivate my patients. They seem ready to do what I tell them when they leave the clinic, but when they come back they are even heavier. They just don't listen!" Sounds familiar? We have heard it thousands of times across all fields of health care. From the perspective of the spirit of MI, we assert that health care practitioners operate under a misassumption that health is naturally a high-priority goal. A bit of self-reflection reveals that **health is generally not a high-priority goal for most people** unless there is some sense of immediacy regarding change. Otherwise, the more immediate demands of daily home and work life take precedence, "I'd love to exercise before work, but I just don't have the time." "I'm happy if I can just pick up a take-out meal of hamburgers and french fries for dinner. That's the best I can do." It is no wonder that patients' ears are not open when it comes to conversations about healthiness.

From the perspective of MI, the challenge is one of increasing intrinsic motivation, the desire to change because *I* think it is a good idea. We must help the patient identify healthiness, holding onto it or getting it back, as a means to a personally valued goal. Take, for example, the obese teenaged boy who is only willing to change his diet and exercise routine when he sees its connection to his becoming a better wrestler; the renal dialysis patient who is willing to modify fluid intake so that she might have the energy posttreatment to walk her grandchild home from school; the smoker who will discuss quitting not because she wants to live to be 90, but because personal discipline is a core spiritual value. These are all people who have identified a connection between healthiness and something they want. It is this discrepancy between current behavior and personal goals, values, and desires that pushes healthiness further up the list of daily priorities. Help a patient develop a discrepancy and watch his ears open up regarding a conversation about change. Discrepancies are discovered through careful listening and strengthened by the reinforcement of patient change talk [12].

Summarizing, at its foundation, MI embraces a core set of attitudes: collaborate and empower, avoid the righting reflex, and develop intrinsic motivation by discovering the discrepancy between current lifestyle and personal goals and values. These attitudes facilitate the *guiding* style that is intrinsic to MI. In the next section, we will address the manner in which listening — what you say and how you say it — brings these attitudes into the consultation room.

3.5.2 LISTENING: THE IMPLEMENTATION OF MI

MI is a client-centered, yet directive, interviewing style. Miller and Rollnick [12] refer to the basic listening skills with the acronym OARS: Ask open-ended questions, affirm, listen reflectively, and summarize. These listening skills serve at least two functions within MI. First, the skills operationalize the concept of empathy that is central to MI, the practitioner's goal of understanding all sides of the issue regarding behavior change. In the context of discovery, a few well-conceived open questions followed by small summaries of what the patient says and means are critical to the development of a comprehensive understanding of the patient's beliefs pro/con change.

Second, careful listening is an effective alternative to instruction and confrontation in the face of patient resistance to change. From an MI perspective, the first line of intervention in dealing with a resistant patient is to listen well. Confrontation alternately breeds more confrontation and the overuse of direct persuasion may be considered a principal source of conflict in a practitioner–patient relationship [13].

Summarization is a deceptively simple listening skill that is critical to the directive side of MI. Summarization allows the practitioner to present a comprehensive yet pithy overview of the behavior change dilemma to the patient in a fashion that allows for gentle prods in the direction of increased commitment to change. For example:

Practitioner: So, you used to be somebody who could eat whatever you wanted, just eat things that tasted good, not worry about the amount you ate, and you were big into exercise.

Patient: Yes, and now that you mention taste I don't find food tastes that good; I don't feel like I taste it. I just eat it, but before, I remember "Oh that tasted so good" or I have memories of the past, "Oh, I always liked that" and now I eat it and it's like ugh, but I eat it anyway.

Practitioner: Things used to taste good and now when you eat the same things...

Patient: They have no taste to them. They are just a means for me to fill my stomach.

Practitioner: Kind of lost some of the fun and pleasure of eating. And back in the old days, not only did you enjoy the tastes, but exercise was a big part of your life and there may have been some connection between the exercise and being able to eat and maintain the weight you wanted.

The fourth listening skill, affirmation, serves two distinct functions: first, the patient's participation in the health behavior change discussion is clearly reinforced; second, affirmation leads to empowerment. For example, consider these statements of affirmation: "I can see that you're very invested in becoming healthier." "You're making some difficult choices regarding your diet. It's very important to you to control your blood sugars without insulin." Affirm and empower patients and they are more likely to persist with health behavior change.

3.5.3 INSTRUCTING WELL

MI is, at its core, an example of the guiding style of consultation — a style of great utility when working with patients regarding the initiation and maintenance of lifestyle change. There are, however, within MI, and within the world of health care, times when effective instruction is critically important. From an MI perspective, the goals of effective health education are twofold: 1) provide relevant information, and 2) maintain rapport. The best dose of education is ineffective when it falls upon closed ears. Maintain the balance of power, keep the information relevant, and patient interest will be sustained.

Instruction is "top-down" by its very nature and, as such, creates a challenge with respect to collaboration. To counter this natural noncollaborative tendency, the MI clinician can employ a very simple but effective technique — Ask permission first: "Do you mind if I ask you a few personal questions?" "With your permission, I'd like to propose a plan." "If you don't mind, may I share a bit of information...?" *Ask Permission First* is similar to the now ubiquitous knock on the door of health care practitioners just prior to entering the examination room — a very simple, inexpensive tool for communicating respect and empowerment. MI practitioners have found that the simple asking of permission frequently allows them to provide expert information and advice without falling into the "expert trap," wherein the patient stops listening not as much out of disinterest but rather because of the experience of being infantilized or talked down to. Maintain rapport by balancing interpersonal power and patients will become more amenable to instruction.

A second challenge regarding effective instruction is the need to keep information relevant and succinct. Consistent with the spirit of MI, we follow the formula, *Elicit-Provide-Elicit*, to effectively exchange information. Rather than delivering a chunk of information based upon our *a priori* assumptions of what the patient needs to know, we begin by simply eliciting, from the patient, questions and concerns, followed by careful listening. Here is an example:

Practitioner: I'd be interested in just getting a sense from you what you know about nutrition and healthy diet and maybe what questions you have. And you've done some reading and thinking about this. Would this be OK?

Patient: Well, I know that that you shouldn't skip meals, and that people think if they haven't had breakfast, it's good because they haven't consumed those calories, then they feel that they can eat lunch and even dinner. But if I do that, if I don't eat breakfast, most of the time by lunchtime I will eat anything, stuff I wouldn't even touch normally. I'm not a big French fry person but where I work, right next door, there's a lunch counter with french fries.

Practitioner: French fries coming out of the woodwork.

Patient: Yes, you order a sandwich and you get 20 lbs of French fries. And I know that for lunch, almost every day, I eat that. I know that's not good. Then I'm stuffed 'til like about seven o'clock. By the time I get home, I'm hungry again and I need to *do something quick*. I don't have anything to prepare, so I open up a can of something, usually something cheesy or fat. And I know it's fat and I don't add any vegetables or anything and that's what I eat.

Practitioner: So you know that skipping meals is a problem, that it is healthier to eat three meals a day. And you've experienced that if you do skip a meal at lunchtime, you're just so ravenous that you go ahead and eat for dinner the things you wouldn't normally eat because you don't particularly like their taste. You have this sense about yourself that if you don't kind of pace out your eating, you start to make the wrong choices. Perhaps we could put our heads together and discuss some options regarding pacing, healthy choices, and how to manage that stressful evening meal."

Having elicited a short list of patient concerns, the practitioner is now challenged with the task of providing information in a manner that maintains rapport and patient involvement; in other words, to instruct in the spirit of MI. Three keys to success are: 1) use neutral conditional language; 2) offer a menu of choices; and 3) take “reflection breaks,” small bits of listening interspersed in with the instruction.

Affectionately called “wiggle words,” the use of neutral and conditional language is fundamental to MI-spirited information exchange. Substitute “I think” and “you should” with phrases that empower the patient by allowing for personal choice, “one option you might consider...; perhaps you could start with...” Deliver information in the third person tense. Rather than, “I recommend,” try, “Experts suggest.” For “You should,” substitute “Some of my patients have found...” Words that allow choice empower patients and maintain their interest.

The concept of a menu of choices is also critical to maintaining the spirit of MI while providing instruction and negotiating treatment goals. Offer patients a short list of choices and you will find that they feel more empowered. The act of decision-making by patients when working with a menu of choices also facilitates their commitment; people are more likely to persist with goals they have self-selected. Furthermore, the menu provides hope in the face of failure, as there is always another plan of action to try if the first plan fails.

Reflection breaks are the third key to successful MI-spirited instruction. A reflection break is merely an opportunity to maintain rapport and avoid information overdose through the use of small summaries of the patient’s utterances. Consider this example: deep into a period of education about the importance of eating more vegetables, the patient interjects, “Well, I guess I could start eating a bit of broccoli and asparagus for lunch.” The nutritionist might respond in one of two ways to this utterance: 1) continued instruction: “Yes, you’re absolutely right, and I’d also recommend some carrots and lettuce...” or 2) provide a reflection break, “So you’re thinking of adding some broccoli and asparagus to your lunch,” to which the patient might respond, “Yes, and maybe there are some other veggies I could try like carrots and celery.”

What are the benefits of the reflection break? Patient interest is maintained through active participation, the practitioner gains direction, and collaborative problem solving is encouraged. Whatever the task, effective listening is key to maintaining the spirit of MI.

3.5.4 TECHNIQUES: REACHING INTO THE MI TOOLKIT

Following the impetus of Rollnick [22] and others, a variety of techniques that are helpful adjuncts to the more open-ended conversational style of MI have been developed. These techniques provide a means of structuring MI-spirited conversations that often integrate easily into the everyday world of the health care practitioner. Three particularly helpful techniques are: Agenda Setting, Good - Not So Good, and Importance–Confidence.

3.5.4.1 Opening the Door: Agenda Setting

“I’ve got so much to cover and there is so little time; how can I possibly get the job done!” What health care practitioner has not uttered these words now and again?

Topics that you may want to raise with your provider
Please mark the topic that is most important to discuss today

Weight	Fat in Foods	Carbs
Stress	Smoking	Skipping Meals
Exercise	Snacking	Portion Size
Calories	Other	Alcohol

FIGURE 3.4 An agenda-setting chart.

As an MI technique, agenda setting [17] provides a means to both actively engage the patient and increase the effectiveness of the health care consultation. Using a simple chart to elucidate a menu of choices (Figure 3.4), the practitioner elicits from the patient preferences regarding topics to address during their office visit. The chart may be geared toward topics that are often major concerns for patients, such as smoking, stress management, domestic violence, shelter anxiety, weight loss, alcohol use, and sexual concerns. The chart could also be modified to address the needs of a more focused consultation, for example a patient with diabetes: blood sugar monitoring, diet, exercise, medications, foot care, and self-care barriers. The goal of the agenda-setting technique is to provide the patient with the opportunity to discuss that which they are most ready to change and the practitioner with the opportunity to deliver a dose of tailored education to an interested individual. Consider this dialog:

Practitioner: Thanks for coming in today, Mr. Smith. I’d like to spend about 15 minutes talking to you about your eating and weight as factors in your blood sugar control. Would that be all right?

Patient: Well, it’s not my favorite subject, but I guess we can give it a go.

Practitioner: Yes, many of my patients feel that way. They have many concerns about their diets, some of which I have on this chart. Would you like to see if any of them relate to you? For some of them, it is not knowing what to eat, whether they are getting too many carbohydrates or fat; others are not sure when they should eat, or worry about how stress affects their eating; sometimes the concern has to do with smoking or alcohol use. And often it is something else altogether, which is why we leave some blank circles. Where would you like to start?

Patient: Well, I know that I need to cut back on the steak and cheese but I just don't fancy myself eating tofu and tuna fish all day long.

Practitioner: So you think you may be eating too much saturated or "bad" fat, but the alternatives are not too appealing to you.

Patient: I used to eat really healthy foods and kept my weight down. But since I started my new job, I seem to crave steaks and fatty food.

Practitioner: So, stress could be a factor in what you eat.

Patient: Yeah. That's what I should work on.

Perhaps there is a pressing clinical concern that must be addressed or another issue of importance to the practitioner. How can these situations be integrated into agenda setting? Try negotiating a primary and a secondary agenda, as follows:

Practitioner: So, let's put our heads together regarding ways to manage stress. I'd also like to reserve a few minutes to discuss blood sugar monitoring. I know from our previous discussions that this has been a challenge and I think it's important to keep our eyes on that. Would that be OK, too?

In the service of patient empowerment and the minimization of resistance, if feasible, address the patient's concerns first, followed by the concerns of the practitioner. Agenda setting is easily adapted to briefer interventions by limiting the choice to a fixed list of two or three topics. Critical, however, is the offering of choice.

Practitioner: When it comes to managing weight some people prefer to focus on changing what they eat; others prefer to look at activity and exercise. What would you prefer to discuss today?

3.5.4.2 Listening to Learn: Good–Not So Good

Faced with the reluctant patient, how does one achieve a productive consultation? Jumping ahead of the patient's readiness often results in the mutual frustration of a one-sided lecture falling upon deaf ears. One option is to reach into the MI toolkit and pull out the Good–Not So Good technique.

Good–Not So Good is simply a structured conversation addressing the content of the leftmost column of the decisional matrix (Figure 3.3), organized in a manner consistent with the spirit of MI: appreciate ambivalence and avoid the righting reflex. Using the listening style, the practitioner first queries the patient about the enjoyable, pleasurable, and hard-to-give-up aspects of the target behavior (status quo talk). This is then followed by a query about the other side of the ambivalence — that which is less good (change talk). Words are chosen carefully so as to avoid an argument. For example, "What is not-so-good" is chosen over "What don't you like about..." or "What's a problem with..." The goal is to provide the opportunity for a brief but balanced conversation about the target behavior in a manner that leaves the patient, not the practitioner, articulating the concerns. Again, people are more effectively influenced by what they say than by what they hear.

Practitioner: I gather that you're not all that excited about discussing cutting down on the carbohydrates and fats. So, I wonder if it might be helpful to take a step back and look at what we're asking you to give up, if you do make some of these changes. How's that sound?

Patient: OK.

Practitioner: Well, what do you like about your current eating? What would you miss if you did change?

Patient: Gosh, No one has ever asked me that! The stuff just tastes good. I guess the worse it is for you, the better it tastes going down. I go crazy over chocolate and I just can't seem to get through the day without some chips.

Practitioner: So, you like the taste of the sweets and crave the salty snacks, too. What else about what you are eating makes you feel good?

Patient: Things at home have been rough lately, with my three teenagers and the little one; the only time we have a bit of peace is when we're sitting down to a family dinner. I know I eat too much then, but I really look forward to that time together.

Practitioner: Big portions seem to be an essential part of the family dinner. *(Query continues)*

Practitioner: Now, how about the other side. What is not so good about your current eating? What do you like a bit less?

Patient: I hear all the lectures and the threats. If I don't change, I'm headed for insulin, I guess. And it's getting to where even the stretch pants don't fit.

Practitioner: People are really on you about your health and you've also noticed the effects of the weight gain on your body size.

Patient: Yeah, and the breathing is worse. I can hardly get up the two flights of stairs in my house. When the little one cries, it takes me a good 5 minutes to get to her.

Practitioner: Sounds like that really concerns you; not being able to be there for your child.

Patient: Yeah. Can you imagine if there was a fire or something?

The goal of Good–Not So Good is to structure a helpful conversation with the patient not yet ready for health education or treatment planning. Resistance is reduced by first eliciting status quo talk. The more confrontational change talk query follows next, with the patient in the position to articulate concerns, often revealing a particularly personal concern tied to a core value, such as being a good parent who can protect a child. Having articulated concern, interest tends to pique regarding a conversation about steps toward healthiness.

3.5.4.3 Guiding toward Readiness: Importance–Confidence

The Importance–Confidence scaling technique is a wonderful technique developed by Rollnick [22]; incorporated into this simple technique are all the basic elements of MI: listen carefully, appreciate ambivalence, elicit change talk, empower and collaborate. The scaling exercise yields for the practitioner a clear sense of how ready the patient is for change and how to be most helpful.

Importance and confidence reflect two conceptually independent dimensions that underlie patient readiness to change: *Why should I?* (Importance) and *How can I?* (Confidence). Simplifying, a 2 × 2 table of high–low importance vs. high–low confidence yields the following four situations, exemplified by these typical statements:

High Importance/High Confidence: “I really want to lose weight so that I can get off insulin. I know that with a dietitian’s guidance, I can do it and keep it off.”

High Importance/Low Confidence: “I really want to lose weight so that I can get off insulin, but I have tried a million diets and they just don’t work for me.”

Low Importance/High Confidence: “I have lost weight before so I know I can do it, but what’s the point? My whole family has diabetes so losing weight won’t stop me from getting it.”

Low Importance/Low Confidence: “There is no point in me trying to lose weight; I have always been fat and couldn’t lose it if I tried.”

Imagine the possibilities of mismatching professional advice to patient readiness, as follows:

Practitioner: For patients who have already had a heart attack, eating a lot of saturated fat is the worst thing for their health; it’s even worse than for people in general. I need to strongly encourage you to cut back!

Patient (High Importance/Low Confidence): With all due respect, Doctor, you’re preaching to the choir. I know that ice cream, clam chowder, steak, and cheese are all heart attack foods. I’m scared to death of another heart attack, but I’ve tried everything and nothing seems to work. I think I’ll be eating this stuff ‘til my dying day!

Practitioner: All you have to do is go on a diet. I will refer you to a dietitian immediately. We can deal with cravings with some medication. And a little exercise will help, too. We’ve got plenty of tools at our disposal to make the process simple and easy.

Patient (Low Importance): “I’m sorry Doctor, but what I eat makes me happy, it’s a comfort to me since the kids have left home. Since I quit smoking, I don’t get much enjoyment from anything else in life. It’s my last vice. It’s just not that big of a deal!”

In the first case, the practitioner has mistakenly assumed that the barrier to change falls in the “*why should I?*” arena and passionately delivers a dose of instruction that at best is redundant with the patient’s current knowledge-base and, at worst, is perceived by the patient as evidence that the practitioner just has not listened well. The second case is a fine example of the righting reflex, where, by assuming that the barrier is in the arena of “*how can I?*” the practitioner jumps way ahead of the patient’s readiness to take action, resulting in a consultation marked by discord and conflict.

Importance–Confidence provides a means of avoiding these rapport-breakers by facilitating an MI-spirited conversation about change that both informs the practitioner about how best to help the patient and also allows the patient to verbalize change talk. This is implemented with six simple questions:

How important is it for you right now to change? On a scale from 0 (not at all important) to 10 (extremely important), what score would you give yourself?

- a. Why are you at (X) and not at 0?
- b. What would need to happen for you to get from (X) to (X + 2)?

If you did decide to change, how confident are you (0, not at all confident; 10, extremely confident) that you could do it?

- a. Why are you at (X) and not at 0?
- b. What would need to happen for you to get from (X) to (X + 2)?

Notice that the “*downward*” question precedes the “*upward*” question, with regard to both Importance and Confidence. Often called the “Colombo question” after the 1980s television detective known for his subtle questioning, the downward question is critically important to this MI tool. “*Why is it an 8 and not a 0?*” both demonstrates an attitude of acceptance and also invites the patient to verbalize change talk, expressed as concerns regarding current behavior. The exceptionally important and more confrontational question, “*What would it take to raise your score,*” then follows.

Using Importance–Confidence, a practitioner can, in a matter of minutes, obtain a good idea of how ready a patient is to change the target behavior, and whether to proceed by initially exploring importance or building confidence.

3.5.5 BRIEFER INTERVENTIONS

“*But how can we do this in just a few minutes?*” This is the most frequent and most legitimate question posed to MI trainers. The answer is at once both simple and a bit complex. The deceptively simple answer is, try to sandwich as much MI as possible into your conversation. The somewhat more complex answer is, “Think about the three styles and try to flexibly move between them in a manner that meets the needs of your patient.”

The MI sandwich refers to the integration of the fundamentals of the MI spirit and listening style into everyday practice [23] For example, the spirit of collaboration is easily established within the first few minutes of a consultation by employing some of these simple strategies: 1) communicate clearly about the purpose of the visit and how this consultation will address the patient’s expressed concerns; 2) ask permission before proceeding; emphasize that you will be sharing ideas back and forth, and remember to offer a menu of options at the appropriate moments; 3) set an agenda together when appropriate; and 4) thank the patient and affirm his or her efforts. These strategies are among the options that will promote the spirit of collaboration and empowerment.

As with the longer versions of MI, effective listening is critical to brief implementations. Listen with small summaries. Carefully choose your words. Offer some wiggle words and avoid the use of first person directives. When you instruct, elicit first, and then educate. Look for opportunities for reflection breaks.

Finally, the practitioner who becomes *3 Styles-Savvy* — aware of the communication style being used and purposeful about matching style to situation — will

find the integration of MI into briefer conversations quite straightforward. Listen in response to resistance. Guide with the MI toolkit to stimulate interest and to open ears. Instruct with options and then listen some more.

These basic principles will guide the integration of MI into everyday health care practice, whether we are talking about specialist mental health, health behavior change consultations, or of the more frequent corridor conversations that so impact the patient's experience of the health care system.

3.6 WHAT THE RESEARCH SHOWS

There have been several reviews of the clinical usefulness of MI [6,8,24–27]. Over 400 published papers on MI have been published to date, including around 70 outcome trials [27]. Given space constraints, we will discuss these outcome findings only briefly here. However, the reader is encouraged to seek out the reviews mentioned above for a deeper understanding of the findings as well as the complexities of research in this area. It is notable that there are numerous ongoing studies both in the U.S. and overseas, applying much more stringent MI training and intervention standards than were used even 5 years ago, that will come to fruition soon and help further clarify the role of MI in health promotion generally, and obesity in particular [26]. Generally, the findings to date have provided encouragement and support for our clinical methods and have prompted further refinement of MI interventions to fit specific patient groups and settings.

Of particular relevance to the management of obesity are five studies focusing on diet and physical activity that will be outlined below. Overall, it should be noted that the MI clinical approach itself has evolved since the mid-1990s and critical MI counseling elements have been refined. For example, research has clarified the importance of empathy and adherence to the core MI spirit of collaboration, autonomy support, and eliciting change talk. Recent intriguing findings reported by Amrhein et al. [28] have also suggested that fostering strong commitment language from the patient may be one of the most important mediators of behavior change; that is, the best predictor of change is the patient's verbalization of a concrete plan of action. Generally, in MI intervention studies, we have seen dramatic improvements in the standards of interventionist training and treatment fidelity, including routine analysis of audio tapes of interventionist-patient interactions using standardized coding tools to measure, empirically, the presence of important MI counseling attitudes and behaviors [29].

What have MI review studies reported to date on the clinical usefulness of MI? Zweben and Zuckoff [24], in their review of the impact of MI on treatment adherence, identified 21 studies from 1988 to 2001, including interventions targeting alcohol and drug abuse, dual psychiatric diagnoses, diabetes, weight control, exercise, HIV prevention, and eating disorders. Despite problems with internal validity seen in many of these studies (i.e., small samples, lack of control group, limited description of interventionist training or the intervention, insufficient precautions to ensure treatment fidelity across conditions), the adding of an MI component has produced significant adherence effects and helped patients move from one level of treatment adherence to a higher one. For example, Borsari and Carey [30] in a randomized,

controlled trial found that MI reduced binge drinking among college students in the MI intervention group (using a single MI session) by 35% compared to 15% for controls. Scales [31] observed that motivational enhancement therapy, a brief MI protocol, produced lower scores for patients in cardiovascular rehabilitation on a linear score combining perceived stress, physical activity, and dietary fat. Treasure et al. [32] found a similar impact when MI was combined with a behavior intervention in the treatment of bulimia. Hodgins, Currie, and el-Guebaly [33] concluded that a single session of MI reduced days gambling and amount of money lost by problem gamblers; this effect was much more robust than that obtained with a self-help book.

More relevant to obesity, Resnicow et al. [34] reviewed five outcome studies evaluating the impact of MI counseling on diet and physical activity change [26,35–40]. Berg-Smith et al. [35] report that children receiving two sessions of MI for diet reported significant improvement in fat and calorie intake. Mhurchu et al. [36] observed no differences in main outcomes between hypertensive patients receiving an MI condition involving three MI sessions and those receiving a standard dietary intervention.

In a pilot study, Smith et al. [37] found older, obese women with type 2 diabetes, receiving an MI intervention to have greater group attendance, more frequent blood glucose monitoring, and improved blood glucose control (i.e., 1% HbA1c drop) compared to a behavior therapy intervention. In a subsequent randomized, controlled trial designed to evaluate the incremental benefit of MI to improve outcomes in behavioral obesity treatment [37], 217 overweight (average BMI = 37) women (38% African-American) with type 2 diabetes received either a group-based behavioral weight control program with supplemental individual MI sessions or the same weight control program with health education sessions (attention placebo control). Women in the MI group lost significantly more weight than those in the control group at 6 months (−4.7 vs. −3.1 kg, $p < 0.02$). This superior weight loss was mirrored by enhanced adherence to the treatment program on all process variables examined over the initial 6 months: session attendance (19 vs. 17, $p < 0.006$); number of weekly self-monitoring diaries submitted (17 vs. 14, $p < 0.002$); average diary rating (1.4 vs. 1.2, $p = 0.002$); and changes in caloric expenditure in moderate to vigorous exercise (+955 vs. +742 kcal, $p < 0.04$). Weight losses were strongly associated with attendance, diary submission, and diary ratings ($r = 0.45$ to 0.52 , $p < 0.001$) and modestly associated with increased caloric expenditure ($r = 0.21$, $p < 0.03$), suggesting that enhanced engagement in the treatment program accounted for superior weight losses in the MI condition at 6 months. The pattern remained consistent in the 12 months of follow-up. Thus, MI appears to facilitate adherence to weight loss maintenance efforts, as well as weight loss induction and as such merits consideration for inclusion in standard behavioral weight control programs.

Harland and colleagues [39] obtained data indicating that MI enhanced exercise behaviors among sedentary but healthy general practice patients at 39 months compared to controls; but this difference disappeared at 1 year follow-up. Woollard et al. [40] found significant improvements in systolic blood pressure of 6 to 8 mm Hg as well as reduced alcohol and salt intake for hypertensive patients receiving one of two levels of MI counseling compared to a usual care condition. Resnicow et al.

[26] increased fruit and vegetable consumption among African-American adults by one serving per day following an MI intervention delivered by trained dietitians relative to comparison and control conditions, although analysis of tape-recorded phone intervention sessions, however, suggested only moderate treatment fidelity to the spirit and techniques of MI.

Overall, the data regarding the impact of MI generally, and on obesity and related problem areas specifically, have been promising, particularly the randomized clinical trial (RCT) conducted recently by Smith-West et al. [38] on obese diabetic patients, which is part of a new wave of MI intervention studies with high MI training and treatment fidelity standards. We will continue to be informed by these more sophisticated methodological papers conducted using the behavior change consortium (BCC) guidelines [29] and specifically with use of interview coding strategies such as that provided by the MI Treatment Integrity (MITI) tool [41]. We will see an improved focus on measuring MI-related mediators such as importance of change and self-efficacy as well as the amount and quality of patient change talk that new research is showing to be important. These enhancements, as part of an overall strengthening of the evaluation research in MI studies, will likely lead to a clearer picture regarding what type and dose of MI is required for what patients and in which clinical contexts to produce the maximal health benefits.

3.7 CONCLUSIONS

MI and its derivative, Health Behavior Change Counseling, instructs us to appreciate the limits of a direct-persuasion model of interpersonal influence, guides toward an understanding of ambivalence and the value of eliciting patient change-and confidence-talk, and models the use of effective listening skills to build, engage, understand, and facilitate behavior change. Whether one has the luxury of extended patient contact or must work within the parameters of a brief scheduled or opportunistic exchange, there are opportunities to integrate elements of the MI guiding style into everyday practice. Start at the foundation of the MI learning pyramid, using what you say, and what you avoid saying, to communicate respect, empowerment, and a willingness to hang in there with patients as they struggle with the decision to change. Try to answer the questions, "Why would this particular patient want to modify his or her eating and activity behavior at this particular moment in time?" "What would the patient gain and what would he or she have to give up?" Bring the spirit of MI into the consultation through effective listening: Ask a few open questions to elicit your patient's concerns and ideas regarding change. Follow this with reflective listening, small summaries of what you just heard. Listen, rather than argue when you hear resistance from the patient. As the decisional matrix informs, there are always compelling reasons in the short term not to be eager to change health behavior.

Avoid instructing if patients' ears are not open. Give them some *wiggle room* by couching advice in neutral and conditional language. Reach into the MI toolkit and use a technique to guide toward readiness for health education. Finally, when you start to hear change talk, offer the patient options as you negotiate a plan of action.

RESOURCES

Motivational Interview Network of Trainers, an international organization of MI trainers and researchers all of whom have completed the Training New Trainers workshop under W.R. Miller, Ph.D. and/or S. Rollnick, Ph.D., www.motivationalinterview.org.
Institute for Motivation and Change, an M.I. training institute, www.miinstitute.com.

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