

## Brief Motivational Interventions: An Introduction

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This article is an introduction to brief motivational interventions, which is an effective strategy to address alcohol-use disorders and the public health issues these disorders present. In this article, we summarize core concepts and our clinical ex-

periences. To explore the contrast between these interventions and more traditional approaches to patient-provider interaction, the article describes strategies used in brief motivational interventions, answers common questions about the pro-

cess, and provides references and resources for those who would like to learn more.

**Key Words:** Brief intervention, Motivation, Ambivalence, Change.

*J Trauma.* 2005;59:S21–S26.

**B**rief motivational intervention differs from other patient-provider interactions in that the interviewer explores a patient's motivation to change rather than prescribes a specific course of action.<sup>1</sup> Ambivalence about change is a common phenomenon among those with alcohol problems. Even among patients committed to abstinence, ambivalence or mixed feelings about drinking and changing behavior may fluctuate from moment to moment. Because many patients are ambivalent about stopping or changing potentially harmful behaviors, brief motivational interventions are structured to focus on the patient's perspective of the problem and what, if anything, the patient wants to do about it. Ambivalent patients might resist being labeled as alcoholics, problem drinkers, or being in denial. However, if patients do not feel judged, most will be open to at least discussing their alcohol use and possibly considering the goal of avoiding future injuries and hospitalization.

In trauma centers, brief interventions are opportunistic. Although injured patients are not actively seeking treatment for alcohol problems, motivational interventions present op-

portunities to capitalize on alcohol-related injury to help motivate changes in drinking behavior. In contrast to traditional approaches that offer only brief advice and are less patient-centered, motivational interventions avoid confrontation or direct persuasion. Confrontational tactics tend to discourage a patient's motivation to change because the emphasis is on education or the authority of the medical staff, not on individual responsibility and the patient's desire to change. When properly implemented, brief motivational interventions shift the focus from the provider to the patient; the patient is seen as the expert. Therefore, the primary task in conducting motivational interventions should be to elicit ideas from patients about the need for change rather than to confront patients about the reasons change is needed. Most patients already know that change is required, but they are either unable or unwilling to take action. The motivational intervention can be the catalyst in countering this ambivalence.

### What Is a Good Way to Begin a Motivational Intervention?

The interviewer should begin with an opening statement to indicate that the ensuing discussion about alcohol use will be different from interactions the patient may already have had with medical staff. In this encounter the patient, not the interviewer, will control the agenda of the discussion. The patient also needs to know how much time the discussion will take, along with the goals and expectations in broaching the topic of alcohol use. The statement should conclude with an open-ended question or statement designed to elicit a response from the patient. Here is an example:

*'We've talked a lot about your injury, and I've answered your questions about what you need to do to recover from the surgery. Right now, I would like to take about 15 or 20 minutes of your time to hear about your impressions of what happened, how alcohol may have been related to your injury, and what, if anything, you can or want to do to keep this from happening again.'*

Submitted for publication February 2, 2005.

Accepted for publication February 21, 2005.

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This article was written for the proceedings from a conference called *Alcohol Problems among Hospitalized Trauma Patients: Controlling Complications, Mortality, and Trauma Recidivism* in Arlington, Virginia, May 28–30, 2003. It does not reflect the official policy or opinions of the Centers for Disease Control and Prevention (CDC) or the U.S. Department of Health and Human Services (HHS) and does not constitute an endorsement of the individuals or their programs—by CDC, HHS, or the federal government—and none should be inferred.

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DOI: 10.1097/01.ta.0000179899.37332.8a

## What Are the Basic Strategies of Brief Motivational Interventions?

Four fundamental strategies are typical of patient-centered interventions. These strategies (represented by the acronym OARS) will help the interviewer to listen, to elicit important information, and to build rapport with the patient and should be used throughout the intervention.

### Open-Ended Questions

In contrast to motivational interventions, typical medical interviews use closed-ended questions requiring simple yes or no answers, which tend to yield limited information. Open-ended questions invite patients to explore the reasons they have a problem and to elaborate in their answers. For example, 'What's drinking like for you?' or 'How do you feel about your drinking?'

### Affirmations

Highlighting the patient's individual strengths, personal values, and goals by using compliments or encouragement helps build rapport. Affirmations should be specific and genuine. Examples may include, 'It sounds like your family is really important to you' or 'Showing up at work regularly and on time appears to be an important goal for you.'

### Reflections

Short restatements of a patient's thoughts and feelings build rapport and ensure effective communication between the interviewer and the patient. By repeating the patient's responses, interviewers can be assured they correctly understand what the patient is saying. Reflections can be verbatim (restating the patient's own words) or paraphrasing statements.

### Summaries

Summaries combine two or more patient statements from the larger conversation and are transitional tools that can be used to determine whether the interviewer and patient have communicated effectively. In other words, summaries ensure that interviewers and patients are on the same page. At this point, interviewers can correct any misperceptions they might have about the patient's responses.

'The whole is greater than the sum of its parts'; summaries often add meaning or present a clearer picture of what the patient has disclosed. As a result, patients may be encouraged to further explore their situations.

## What Is Empathy, and Why Is It So Important?

Empathy is quite different from sympathy, which is a form of communication that accepts, endorses, or condones behavior. The goal of empathic communication is to accurately understand the patient's perspective and behavior. To convey empathy to the patient, interviewers should use reflective statements like: 'It sounds like you're saying...' or

'What I hear you saying is that...'. Empathy is an iterative process guided by patient feedback. Because this process allows interviewers to be emotionally neutral and nonjudgmental, empathy builds patient trust and generates useful information that can be used to enhance the success of the intervention.

As discussed in the previous section, the elements of OARS are techniques to ensure that the interviewer understands the patient's perspective and expresses empathy. An empathic style is more important than any single technique and is a very strong predictor of patient outcomes. In a study by Miller and Baca,<sup>2</sup> the more empathic the therapist had been during interview sessions, the less the patient drank at follow-up. Conversely, another study by Miller et al.<sup>3</sup> demonstrated that the more frequently the therapist confronted the patient, the more the patient drank. Empathy and hope play a critical role in patient outcomes. If the interviewer does not communicate empathy, a therapeutic alliance will not be established. Consequently, more specific tools or concrete techniques are unlikely to be helpful if empathy is not expressed.

## How Can Interviewers Gather Specific Information About a Patient's Experiences?

Once rapport has been established through empathic listening, interviewers can ask specific questions, such as the following examples, about the behavior under discussion.

1. What is a typical day like for you on a day when you drink?
2. How important is it to you to make a change in your drinking? How confident are you that you can make a change?
3. What do you like and dislike about your drinking habits?
4. How would your life be different if you were to change your drinking?
5. What are some of the most important things to you?

## Typical Drinking Day

Unlike a closed-ended question like 'Do you drink?', which leads to a simple yes or no answer, 'Tell me about a typical day for you on a day when you drink?' is an open-ended way of encouraging patients to describe the who, what, when, where, with whom, and why of their drinking. It provides valuable insights into patterns of consumption, reasons for drinking, and potential triggers for use. Not only does this information provide momentum to the discussion, it will prove useful if a change plan is later developed. One common pitfall is the temptation to focus on exactly how much or how often patients drink. Although consumption patterns are informative, the focus of the intervention should be on generating information about the problems alcohol use creates and in determining the level of motivation to change behavior.

## Importance and Confidence Questions

‘On a scale of 0 to 10, where 0 is not at all important and 10 is extremely important, how important is it for you to change your drinking habits?’ and ‘Again, on a scale of 0 to 10, if you decided to change your drinking habits, how confident are you that you could?’

These questions provide a quick way for the interviewer to determine patient motivation and confidence levels; the patient may even initiate change talk. For example, a patient might not think that changing his drinking habits is very important and, consequently, rate the importance question as a 3 on the 0 to 10 scale. If the interviewer responds by asking, ‘Why are you a three and not a zero?’, the patient is set up to explain why he is somewhat motivated to change. The interviewer should listen very carefully to the words the patient uses, because the patient’s response can often be used as reflective statements later. By repeating the patient’s own ideas, the interviewer is perceived as more neutral than when advice is interjected. The next logical step in this interaction is to ask, ‘What would it take for you to get to a higher number?’

This strategy also works for helping less-confident patients focus on experiences in which they did feel confident. Reinforcing the patient’s sense of self-efficacy is important in motivating behavior change. Otherwise, the motivation to change behavior may be stymied.

The importance and confidence questions provide a great deal of background information, which helps interviewers prioritize the elements of the intervention. For example, if a patient gives importance a high score, the interviewer may want to focus on building confidence or discussing a change plan. However, if a patient does not believe that change is important, these strategies may be counterproductive. Raising the importance of change becomes the task at hand. Although many patients may not see the need to quit drinking permanently, they may understand and may be willing to discuss the potential benefits of abstaining for a defined period of time, reducing how much or how often they drink, or changing the context in which they drink. Sometimes the issue is not a patient’s overall level of motivation but determining specific parts of the behavior a patient is willing to or interested in addressing.

## Pros and Cons

The following questions provide other ways of exploring patient motivation: ‘What are some things you like about drinking? What are some things you don’t like about drinking?’ (preferably in this order). This discussion becomes essentially a cost benefit analysis of current behavior—evaluating the disadvantages and advantages of the status quo versus that of change. As the interviewer begins to understand the patient’s perspective, it may become apparent that important personal goals or values conflict with the patient’s choice to drink heavily. Identifying and discussing the im-

portance of values and achieving goals can change how injured patients perceive themselves, ultimately leading to behavior change.

## Values and Goals

Finally, interviewers should identify how the patient’s personal values are connected to the patient’s goals. For example, it may be easier to move toward certain behaviors (becoming physically healthy) than to move away from a behavior (stopping drinking). People with alcohol problems usually need a reason not to drink. That reason may be family, job performance, or personal health and well-being. Listening for and affirming these values will help move patients toward change. Phrases such as, ‘You’re the type of person that...’, ‘You see yourself as...’, or simply ‘is important to you’ achieve this quite succinctly. Another way of motivating change is to ask the evocative question, ‘If you could wake up tomorrow to a better life, what would it look like? How would it be different?’, or, more specifically, ‘In a year or so when your injury has healed, where would you like to be?’

One of the objectives of brief intervention is closing on good terms. This leaves the door open for future interventions by other health care workers and increases the likelihood that patients will seek treatment as they become more motivated to address their drinking problem. Behavior change does not happen all at once. By helping patients identify and affirm their values and goals, the interviewer can ensure that the intervention ends on a positive note.

## What If Patients Are Not Motivated to Change?

Physicians are trained to diagnose a problem and treat it. Therefore, it may be very difficult for them to respect a patient’s autonomy, particularly when the patient chooses not to change behavior or refuses to commit to any particular course of action. The physician’s natural, almost instinctive reaction is to assume the expert role and provide information and advice and perhaps a referral to a specialist, hoping that these approaches will motivate patients to change harmful behavior. Efforts such as these usually increase the patient’s resistance to change.

The section below describes how to determine when it is appropriate to give advice about changing behavior. In some circumstances, the same desire for resolution that motivates physicians to give unsolicited advice can propel ambivalent patients toward change. At the very least, showing empathy and closing an intervention on good terms leaves the door open so that patients can pursue treatment at another time. That is, the next time a health care provider broaches the topic of alcohol use with these patients, they may be more receptive.

An injury may make patients more willing to discuss their alcohol use, especially when they were injured while drinking. As a result, they may begin to think about such high-risk behavior and consider changing their drinking hab-



its. This openness should be encouraged. Avoid getting ahead of patients (i.e., rushing them into making commitments). Many patients are in the early stages of change; they either do not believe they have a problem, or they are ambivalent about taking action to change the status quo. Pushing them to prematurely commit to behavior change is counterproductive. Moreover, interviewers should avoid advocating change or worse, resorting to coercion or direct persuasion. Although these strategies are tempting, they often result in the patient arguing for the status quo and presenting reasons for not changing. In contrast, by helping patients to explore the advantages and disadvantages of their current behavior, interviewers can show the discrepancy between current behavior and possible long-term goals or personal values. For more information on the stages of change model, see the article in this issue by Dunn et al.

The critical issue in motivational intervention is not whether patients are motivated to change but in determining what they are motivated to change and why they are motivated to make particular changes. Instead of focusing on why they do not want to change, interviewers should explore the patient's stage of change. The key question for the patient is, 'What, if anything, do you want to do about your drinking?' or 'Where does that leave you?' The patient's responses to these questions will help the interviewer decide the next step, which may involve developing a change plan.

## What Is a Change Plan?

A change plan involves identifying specific steps the patient would be willing to take to change drinking behavior, and a timeframe for doing so. If the patient is interested in changing drinking behavior, a change plan can be helpful. However, as mentioned earlier, the decision to develop a change plan is up to the patient; otherwise, it is premature. Before a change plan is developed, the interviewer should identify what specific behavior the patient wants to change and what the patient hopes to achieve by changing that behavior. Developing a change plan is a collaborative effort involving the following steps.

1. Setting specific goals (e.g., stop drinking for a period of time, complete abstinence, drinking less frequently, or drinking less per occasion and avoidance of high-risk situations such as drinking and driving).
2. Identifying high-risk situations and possible obstacles to change (e.g., friends or family who encourage drinking and events and environments that encourage heavy drinking).
3. Identifying strategies and people who can offer support (e.g., a friend or family member who has successfully changed their drinking).
4. Evaluating whether to obtain a more formal assessment or seek additional help (e.g., in- or outpatient treatment, self-help groups, or churches and other support groups in the community).

With patients who are ready to take action, the interviewer should take time to discuss the details of each component of the change plan.

## What Is a Good Way to End Brief Motivational Interventions?

Regardless of the patient's level of motivation to change, it is important to close the intervention on a positive note by expressing hope or optimism that change is possible. The interviewer should provide a summary of the patient's perspective of the problem and what, if anything, the patient is willing to change. If patients are ambivalent about their use of alcohol, these summaries may simply contain reflective statements of ambivalence and a recount of both the positive and negative aspects of alcohol use. Specific actions that patients are willing to take or people with whom they are willing to talk, should be included in the summary. In addition, the interviewer should reinforce personal values, goals, and strengths that will facilitate the patient's efforts to change.

## When and How Is It Appropriate to Give Advice or Information?

Interviewers may give advice in an attempt to be helpful. However, giving unsolicited advice or information often leads to resistance and should be avoided. In response to this urge, the interviewer should consider whether a particular piece of advice is critical to a patient's safety or if it will promote a patient's motivation to change. Before offering advice, interviewers should first determine what the patient knows about the topic under discussion. For example, if the patient was intoxicated and involved in a motor vehicle crash, the interviewer may want to warn the patient about the effects of driving while under the influence of alcohol. Instead, they could ask, 'What do you know about the effects of alcohol on your ability to drive?' Often, interviewers will learn that patients already know the answer to this question.

When advice is truly appropriate, it should be offered only after obtaining the patient's permission by using the elicit-provide-elicited approach.<sup>1</sup> First, the interviewer must attain the patient's implied or explicit permission to provide information or advice by asking, 'Would you mind if I shared a concern that I have with you?' or 'This may or may not matter to you, but I am worried about your plan to cut down on your drinking. Would you mind if I explained why?' Such questions convey respect for the patient's autonomy. Finally, after interviewers receive permission and provide advice or information, they should elicit the patient's reactions. This allows patients to process the information and determine how well it fits their experience. Equally important, if the advice is ill-suited, patients can reject it with minimal damage to the rapport already established.

## Should Patients in Denial Be Confronted?

During a motivational intervention, it is best to avoid argumentation or confrontation, which generally leads to re-

sistance. Resistance is not a fixed personal characteristic of a particular patient, but rather the patient's reaction to a perception that the interviewer is an adversary. For example, when a patient describes reasons for not changing his drinking behavior, the interviewer may be tempted to respond by enumerating reasons for changing. If this happens, the stage is set for the two to harden into adversarial positions. However, if the interviewer interprets resistance as a warning sign that communication is proceeding poorly, changing strategy may avert this resistance. The interviewer can reestablish rapport by using the basic elements of motivational interviewing—OARS.

### Why Not Just Prescribe Medication?

Naltrexone and acamprosate help reduce a patient's craving, and consequently, the amount of reinforcement that alcohol provides. Research has supported the use of these medications for the treatment of alcohol disorders.<sup>5</sup> Naltrexone and acamprosate are approved for this use by the Food and Drug Administration, and the effectiveness of both is currently being evaluated in Project COMBINE.<sup>6</sup> However, medication should only be used in conjunction with more intensive alcohol treatment methods to enhance compliance, ensure treatment retention, and avoid relapse.<sup>7</sup> Unless a patient's progress can be monitored for an extended period of time, it may be inappropriate to prescribe such medications in the emergency department or a trauma care setting. Although medications are potentially useful adjuncts to intensive psychosocial treatment for alcohol-dependent patients, patients with less severe alcohol problems, probably most patients presenting to trauma centers, may be unwilling or uninterested in medication as a useful tool for changing their drinking behavior. In these situations, giving a prescription could be as counterproductive as giving unsolicited advice or a referral during intervention. In any case, prescribing a medication should not preclude motivational intervention because medication adherence also depends upon motivation to change.

### Which Patients Need More Than a Brief Intervention?

Although most trauma patients will not need specialist treatment, a brief intervention can identify patients that do need additional assessment or treatment and can provide a way to motivate these patients to accept the help they need. More intensive treatment options range from self-help groups, such as Alcoholics Anonymous, to medical detoxification, to outpatient or inpatient treatment, and to long-term residential services. The type of treatment most useful to a particular patient at any given time is, in large part, determined by the patient's preference, treatment history, and access to care. Although many patients in an urban trauma center may not have insurance or community treatment centers may be limited in some areas of the country, Alcoholics Anonymous is ubiquitous and free of charge. Because screen-

ing instruments used with brief interventions are not diagnostic instruments, a comprehensive assessment by a specialized substance-abuse counselor may be warranted to determine the appropriate level of treatment required. Therefore, further evaluation should be a precondition to choosing the most appropriate treatment option. More intensive treatment may be appropriate for some patients who have a history of alcohol or drug dependence, as suggested by previous treatment or liver damage or for those who have failed to achieve goals despite previous counseling.<sup>8</sup> Others who might benefit from additional treatment are patients with little or no social support for maintaining sobriety, those with a history of severe withdrawal symptoms such as hallucinations or seizures, and those with significant comorbid psychiatric or medical problems.

If patients have experienced or are experiencing one or more of these problems, a comprehensive assessment and, possibly, more intensive treatment may be beneficial. However, this does not give the interviewer license to provide unsolicited advice about treatment or to direct the patient to enter intensive treatment. Treatment and assessment options should be introduced using the elicit-provide-elicited approach described earlier. The patient's frustration and discomfort probably equal the interviewer's concern. As a result, the interviewer can usually capitalize on the topic once the patient broaches it. If the patient has sought previous treatment, the interviewer should ask which treatment was helpful and if the patient feels similar treatment would be helpful now. In this manner, a brief intervention can serve as an effective entry point into more intensive treatment.

### How Can the Quality of Motivational Interventions Be Evaluated?

The litmus test of whether interventions are working lies in how the patient talks. Statements like 'I should do something about this,' 'I want to change my drinking,' 'I am going to stop drinking,' or 'My drinking isn't helping me' indicate progression toward change and that the intervention is succeeding. These statements are referred to as change talk, and eliciting them is a major short-term goal of brief motivational interventions.

Objective rating scales of adherence to motivational interviewing are available. Both the Motivational Interviewing Skill Code and the Motivational Interviewing Treatment Integrity assess the interviewer's fidelity to the principles and techniques of motivational interviewing. These measures were developed to encode audio or videotapes of motivational interventions. Feedback from the Motivational Interviewing Skill Code or Motivational Interviewing Treatment Integrity can help guide interviewers in refining their intervention skills and ensure adherence to the principles of brief motivational interventions. For additional information, see [www.motivationalinterview.org](http://www.motivationalinterview.org).

## Who Can Provide Brief Motivational Interventions and How Much Training Is Required?

Virtually anyone who is interested and wants to learn motivational interviewing can effectively conduct brief motivational interventions. A medical background is not required, and some programs have successfully used interviewers who do not have college degrees.

Although this article is a reasonable introduction, in-service training is required, and as little as 4 hours up to a day of training is adequate for effective implementation. The original text on this topic is Miller and Rollnick's *Motivational Interviewing: Preparing People for Change*,<sup>1</sup> but *Health Behavior Change: A Guide for Practitioners*<sup>9</sup> provides additional useful information. Moyers and Waldorf<sup>10</sup> provide an excellent introduction in a single chapter that is more detailed than this article.

Training is available in a variety of forms. A series of videotapes that show patient interviews and illustrate the fundamentals of motivational interviewing is available at [www.motivationalinterviewing.org](http://www.motivationalinterviewing.org). This website provides access to basic and advanced training workshops available across the country, workshops for groups and institutions, and a list of qualified trainers who are part of the worldwide Motivational Interviewing Network of Trainers. Trainers are available to conduct 2- to 3-day specialized training sessions on site. This type of training is often preferable when an institution begins a brief intervention program and needs to train a number of interviewers.<sup>4</sup>

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