HUB Steps
Motivational Interviewing Counselors Manual

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Roles and Responsibilities of MI Staff

Position Title: Motivational Interviewing (MI) Intervention Director

Education: Doctoral degree in psychology

Requirements: Research and data collection management experience
Excellent oral and written communication skills
Organized and detail oriented
Motivational interviewing expertise

Major Duties:

- Design the MI intervention process to include
    - Outline all study procedures related to MI
    - Design in-person and telephone counseling activities
    - Monitor between session counselor preparation
    - Develop the manual of procedures for the MI intervention
- Design and implement MI counselor training
- Oversee the fidelity monitoring of the MI intervention including
    - Training raters
    - Overseeing the collection of fidelity data
    - Supervising data entry
- Provide monthly supervision of MI counselors during the intervention and maintenance phase of the project
- Supervise the MI coordinator, oversee activities, and monitors performance of all aspects of the MI intervention
    - Meet weekly with the MI coordinator to plan and problem solve and develop MI counselor supervision plans
- Communicate regularly with project staff
- Support the implementation of the data quality control plan
- Attend required project meetings and conferences
- Actively engage in data analysis
- Write/contribute to research manuscripts stemming from the project
- Develop and support conference presentations related to the project

Position Title: Motivational Interviewing (MI) Coordinator

Education: Doctoral student in psychology

Requirements: Research and data collection management experience
Excellent oral and written communication skills
Organized and detail oriented
Motivational interviewing experience

Major Duties:

- Oversee activities and monitors performance of all aspects of the MI intervention including in-person and telephone MI sessions.
- Coordinate MI counselor activities, including
    - Training
    - Oversight of on-site and telephone MI implementation
    - Ensure MI counselors are following intervention protocols (e.g., completing paperwork, submitting fidelity monitoring materials, and have the needed materials for follow up in person and telephone sessions)
    - Assist in developing counselor coaching plans
    - Monitor MI counselors assistance in entering data
    - Liaison with the process evaluation coordinator
- Administer MI intervention (in-person and telephone) as needed
- Serve as a link between the MI Intervention Director and MI counselors
    - Mediates issues and disputes
- Support the implementation of the data quality control plan
- Attend required project meetings and conferences
- Provide other project support services as needed and defined by the project team. This may include but is not limited to entering data, making phone calls, updating protocols, conducting research/literature reviews, etc.
- Other services as required by the project team.

Position Title: Motivational Interviewing (MI) Counselor

Education: Graduate student in psychology and/or dietetics

Requirements: Research and data collection management experience
Excellent oral and written communication skills
Organized and detail oriented
Motivational interviewing experience (preferred)

Major Duties:

- Actively participate in MI training sessions
    - Read materials
    - Active involvement in didactic and experiential activities
    - Provide feedback to other MI counselors
    - Be receptive and open to feedback from others
- Provide MI counseling sessions in person and over the telephone
- Attend all training sessions and all intervention sessions
- Complete all study paperwork
- Provide required fidelity monitoring materials to the MI coordinator
- Actively communication with the MI coordinator about needed materials or questions and to problem solve
- Support the implementation of the data quality control plan
- Attend required project meetings and conferences
- Provide other project support services as needed and defined by the project team. This may include but is not limited to entering data, making phone calls, updating protocols, conducting research/literature reviews, etc.
- Other services as required by the project team

Selection and Training of MI Staff

Selection of MI Staff - MI staff will be selected by the MI Intervention Director in consultation with the project investigators. Individuals selected to serve as MI counselors will be graduate students in counseling psychology or nutrition and food systems. In addition, individuals should (a) have a basic understanding of MI, (b) have an interest and basic ability to provide health focused counseling, (c) be willing to participate in intensive training, (d) possess multicultural awareness and (e) have a flexible schedule to be available for all intervention and follow-up sessions. Those selected to be MI counselors will have demonstrated abilities including conscientiousness, attention to detail, adherence to instructions and treatment protocols, and independent thinking and adaptability.

Training of MI Staff – Staff will be trained using a modification of the process described by Miller and colleagues (2004). As such training will integrate reading, didactic and experiential training with objective observation, feedback, and coaching (supervision). To that end, participants will participate in 24 hours of direct training that includes (a) didactic training, (b) experiential exercises and (c) feedback/coaching on the implementation of MI. The first eight hours of training will focus on didactic presentation and skill building around the use of Motivational Interviewing (principles, tenants, strategies). The second 8 hours will include information on nutrition counseling and important information related to study assessment results (e.g., normal and abnormal hypertension), study protocols described in this manual and more in-depth practice of skills. The final 8 hours will focus on review of study protocols experiential exercises with observation, feedback, and coaching.

MI Readings:

Fontenot Moliason, E. (2002). Stages of change in clinical nutrition practice. *Nutrition Clinical Care, 5*, 251-257.

Prochaska, J. O., Johnson, S. & Lee, P. (2009). The transtheoretical model of behavior change. In S. A. Shumaker, J. K. Ockene, & K. A. Riekert (Eds.). *The Handbook of Health Behavior Change (3rd ed)*. New York

Prochaska, J. M., Prochaska, J. O., & Johnson, S. S. (2006). Assessing readiness for adherence to treatment. In W. T. O'Donohue, & Levensky, E. R. (Eds.). *Promoting Treatment Adherence: A practical handbook for health care providers*. Thousand Oaks, CA: SAGE.

Rollnick, S., Miller, W. R., & Butler, C. C. (2008). *Motivational interviewing in healthcare (pp. 3-120).* New York: Guilford Press.

Nutrition Readings

National Institutes of Health (NIH). (2006). *Your guide to lowering your blood pressure with DASH*. Rockville, MD: NIH Publication No. 06-4082

Didactic session: This session will follow similar procedures to those discussed by Miller and colleagues (2004) and Baer and colleagues (2004) and endorsed by the Motivational Interviewing Network of Trainers (MINT). Specifically, this training will provide an overview of (a) the stages of change, (b) major tenants of MI, (c) project specific MI strategies (assessing readiness and importance, raising awareness, decisional balance, exploring goals & values), (d) developing a change plan and (e) the project protocols. Teaching tools will include written and PowerPoint materials developed specifically for the counselors and demonstrations of the intervention in action through video and live demonstration.

Experiential: Participants will participate in three types of experiential exercises that are aimed at developing skill in MI. First, participants will participate in various skill building exercises during the didactic training that have been developed by the MINT (2004). Next, after learning about a specific MI strategy MI Counselors will practice the

skill in participant triads in which they will serve as a mock client, counselor and observer. Finally, MI Counselors will participate in 30 minute counseling sessions that will follow the in-person and telephone formats with volunteers who are not involved in the project. These experiences will provide the participant an opportunity to practice the newly learned skill and receive feedback on how to modify the skill to be more effective, as feedback has been found to be effective in facilitating technology transfer.

Study protocols: MI Counselors will be thoroughly trained in the study protocols including the procedures contained in this manual. Specifically, counselors will be informed of the processes involved in both the in-person and telephone follow up sessions. Instructions for completing study measures, submitting materials, and supervision/coaching will be provided.

Study Measures: MI Counselors will also be trained in how to use the various study measures they will need to complete. Specifically, counselors will learn how to complete the in-person session MI Checklist (Appendix I), the phone MI session checklist (see Appendix I), and the Therapist Evaluation of MI (see Appendix I). Counselors will gain practice completing these measures as part of their experiential training activities to ensure they understand the use of the measures and to build agreement among counselors on ratings to enhance consistency. Counselors will be provided with an overview of each measure, when the measure is to be completed, and procedures for submitting measures.

MI Intervention Phase

Each participant will receive an in person MI focused feedback session as part of each data collection during intervention phase (baseline, 3 months, 6 months). As outlined in the appendix, the in person session will involve review of the Know Your Numbers card and brief

discussion aimed at increasing participant internal motivation to change their eating and exercise behaviors. Each session will conclude with the development (or refinement at 3 & 6 months) of an individualized behavior change plan. Specific procedures are outlined in the appendix.

MI Maintenance Phase

Participants will receive either a low (n = 4) or a high (n = 10) dose of MI focused follow-up telephone calls during the maintenance phase. As outlined in the appendix, these calls will involve the MI counselor assessing the degree to which the participant is adhering to their change plan and which processes of change is best to emphasize during the conversation. The goals of these phone calls are to build upon successes and develop new behavior change goals or to further build motivation for behavior change. Specific procedures are outlined in the appendix.

MI Counselor Supervision & Fidelity Monitoring

MI Counselor Supervision/Coaching - An initial group coaching meeting will be conducted **2 weeks** after the foundational MI training sessions to allow counselors to gain additional training and coaching in the most efficient way and to ensure retention of MI skills. The group session will focus on review of MI, study protocols and problem solving related to implementation difficulties, and adapting MI for their clients. Follow up group coaching sessions will be conducted one time per month during the active data collection portion of the project (e.g., when in person and follow up calls are being conducted) by MI Intervention Director. Coaching sessions will include counselor level process evaluation (CEMI, TEMI, and session checklists), and discussion of session content. The goal of coaching sessions is to continue counselor skill development, prevent drift from protocols, and problem solve about implementing MI.

Counselor Process Measures – Session integrity will also be accessed through counselor completed process measures. There are three measures that the counselor will complete as part of providing MI counseling. Two of the measures, the Therapist Evaluation of MI (TEMI) and the In-Person Check list, will be completed after each in-person session with a participant (i.e., after every in-person counseling session). For each measure the counselor should complete the measure immediately after the session to ensure the best accuracy.

In-person session measures – After each in-person MI session the counselor is expected to complete two measures. The first measure is a checklist of activities completed during the MI session. The second measure is the Therapist Evaluation of Motivational Interviewing (TEMI). Before beginning MI sessions the MI counselor will receive a packet that contains session checklists and TEMI's with the counselor's id number and session number on them from the MI coordinator. The packet will include one checklist and TEMI for each client. Upon receiving the participant's Know Your Number's card at the beginning of a session, the counselor will place a sticker (included in participant file) with the participant's ID number on the checklist and TEMI- as well as the change plan (included in participant's file). Once an MI session is completed with a participant, the counselor will complete the checklist and TEMI. After completing these measures the counselor will place them in a folder and return the folder to the MI coordinator/or designated area at the end of their scheduled time. The MI coordinator will separate TEMIs and Checklists, order TEMIs and give completed TEMIs to the Data Coordinator. The MI coordinator will give the completed checklists to the MI Intervention Director by the following Monday after data collection.

Telephone sessions: After each telephone MI session, the counselor is expected to

complete the follow-up checklist. Before placing the phone call, the MI counselor will receive the follow-up checklist with the participant action plan. The counselor will ensure that the participant ID number is accurate and add her/his counselor number. Upon completion of the session, the counselor will return the completed checklist to the MI coordinator who will provide the checklist to the Data Coordinator. Telephone sessions will be recorded with participants' consent.

Tape Submission and Security – Phone MI session may be taped using a digital voice recorder. If taped, the MI coordinator will upload the audio files from the digital voice recorder to a password protected computer in a locked office at the University of Southern Mississippi. At no times should audio files be removed from the University. All session audio and related files are confidential material. While reviewing session content it is imperative that all MI staff, including fidelity monitoring coding assistants ensure that they are in a place where non-project individuals cannot see or hear the sessions. ALL session materials are to be handled like protected health information. Therefore, all materials are not to be left unattended, and content of sessions are not to be discussed with anyone except project staff. These steps will help to ensure the confidentiality of all participants.

Fidelity monitoring – When possible, session integrity will be assessed using the Motivational Interviewing Supervision and Training Scale – Revised (MISTS-R) by volunteer research assistants (see Appendix I). Trained raters not involved in the project will review a stratified sample (session by counselor) of session recordings. Session segments will be selected from all recorded phone sessions during the maintenance phase of the study. Length of segments will be 10 minutes will be reviewed for a minimum 34 sessions for each counselor.

Training of raters and the rating process will follow the process outlined by Madson and colleagues (2005) and described in the MISTS-R Rater Manual (Madson & Loignon, 2007). Specifically, raters will be trained in MI through directed readings (e.g., Miller & Rollnick, 2002), didactic and skill building seminars, and practice ratings of MI sessions. Raters will participate in three sessions each lasting approximately two hours in length and will follow training guidelines endorsed by the MINT for developing basic knowledge and skill in MI (MINT, 2005). The first session will focus on training raters in the concepts of MI, MI skill building activities, and how to evaluate MI. The second and third sessions will include an in-depth discussion of the MISTS-R. Raters will develop an in-depth knowledge of the MISTS-R rating manual and a thorough examination of the MISTS-R with a discussion of each individual item. After developing knowledge of the MISTS-R, raters will conduct practice ratings with non-study sessions until a minimum of 80% agreement is reached prior to beginning ratings. The final session will involve project planning, data collection, and scheduling booster sessions.

Motivational Interviewing Information

Introduction

Often healthcare workers believe that patients who are unmotivated are hopeless and unchangeable. Countering this assumption is Motivational Interviewing's (MI) premise and starting point. Motivational interviewing argues that motivation is actually flexible and, more importantly, can be affected by the healthcare worker's relationship with the patient. Proponents of MI argue that the way in which a healthcare worker introduces the idea of behavior change and deals with a patient's hesitation to make behavior changes will influence a patient's motivation and even his or her long-term health.

The "Spirit" of MI

The philosophy of MI, sometimes called the "spirit" of MI, can be summarized by three characteristics of the healthcare worker-patient relationship: *collaborative, evocative,* and *honoring patient autonomy.*

- *Collaborative*. MI depends on a relationship between the patient and healthcare worker resembling a partnership. Instead of the clinician directing the patient and using the presumed power difference for his or her advantage, in MI the patient and healthcare worker participate in a discussion regarding behavior change. The MI consistent clinician recognizes her/his expertise and the expertise of the patient. This collaboration is a defining point of MI because health behavior change is in the hands of the patient.
- *Evocative*. While traditional healthcare tends to focus on asking the patient what he or she lacks and on filling in that gap (e.g., medication, knowledge), MI asks, "What does the patient already have to aid in making a behavior change?" While a patient may lack the desired level of motivation, all individuals are somewhat motivated to make changes and every patient has ambitions and concerns. One of MI's purposes is to establish a

personal connection between the patient's health behavior change and what he or she values. By identifying a patient's aspirations and perspectives, a clinician can evoke from patients their own arguments for making changes in their behavior.

- *Honoring patient autonomy.* Motivational interviewing depends, in part, on a clinician's separation from the client's final decision to make a change in his or her behaviors. This does not mean that the healthcare worker should not care about the client; instead, it implies that an individual is responsible for his or her behaviors. The practitioner can provide information, advice, and concerns about behavior, but ultimately, the decision to make a change is in the hands of the patient. Acknowledging the patient's autonomy to decide, often aids in the process of change as the patient sees that he or she has freedom and ultimate responsibility for making changes.

Four Guiding Principles

Four principles help guide the practice of motivational interviewing. They are (1) resisting the righting reflex, (2) understanding and exploring the patient's motivations, (3) listening with empathy, and (4) empowering the patient and encouraging hope and optimism. The four principles form an acronym, RULE: Resist, Understand, Listen, and Empower.

R: Resist the Righting Reflex

Individuals who become healthcare workers tend to want to heal pain, make things right, and endorse well-being. When these individuals witness someone making poor choices, specifically poor health choices, they have a strong urge to try to stop the individual. This motivation is often not only what leads people into the field of healthcare, but it is also what makes the desire to correct someone's behavior an automatic reflex. However, practitioners who give into the urge to correct, often experience the opposite of what they want and hope for.

Instead of choosing to change a behavior when they are told to, patients often resist change, particularly when they sense persuasion. This is not because patients are lazy or even in denial concerning their need to make a change. Instead, people are naturally resistant to another individual's attempt to influence their behavior. This resistance is particularly powerful when someone is experiencing ambivalence (i.e., feeling two ways about the same thing) toward a behavior. For example, overeaters often are aware that their eating is problematic, and they are often aware of some of the negative consequences of their eating. However, these individuals enjoy food and do not want to see themselves as having an "eating problem." Instead they would rather see their eating as normal. Almost all overeaters feel two ways about their eating.

When a patient sees the healthcare worker "taking sides" with the healthy part of the patient's internal dialogue, making a case for why he or she needs to change, the patient's natural response will be to make an argument against making a change. While a practitioner's reflex may be to make a stronger argument, this will likely cause a patient to argue more. Because people have a tendency to believe what they hear themselves say, a practitioner who is arguing with a patient is only solidifying the patient's argument against making a behavior change. Instead of the clinician arguing for behavior change, the patient should be the one who is making a case for behavior change, especially saying the arguments out loud. Because many patients are ambivalent about making changes in their behaviors, it is the healthcare worker's job to help them work through this ambivalence and aid them in making a case for a healthier lifestyle.

U: Understand the Patient's Motivations

Each patient has reasons for making a behavior change, and those reasons will be more likely to persuade them to change than the practitioner's reasons. Being interested in a patient's own motivations and values is an important part of motivating a client to change. Because

consultation time with each patient is limited, this may sound unreasonable and like a waste of time. However, MI argues that this limited time is better spent asking patients why they are interested in making a change, than the practitioner telling patients why they should change. This principle again is focused on the patient voicing the reasons for change, not the practitioner.

L: Listen to the Patient

MI requires listening to patients with empathy in order to understand the patient's reasons for making a change. Although practitioners are often viewed as the "expert" on a subject (e.g., good nutrition, medication), typically answers to questions involving a behavior change will come from the patient and the skill of listening is called on for gathering these answers. Empathic listening is a skill that will be addressed later in this manual.

E: Empower the Patient

When the patient takes an active role in the decision making process and feels empowered to make a change, the outcome are typically more positive and changes are often made. While a practitioner is knowledgeable regarding regular exercise and how this will improve the patient's life, the patient is the expert on how to fit exercise into his or her daily life. Therefore, a patient will likely know how to best accomplish the goal of behavior change. In this process, the practitioner's roles are to offer support on the patient's belief that he or she can make a behavior change and to help the patient feel comfortable sharing his or her expertise in the consultation.

Transtheoretical Model Information

Overview

The Transtheorectical Model (TTM) is an integrative framework for understanding how people progress in adopting and maintaining healthy behavioral change. The TTM describe six stages of change and ten processes of change based on systematic integration of principles from leading theories of psychotherapy and behavioral change (e.g., consciousness raising from the Freudian tradition, contingency management from the Skinnerian tradition, and helping relationships from the Rogerian tradition) (Prochaska, J.O., Redding, C. & Evers, K. 2002).

The TTM assumes that behavior change is a process that occurs over time through a sequence of stages. The stages of change are levels of readiness in which an individual progresses in order to maintain healthy behaviors or terminate maladaptive behaviors. However, movement through the stages is not necessarily a linear progression toward change. An individual may cycle through inactive phases of the stage model and continue to display chronic behavior patterns due to a combination of biological, social, and behavioral (i.e., self-control) factors (Prochaska, Johnson, & Lee, 1998).

Without intentional interventions which target individuals in inactive stages, many at-risk populations will not be served by traditional action-oriented prevention programs. Greater impact can be promoted through the use of stage- vs. action-paradigms. Stage paradigms reach individuals who appear resistant in engaging in treatment or are ambivalent about change. In order to engage these "resistant" or inactive individuals into treatment, specific processes of change should be applied at specific stages in order to assist with progression toward behavioral change. These processes help individualize interventions by matching processes of change to an individual's stage of change (Prochaska, Johnson, & Lee, 1998).

Core Constructs

The following section outlines the core constructs of the transtheoretical model. TTM emphasizes six stages of change, ten processes of change, decisional balance, and self-efficacy.

Stages of Change

Precontemplation

In the precontemplation stage individuals have no intention of taking action within the next 6 months. They are usually uninformed or underinformed about the consequences of their behavior or have become demoralized about their abilities to change due to past failed attempts. These individuals are often viewed as resistant, unmotivated, or not ready for the intervention or programs.

Contemplation

In the contemplation stage, people are considering change. They are aware of the pros and cons of change, yet they are more attentive to the cons. The evaluation of the costs and benefits of behavior change can produce ambivalence which can trap individuals in this stage for long periods of time. Individuals in contemplation are not ready for traditional action-oriented program.

Preparation

Preparation involves individuals who are intending to take action in the next month. They have displayed significant action in the past year and have a plan of action. These people should be recruited for action-oriented programs.

Action

The action stage describes individuals who have made specific overt changes in their lifestyles within the past 6 months. The TTM does not view all modifications of behavior as

behavioral change. Change must be consistent, lifestyle changes that have been proven to reduce risks of normally unhealthy behaviors. For instance, 6 months of consistent healthy dieting and exercise lead to reduced levels of sodium as well as 6 months of fasting. Yet, the consistent dieting and exercise have been accepted by dietitians and experts as an appropriate method of reducing risk for disease. Although fasting may lead to similar results, TTM does not view the behavior modification as sufficient to reduce ongoing risks for hypertension. The model suggests that individuals must attain a criterion that has been set by scientists and professionals as sufficient to reduce risks for disease.

Maintenance

Individuals in the maintenance stage are working to prevent relapse but do not apply change processes as frequently as do people in the action stage. They are less tempted to relapse, more confident that they can continue their changes, and may remain in this stage from 6 months to about 5 years.

Termination

Termination is characterized by zero temptation and 100% self-efficacy. These individuals are certain that they will not return to past unhealthy behaviors even if they are experiencing depression, anxiety, boredom, loneliness, anger or stress. The termination stage may not be an ideal goal for a majority of people.

Processes of Change

Processes of change are covert and overt activities that can be used to assist participants in progressing through the stages of change. As individuals move from stage to stage, processes of change serve as intervention to increase awareness, address ambivalence, prevent relapse, and increase problem solving when attempting to attain behavioral change. The ten processes of

change are described below as well as prompts that help counselors consider when to utilize specific processes.

Consciousness Raising: attempts to increase the available information to the client in order to increase his/her awareness of the issue at hand. Counselor presents education to the participant regarding his/her environmental events as well as feedback information that is presented to the participant regarding his/her own actions and experiences.

- *Deciding Factor*: Use when participants do not appear to think a problem exists, appears resistant, unmotivated, and not intending to change their behavior in the foreseeable future.

Dramatic Relief: is aimed to help participants freely express their emotions and experiences of behavior change.

- *Deciding Factor*: Use when participants block emotions or expresses unacceptable emotions in other forms (e.g., upset about assessment results displayed as anger toward counselor).

Self-Reevaluation: focuses on modifying the client's internal response to external consequences. It also allows the participant to envision and assess him/herself with and without the problematic behavior.

- *Deciding Factor*: Use when behavior is controlled by consequences or when value clarification is needed.

Environmental/Social Reevaluation: places emphasis on how the participant's behavior affects his/her environment (physical/social).

- *Deciding Factor*: Use when environmental factors prove to be beneficial or problematic to the client's behavior.

Self-liberation: allows the client to become more aware of new alternatives and the experience of factors associated with those alternatives.

- *Deciding Factor*: Use when participant decides to commit to change problematic behavior

Social liberation: highlights changes in the environment that make more alternatives available to the client.

- *Deciding Factor*: Use when new alternatives arise in the environment.

Counterconditioning: attempts to change the participant's response to a stimulus (learning to do a healthy behavior opposed to an unhealthy behavior).

- *Deciding Factor*: Use when a participant expresses an aversive response to an otherwise unthreatening stimulus.

Stimulus Control: attempts to change/control the environment that causes behavioral problems for the client.

- *Deciding Factor*: Use when a participant continues to have stimuli in their environment that impedes healthy behavior change.

Contingency Management: involves the modification of contingencies in the client's environment (ie: Rewards and Punishments)

- *Deciding Factor*: Used when behavior is controlled by its consequences.

Helping Relationship: focuses on the participant's acceptance of trust and support from others during his/her attempt to change.

- *Deciding Factor*: Used when client is in need of external support and social reinforcement.

Decisional Balance and Self-Efficacy

Decisional Balance is the core construct of TTM that reflect how an individual weighs the pros and cons of behavioral change. It is often used when a participant is ambivalent about a potential option.

Self-Efficacy consists of two parts; confidence and temptations. Confidence is the primary construct of self-efficacy. When an individual possesses situation-specific confidence, he or she can cope with high-risk situations without relapsing back to unhealthy or maladaptive habits. Temptations are difficult situations most commonly described as negative affect (emotional distress), positive social occasions, and cravings that intensify the urge for an individual to engage in previous maladaptive habits.

Integration of Motivational Interviewing and Transtheoretical Model

According to the Transtheoretical Model, precontemplative and contemplative participants may present to counseling as difficult, resistant, and noncompliant. In many cases, these participants are less likely to receive effective help due to high attrition rates or lack of engagement in treatment protocols. Through use of a method of intervention described as Motivational Interviewing (MI), these types of patients are more likely to enter, stay in, and complete treatment and follow-up visits. MI works by activating clients' own motivation for change and adherence to behavior change. MI skills increase your ability to resist the righting reflex, understand your patient's motivations, listen to your patient, and empower them. These skills optimize clients' readiness to change as you integrate processes of change which are aligned to the participants' corresponding level of change.

Integrating processes of change into educational or counseling sessions is critical to increase treatment effectiveness in pre-action stage individuals. Following are counseling

statements that illustrate how Motivational Interviewing dialogue and Processes of Change activities can be integrated to help facilitate participants' progression through the stages of change during treatment sessions.

1. Consciousness Raising
    a. Increasing awareness through personal feedback: "Compared to national norms, your hypertension 'numbers' put you in the 'high risk' category. Let's look at how things have changed with your hypertension."
    b. Bibliotherapy: "You know, what you're talking about reminds me of a book I read on (i.e. hypertension etc.). I thought I would mention it to see if you are interested or what your thoughts were about that."

2. Dramatic Relief
    a. Role Play: "So let's practice you making healthy eating choices when you go out to restaurants. I'll be your friend who wants you to order a few alcoholic drinks and split an appetizer with you."
    b. Grieving Losses: "If you choose to make this change (i.e. increase exercise, decrease sodium intake etc), what would that mean?"

3. Self-reevaluation
    a. Goal Value Clarification: "So you said earlier that being around for your grandchildren is important to you, and these risks for hypertension we've been talking about often result in premature death. How do you resolve that?"
    b. Imagery: "You mentioned that you worried that your children would become unhealthy due to your lack of exercise and cooking healthy meals. If you would for a minute take a look forward, what would you and your family would look like if you were more active and increased healthy food alternatives."
    c. Corrective Emotional Experience: "This information is really having an effect on you."

4. Environmental Reevaluation
    a. Empathy Training: "So your thinking about how your eating preferences affect your children's eating choices. If you were to change your eating habits, how may that affect your family?"
    b. Family Interventions: "You said that you thought that your children would view you as a "better mom" if you reached your goal weight. What would it mean to them if you were to reach your goal?"

5. Self-liberation
    a. Assessing Confidence: "So your goal is to walk 6 miles per week. On a scale of 1 to 10 with one being not confident and 10 being completely confident, how confident are you in your ability to meet that goal?"

b. Testimonials: "You seem excited about the new goals that you have developed for yourself in your choice to increase physical activity. What may be something you can do to share your excitement with others?"
c. Commitment Enhancing Techniques: "So you have written out your goals and the steps that you will take to accomplish them. What do you think you'll do first?"

6. Social Liberation
    a. Advocating for rights of repressed: "In starting this walking program, you've noticed that there aren't enough sidewalks in your community. How might you change that?"
    b. Empowering: "You mentioned that you have close friends who also would like to increase healthy eating habits. Now that you have maintained healthy levels of physical activity and reduced your cholesterol, how might you share your success with them and how might that propel you forward in your goals?"
    c. Policy Interventions: "Since eating lunch in the cafeteria has been somewhat of a challenge for you in eating foods with less sodium, what are some ways that you could communicate with the cafeteria managers about their food item selection that may help meet your needs?

7. Counterconditioning (alternatives to problem behaviors)
    a. Relaxation: "So you eat high fat food when you are stressed. What are some ways you have found to help yourself relax?
    b. Positive self-statements: "Great job! (*Affirmation*) What did you learn from this situation? How can we help you remind yourself of these good things when you are faced with a similar difficult situation?"
    c. Desensitization: "You say that fried foods are difficult for you to resist when eating out. If you wanted to reduce your use of fried foods when eating out what might you do to help you make healthy choices?"

8. Stimulus Control
    a. Avoiding high risk cues: "So for you, not going to the buffet would help you to avoid the temptation for eating fried and sugary desserts. How might you manage this situation so that in the future so you are not faced with that concern?"
    b. Restructuring one's environment: "So you are saying that instead of going home after work and watching movies, that meeting up with your walking coach for some social interaction and exercise would be just as enjoyable? Do I have that right?
    c. Fading Techniques: "Earlier today, you talked about how difficult it is for you to quit eating fried foods. Could I share with you some of the ways other folks have managed that situation?"

9. Contingency Management
    a. Contingency Contracts: "So if you walk your 6 miles per week for two weeks, then you will reward yourself with a new workout outfit or pair of tennis shoes? If you do not walk your 6 miles per week, then in two weeks you will ask your

walking coach to come pick you up to walk the 6 miles. What do you intend to do?"

b. Self-reward/ Reinforcement: "Often times folks help themselves stay on track by rewarding themselves. What may be some ways you can reward yourself for sticking to your plan?"

10. Helping Relationships
    a. Therapeutic Alliance: "What types of step do we want to develop to increase your likelihood of reaching your goal?"
    b. Social Support: "Besides your walking coach, who else might support you in your efforts to decrease your hypertension?"
    c. Self-help groups: "Can I share with you something that has worked for other people in the past? Other people who have struggled to make changes benefited from attending groups with other individuals who struggle to make the same changes. These groups offer a place to get support and seek feedback (i.e. Overeaters Anonymous).

MI Strategies

Agenda Setting

Objectives:

1. Engage the participant in the feedback process
2. Avoid the premature focus trap
3. Set the agenda for feedback process.

Materials/Supplies Needed:

Know your numbers card (See Appendix II). Each participant will have this with them.

Content

Definition: A brief discussion with the participant in which he/she is given as much decision making freedom as possible to help determine what topics are important to discuss. Agenda setting is a good way to avoid the premature focus trap as understanding the participant's perspective and preferences increases willingness to listen. At times, there may be important information to provide or areas to address. As a good guide it is important for you to share that as part of the agenda setting. This is a collaborative process.

Situations in which this strategy is typically used: Agenda setting can be used at various times throughout a consultation when you want to engage the participant in active decision making about the direction of the consultation. However, in this project it will be best used at the beginning of each session. Specifically, using the "know your numbers card" enhances collaboration between the MI counselor and the participant as they decide which information from the card will be used to set the agenda.

Common Phrases/statements that are used in this strategy:

"At this time, if it is ok with you, I'd like for us to take a look at the results from some of the tests you completed today. How does that sound? As you can see from this card, there are several things we can discuss like weight, Body Mass Index, cholesterol, blood pressure, diet and exercise. What, among this information would you be most interested in hearing first?"

"What would be most helpful for us to discuss first?"

"I'd like to discuss your exercise at some point but wonder what you'd like to learn most about?"

Key Questions

Objectives:

1. Engage the participant.
2. Open conversations or topic areas
3. Elicit information and client reaction.
4. Elicit change talk and commitment.

Materials/Supplies Needed:

None

Content

Definition: Questions are a normal part of every conversation. In MI questions are used strategically to elicit information and build readiness to change. As such, questions are short and phrasing is simple so that the participant feels as though they are engaged in a normal conversation. Open questions are to be used more often than closed questions in MI

Situations in which this strategy is typically used: Used at any time in a session.

Common Phrases/statements that are used in this strategy:

Opening Conversations:

What questions do you have about completing these tests today?
How was it for you to complete all of those tests today?

Eliciting change talk

Why might you want to make this change?
If you decided to make this change how would you do it?
What are the 3 most important benefits you see for making this change?
How important is this change, how much do you need to do it?
How would you like things to be different in the future?
If you continue your eating and exercising patterns what do you think will happen?

Move to action

So what do you make of all of this now?
What do you think you'll do?
What, if anything, do you plan to do?

Setting goals

How would you like for things to be different?
What do you think is the first step in making this change?
What may be the good and the not so good things about reaching this goal?

Considering change options

Here are a variety of possibilities that people have used in the past. Which do you think might work best?

Arriving at the plan

What is it specifically that you plan to do?
What do you think is the first step?
How will you go about it?

Eliciting commitment

What will you do?
What among these options will you commit to?
What are you going to do?
What do you intend to do?

Elicit – Provide - Elicit

Objectives:

1. Engage the client.
2. Exchange information in a collaborative participant centered way.
3. Draw from participant what the data means to them.

Materials/Supplies Needed:

None

Content

Definition: A cyclical process of guiding the participant through information exchange. The foundation of EPE is providing the participant with information but also involves asking key questions and listening to the participant.

Situations in which this strategy is typically used: Most often used when you have to provide assessment results.

Common Phrases/statements that are used in this strategy:

Initial eliciting questions:

What would you like to learn most about your diet?
What do you already know about your blood pressure?

Provide information in manageable chunks and focus on the data and not your interpretation:

Assessing Readiness and Importance

Objectives:

1. Ask the participant about the *importance* of changing the behavior
2. Assess participant's level of *confidence* in their ability to change the behavior

Materials/Supplies Needed:

(Optional) Pen and paper for visual aids depicting the readiness-to-change continuum

Content:

Definition: Using a readiness ruler or rating scale can be helpful when asking participants for subjective reports of motivation. To assess readiness for change, an Importance-Confidence Scale ranging from 0 (not at all important) to 10 (extremely important) can assist in describing the participant's developing motivation and may elicit change talk. Although verbal forms of the rating scale are commonly used, visual forms, such as drawing a line with numbers marked 1-10, can also demonstrate scaling questions.

Situations in which this strategy is typically used: Part of assessing readiness and importance is engaging in change talk, or simply questioning the participant about why they rated him or herself a particular number. With using scaling questions, the dietician may ask why the participant is one number and not another. This answer provides perspective on how and why change is important for the participant. Typically, it should be asked why the selected score is higher than a lower number, because it elicits more reasons for changing. If used vice versa, the participant may answer defensively. Defensive answers, answers that the participant believes the dietician wants to hear, also arise if rapport is poor. Therefore, good rapport and a guiding communication style more accurately assess a participant's motivation for change. Other approaches to question delivery include looking backward and looking forward questions. These questions explore how a change in the past or future would affect the participant, subsequently enhancing motivation. Overall, using these types of open questions engage motivation within the participant and assess confidence in the participant's ability to make desired changes.

Common Phrases/statements that are used in this strategy: Using a ten-point scale can provide helpful perspective about the participant's personal dilemma surrounding the desired change. For instance, you can ask the participant:

"How strongly do you feel about wanting to get more exercise? On a scale from 1 to 10, where 1 is 'not at all,' and 10 is 'very much,' where would you place yourself now?"

You can also assess the importance that the participant places on a particular behavior:

"How important would you say it is for you to increase your daily intake of fruit and vegetables? On a scale from 1 to 10, where 1 is 'not at all important,' and 10 is 'extremely important,' what would you say? Why did you give yourself a score of ___ instead of a 1?"

This type of questioning can also be used to assess how confident or certain the participant is in his or her ability to make a change. Assessing confidence through scaling questions may be accomplished by asking:

"On a scale from 1 to 10, where 1 is 'I'm certain that I could not,' and 10 is 'I'm certain that I could,' how confident are you that you could count your daily calories if you decided to? And why did you give yourself a ___ and not a 1?"

Follow up questions: In MI it is important to ask strategic follow-up questions focused on eliciting change talk.

Types of follow up questions include:

"What makes this a X and not a Y"

Typically ask why score is higher (e.g., what makes it a 5 and not a 3)
This leads the participant to describe reasons for changing

"What would need to happen for you to get up to X"

Leads the participant to discuss how they may change

Decisional Balance: Pros and Cons of Changing and Staying the Same

Objectives
To increase the participant's awareness of their ambivalence about changing their eating behavior.

Materials Needed
None

Content:

Definition: The Pros/Cons Decisional Balance allows the participant and counselor to think through positives and negatives of both changing and not changing the behavior in question allows the participant to fully consider change.

Situation in which this strategy is typically used: This strategy is typically used in the exploration or contemplation stage of counseling when the participant is ambivalent about making a change in life. It can be used with a number of different behaviors such as: changing negative eating behavior, deciding to implement an exercise program, deciding to reduce/stop engaging in risky behaviors, and any other decision that needs to be made. This strategy is used to guide the person in making a choice in regards to behavior change and whether or not to move into preparation.

Common phrases/statements used in this strategy: You can introduce the decisional balance exercise by introducing the concept of motivation. Talk about how motivation is influenced by how we view what we will gain and what we will lose by acting in different ways.

> You could say something along the lines of:
>
> "Because most of the things we choose to do have both positive and negative aspects about them, we often experience ambivalence when we consider changing. Ambivalence means you have mixed feelings about the same matter, and those different feelings are conflicting with each other. You want to do something and at the same time you don't want to do it. When people are ambivalent, it is difficult to make decisions because it appears that nothing they do will meet all of their desires. One way to work through this is to look at both sides of the coin by examining our both sides of our feelings at the time."

Exploring Values

Objectives:

Goal 1: Strengthening commitment to change. By simply thinking and talking about goals and values, the participant becomes more committed to the idea of change. In a broader sense, this is a way of eliciting change talk from the participant - one of the core MI strategies for building participant motivation. The more participants articulate their goals and envision the ways their lives could be, the more likely they are to commit to change – and the more closely participants' goals and reasons for change are connected with participant's values, the more committed they will be.

Goal 2: Measuring self-efficacy and readiness for change. The types of goals set by participants provide insight on their sense of self-efficacy, commitment, and readiness for change. Participants who are more confident in their ability to change will set more ambitious and far-reaching goals, while less confident participants will be more hesitant and set smaller goals. This may serve as a cue to back up and talk more about a participant's reasons for change before exploring goals and values.

Goal 3: Building self-efficacy and optimism. Self-efficacy is a necessary factor in a participant's ability to overcome ambivalence and take the appropriate steps to change. It pertains to a participant's acknowledgement of his or her ability to exercise control over a particular event – in other words, a specific form of confidence related to the ability to perform a task or engage in a behavior. As participants begin to achieve short term goals, their sense of self-efficacy or confidence in their ability to make changes will increase. This builds hope and optimism, which are critical in helping the participant move towards making positive change.

Materials/Supplies Needed:

None

Definition:

Exploring and Setting Goals is an interactive process between counselor and participant that involves envisioning and articulating various objectives related to the positive changes for with the participant is striving. The counselor guides the participant through the process of goal setting, but the actual formulation of goals is ultimately the participant's responsibility. **Exploring Values** is closely related to Exploring and Setting Goals, and it involves the elucidation of the participant's personal values, or aspects of life that the participant finds

particularly important. A participant is much more likely to work towards a goal that is valued, so making the connection between the participant's articulated goals and the participant's values can be critical in building motivation for change.

Situations in which this strategy is typically used:

Exploring and Setting Goals and Exploring Values are particularly useful strategies in the **Preparation stage** of change (when the participant has committed to change and is preparing to take action). At this point, exploring goals and values will build optimism and self-efficacy, both of which will **facilitate the participant's transition from Preparation stage to Action stage** (when the participant is actively making changes). Exploring and Setting Goals with the participant will allow the counselor to gauge the distance between the two stages and assess the participant's readiness for change.

Common Phrases/statements that are used in this strategy:

Exploring and Setting Goals and Exploring Values can be introduced to the participant in an **open-ended interview format**. The counselor can start with **broad, open-ended questions** like, "How would you like your life to be five years from now?" or, "What things are most important to you?" These questions will begin the process of exploration and force the participant to think about change at a high level, and the order in which the participant discusses their different values can help give the counselor an idea of their relative importance to the participant.

As the participant begins to explore goals and values, **reflections of feelings** and **restatements** can be beneficial in prompting the participant to elaborate on or move forward with a train of thought, e.g. "So having financial stability for the sake of your children is very important to you," or, "You seem a little uncertain about your ability to order a salad instead of something fried when eating out." This also serves to confirm goals and values with the participant, allowing them to give the feedback to the counselor concerning how well their goals and values are being understood.

Menu of Options

Objectives:

1. Engage the participant in the behavior change decision making process.
2. Elicit from the participant what change options are most important to them.

Materials/Supplies Needed:

Menu of options handout (See Appendix II)

Content

Definition: Presenting a menu of options is a strategy used to engage the participant in the counseling process. The menu allows the participant to choose topics to discuss that are important to them but from a select menu as to focus the counseling session. The menu includes topics that are important to the session – in this case exercise and healthy eating options – while also allowing for open spaces for the participant to include topics important to them.

Situations when this strategy is commonly used: The menu of options is often used in beginning to develop a change plan. In this project the menu will be used to help the participant prioritize which behavior change initiatives are most important.

Common phrases/statements used with this strategy: As an opening strategy it is important to introduce the menu after building motivation to change.

"If you'd like we can talk about some of the ways people change their health behavior. On this sheet are some of the different behaviors people use to become healthier. This circle has some fruit which represents your diet. This circle represents integrating yard work into your activity plan. You also see an empty circle which represents anything you want to discuss about the tests. Which of these areas would seem doable to you?"

Negotiating a Change Plan

Objective:

1. Assist the participant in developing an individualized plan for behavioral change that is specific.
2. Ensure the feasibility of the change plan.
3. Helping the participant to be prepared for behavior change.
4. Outline the specific activities and resources related to change as well as potential barriers.

Materials/supplies needed:

Change plan worksheet (see appendix II)

Definition: The change plan is a concrete roadmap that the participant can follow in order to reach their behavior change goals. To be affective the change plan specifically outlines the (a) behavior to be change, (b) reminders of the motivational factors, (c) change goals, (d) action plan, (e) manageable steps in order toward change, (f) potential barriers and (g) steps to overcome those barriers.

Situations in which this strategy is typically used: Typically the change plan is implemented when someone is at the transition between preparation and action stages of change. In other words, the participant is ready for behavioral action. In this project the change plan will be negotiated after discussing participant results and enhancing motivation and commitment to make behavioral change.

Common Phrases/statements that are used in this strategy:

"Now that we have discussed some aspects of your diet and exercise what do you think you want to do about your eating and exercise?"

"Now that we have come this far, I wonder what you plan to do?"

The changes I want to make are:
"What may be some of the changes you want to make in your eating and diet? "

- It is important to be specific and include goals that are positive (e.g., wanting to increase exercise, eat more fruits and veggies) and not just negative goals (e.g., stop eating fried foods).

The most important reasons I want to make these changes are:
"We discussed several reasons for changing earlier such as [summarize a few points] for you what are some of the most important reasons you want to change?"

My goals for making these changes are:
"Tell me about your overall goals or what you hope you will achieve by making these changes"

- What are the likely consequences of action or inaction
- Which motivations are most compelling.

I plan to do these things to reach my goals:
"There are a lot of things you can do to work toward your goals – what are some of the activities you think you will do to work toward your goals?"

The first steps I plan to take in changing are:
"Of those activities what do you think you can do first."
"In making some of these changes what are some of the first steps?"

- How can the desired change be accomplished.
- Want specific, concrete steps.
- When, where and how will these steps be taken.

Something that could interfere with my plan are:
"Sometimes it helps to think of the things that may get in the way of your plan. What are some events or problems could interfere with your plan?"
"What may get in the way of you making progress on this plan?"
"What could interfere with this plan and how can you stick to the plan?"

- Want to identify what could undermine the plan.
- What could go wrong in the plan
- Get an idea how the participant could stick with the plan despite interference.

Other people who could help me in changing in these ways are:
"Who around you can help support you with your plan?"
"What are some things supporters can do to help you keep with your plan?"
" How can you enlist the support of other people as you make these changes?"

I hope my plan will have these positive results:
"What are some of the results you hope to achieve with this plan?"
"What do you hope will result from following this plan?"

I know my plan is working if:
"How will you know your plan is working?"
"What types of things will show you your plan is succeeding?"

<u>Managing Unrealistic Goals:</u>

If a participant identifies an improbable goal when negotiating a change plan, counselors must rely on the MI skills to help the participant develop a goal that is a realistic and attainable change. For example, if a participant says that he plans to lose 150lbs in 2 months, it is important to emphasize the following MI skills:

1. **Affirm** his/her motivation and excitement about implementing change in his/her life. Counselors should recognize that the participant is involved in change talk and is making

efforts to consider ways in which he could change his lifestyle. Support this motivation and excitement by telling the participant that you see his drive and will to change. This encourages his momentum towards change without necessarily encouraging his unrealistic goal.

2. **Resist the Righting Reflex** when discussing the goal. It is imperative that the counselor does not directly state his/her expert status by rejecting the participant's goal or by offering a new goal. MI encourages the participant to remain empowered while negotiating the change plan.
3. **Utilize the Participant's Expertise** to develop a more realistic and attainable change plan. The participant is the expert of his life and past experiences. By asking him key questions (such as, Have you previously attempted to lose large amounts of weight in a short period of time? What is your experience with dieting and exercise? Tell me about your past successes? Failures?), the counselor is utilizing his experiences to help him think more realistically about past and present barriers.

Incorporate Relapse Prevention and Safeguard Plan to modify his original plan. While discussing his past history, the counselor and participant can integrate activities into his change plan that will prevent relapse to past unhealthy behaviors. For example, the participant may become discouraged if he gains much of his weight back after losing a large amount of weight in a short period of time. His discouragement may lead to eating unhealthy foods and a reduction of exercise. Therefore, the counselor and participant must discuss realistic options in order to avoid that experience and to encourage adherence to the change plan. Further, safeguards can be established to help the participant manage temptation and regression toward unhealthy behavior. These modifications to avoid past discouragements and reestablishments of past unhealthy behavior create a highly individualized change plans that increase the likelihood of a successful and consistent change.

Appendix I

MI Procedures for Intervention and Maintenance Phases

Intervention Procedures

Intervention Phase – Enrollment Session (#1 – 30 minutes max)

Goals

1. Provide each participant with individualized feedback on their health status based on study assessment.
2. Build participant motivation and commitment to increase exercise.
3. Build participant motivation and commitment to eat healthier.
4. Develop an individualized change plan to guide participant behavior change.

Session 1 Processes & Procedure (see Appendix III for session flow chart)

Step	Activities
Assessment Completed	• Comes to MI station
Begin MI Session	• Introduce yourself – Hello my name is XXXXX and I am a **health counselor** for this project. My job is to discuss with you some of the information gathered today based on what you think is important and to help you decide what, if anything, you may want to change in relation to your health and how you may go about changing. o Obtain commitment to participate ▪ "Sound ok to you?"
Set Agenda	• Introduce Know Your Numbers card • Identify which areas are most important for participant to discuss o "This is what we call your know your number's card. This card will be filled in each time you come back here. In looking at this card you will see…… [go through sections HBP, etc] and info about where your score falls in terms of health. In looking at these different areas we looked at which would seems most important for you to discuss. o "Among these things which of them do you think is most important for you to learn about…what's next…."
Present assessment data	• Using Elicit – Provide – Elicit provide information on participant results.
Build motivation	• Use MI consistent strategies to help participant increase readiness to change o "Given this information we just discussed how ready are you to make some changes in relation to your diet or exercise?" o What are some of the good things about your current

	behavior? What are some of the not so good things? o How important is it for you to make some changes in your exercise and diet?
Discuss change options	• Elicit what participant may want to do o "Given all of this, what do you think you may want to do about your diet and exercise?" • Present participant with menu of change options o "If you'd like we can talk about some changes you could make to improve your health." o Here is a sheet that includes some behaviors that can be important in helping people manage similar concerns to yours. ▪ This area represents formal exercise like walking. ▪ This area represents increasing physical activity in your daily life, like taking the stairs rather than the elevator. ▪ This area represents eating healthier which may include eating more fruit and veggies. ▪ You will also notice some empty areas. These represent your ideas that are not represented by the other area. ▪ Are there any areas here you wish to talk about or perhaps there are other things you want to raise that are more important to you in relation to our discussion? • Discuss change options with participant assessing readiness and importance along the way
Develop change plan	• Elicit a plan from the participant o What is it specifically that you may want to do? • Follow change plan worksheet (e.g., reasons, goals, steps…) • Summarize the plan emphasizing the fit for participant (goals, needs intentions and beliefs) • Elicit commitment o What are you going to do?
Close session	• Thank participant for meeting with you • Elicit any questions • Direct them to next station
Complete paperwork	• Complete session checklist • Complete TEMI

Intervention Phase – Follow Up Sessions (2 & 3 – 30 minutes max)

Goals

1. Provide each participant with individualized feedback on their progress or lack thereof based on study assessment.
2. Review change plan for progress and barriers.
3. Re-engage and build motivation and commitment to increase exercise and healthy eating in participants who have not followed the plan.
4. Revise the change plan for participants who have not followed the plan.
5. Positively reinforce progress on the change plan and revise as needed for participants who are implementing the plan.

Sessions 2 and 3 Process/Procedures (follow up session flow chart format)

Step	Activity
Assessment completed	Comes to MI station
Begin MI Session	• Introduce yourself - Hello my name is XX and I am a **health counselor** for this project. My job is to discuss with you some of the information gathered today, talk about the changes you may have already made, and based on what you think is important decide what, if anything, you may want to change in relation to your plan and how you may go about changing. o Obtain commitment to participate ▪ "Sound ok to you?"
Set Agenda	• Re-introduce Know Your Numbers card • Identify which areas are most important for participant to discuss o "Remember this card has information from the tests you just completed as well as last time." o "If you look you will see….." o "Among these things which of them do you think is most important for you to learn about…what's next…."
Present assessment data	• Using Elicit – Provide – Elicit provide information on participant results.
Review change plan and activities	• Elicit from participant how their change plan has or has not been working. o "Remember last time we developed your plan for changing some of your health behaviors. What, if anything, have you chosen to do? o What has worked and has not worked?"
If none or minimal change –	• Assess what has lead to lack of progress

assess reasons for lack of progress	○ "Sometimes making behavior change can be really hard and is something that people often don't recognize. ○ "On a scale of one to 10 how important is it for you to continue with these changes?" ○ What has gotten in the way of you progressing on your plan as you had hoped?"
If none or minimal change – work to build motivation and commitment using processes of change based on barriers identified by participant (note: not all processes will be addressed in session)	• **Consciousness raising**- Elicit from the participant importance of the need to change and hazards of not changing**.** Individualize the risk of the behavior, making problems specific to the participant's current lifestyle ○ "Given some of the information we discussed today what are some of the benefits and drawbacks of staying the same or changing?" • **Self-reevaluation** - Help the participant examine current behaviors to see the mismatch between current behavior & desired behavior. ○ "To what extent have your health goals changed or stayed the same since you developed the plan?" ○ "How do your current behaviors fit or not with those goals?" • **Environmental Barriers**: Help to examine the environment in which the participant lives and identify those factors that will either enable or discourage the necessary change. ○ Sometimes things in folks' lives simply get in the way of them making the changes they want. • **Personal barriers**: Elicit from participant methods to overcome those obstacles that the participant lists as reasons for not changing. ○ What do you think are some of the ways to overcome some of these barriers, if you still want to make some changes? • **Increase self-efficacy**: Help the participant identify successes/progress, rather large or small, that they made. Consider revising goals to make them more realistic and achievable. ○ "Tell me about some of the steps, large or small, that you made in your plan?"
If changes have been made – work to sustain commitment to the change plan (note: not all processes will be addressed in session)	○ **Prevent relapse/problem solve**: Recognize those situations that may cause the participant to resume old behaviors and develop a plan to overcome these obstacles. ○ You seem to be doing a good job. What are some of the situations you noticed where it was harder

	to stick to the plan? How did you manage them? ○ **Cope with relapse**: Explain to the participant that relapse is common and it is not considered failure. Elicit exceptions from participant. Elicit what participant learned from relapse ○ It is common, almost expected, that people will have setbacks when making behavior change. Have you had any setbacks while making changes? ○ What did you learn from this situation? ○ **Helping relationships**: Elicit from the participant ways to establish relationships that will help to support and continue the change ○ Who are some of the folks who have supported you in your plan? ○ Who else may be able to help support you? ○ **Stimulus control**: Help the participant to identify unhealthy behaviors and to replace them with healthy behaviors. Help to identify and remove cues in the environment that lead to unhealthy behavior ○ "What things in your environment, like certain foods, may make it harder for you to stick to your plan?" ○ **Enhance Benefits**: Elicit from participant the benefits of the change and list any additional benefits the participant may not have originally recognized ○ "You seem to be doing great with your plan. What are some of the benefits you are noticing as a result?" ○ "What may be some benefits you originally hadn't considered?" ○ **Increase self-efficacy**: Encourage an overall feeling of confidence in the participant's ability to maintain the change. Continue to set and encourage goals in order for the participant to be successful ○ "Seems like you are doing a really good job with your plan." ○ "What successes have you noticed for yourself?" ○ "Given your success, how confident are you on a scale of 1-10 in your ability to continue this plan?" ○ "What new goals may you want to accomplish given your success thus far?"
Revise change plan as needed	○ Key Questions – Use change plan questions

Maintenance Phase

Goals

1. Review change plan for progress and barriers.
2. Re-engage and build motivation and commitment to increase exercise and healthy eating in participants who have not followed the plan.
3. Positively reinforce progress on the change plan and revise as needed for participants who are implementing the plan.

Follow Up Phone Calls Process/Procedures (follow follow-up flow chart in Appendix III)

Step	Activity
Receive participant change plan	Review change plan

Call participant	• Introduce yourself
	• Participant accepts or rejects call
	• Provide overview of the meeting
	  o Discuss the change plan developed during in-person meetings
	  o Obtain commitment to participate
	  ▪ "Sound ok to you?"
	  o May help to guide toward areas of abnormal results.

Set Agenda	• Re-introduce/orient to project and change plan • Elicit from participant if there is anything they want to discuss in relation to their change plan o "I have a few things I'd like to touch on, but wonder if there is anything related to your change plan you wanted to discuss?"

Review change plan and activities	• Elicit from participant how their change plan has or has not been working.
	  o "Remember last time we developed your plan for changing some of your health behaviors? What if anything have you chosen to do?
	  o What has worked and has not worked?"

If none or minimal change – assess reasons for lack of progress	• Assess what has lead to lack of progress
	  o "Sometimes making behavior change can be really hard and is something that people often don't recognize."
	  o "On a scale of 1 to 10 how important is it for you to continue with these changes?"
	  o "What has gotten in the way of you progressing on your plan as you had hoped?"

If none or minimal change – work to build motivation and commitment using processes of change based on barriers identified by participant (note: not all processes will be addressed in session)	• **Consciousness raising**- Elicit from the participant the importance of the need to change and hazards of not changing**.** Individualize the risk of the behavior, making problems specific to the participant's current lifestyle o "Given some of the information we discussed today, what are some of the benefits and drawbacks of staying the same or changing?" • **Self-reevaluation** - Help the participant examine current behaviors to see the mismatch between current behavior and desired behavior. o "To what extent have your health goals changed or stayed the same since you developed the plan?" o "How do your current behaviors fit or not with those goals?" • **Environmental Barriers**: Help to examine the environment in which the participant lives and identify those factors that will either enable or discourage the necessary change. o Sometimes things in folks' lives simply get in the way of them making the changes they want. • **Personal barriers**: Elicit from participant methods to overcome those obstacles that the participant lists as reasons for not changing. o What do you think are some of the ways to overcome some of these barriers, if you still want to make some changes? • **Increase self-efficacy**: Help the participant identify successes/progress, rather large or small, that they made. Consider revising goals to make more realistic and achievable. o "Tell me about some of the steps, large or small, that you made in your plan?"
If changes have been made – work to sustain commitment to the change plan based on process of change (note: not all processes will be addressed in session).	o **Prevent relapse/problem solve**: Recognize those situations that may cause the participant to resume old behaviors and develop a plan to overcome these obstacles. o You seem to be doing a good job. What are some of the situations you noticed where it was harder to stick to the plan? How did you manage them? o **Cope with relapse**: Explain to the participant that relapse is common and it is not considered failure. Elicit exceptions from participant. Elicit what participant learned from relapse o It is common, almost expected, that people will have setbacks when making behavior change.

	Have you had any setbacks while making changes? o What did you learn from this situation? o **Helping relationships**: Elicit from the participant ways to establish relationships that will help to support and continue the change o Who are some of the folks who have supported you in your plan? o Who else may be able to help support you? o **Stimulus control**: Help the participant to identify unhealthy behaviors and to replace them with healthy behaviors. Help to identify and remove cues in the environment that lead to unhealthy behavior o "What things in your environment, like certain foods, may make it harder for you to stick to your plan?" o **Enhance Benefits**: Elicit from participant the benefits of the change and list any additional benefits the participant may not have originally recognized o "You seem to be doing great with your plan. What are some of the benefits you are noticing as a result?" o "What may be some benefits you originally hadn't considered?" o **Increase self-efficacy**: Encourage an overall feeling of confidence in the participant's ability to maintain the change. Continue to set and encourage goals in order for the participant to be successful o "Seems like you are doing a really good job with your plan." o "What successes have you noticed for yourself?" o "Given your success, how confident are you on a scale of 1-10 in your ability to continue this plan?" o "What new goals may you want to accomplish given your success thus far?"
Close call	o Provide a brief summary of what was discussed on the call, emphasizing change talk and commitment to change plan. o Based on our discussion it seems like……. o Close call o Thank you again for talking today. Please remember we will be calling you again.
Complete paperwork	o Session Checklist
Return change plan and checklist	o Returned to MI Coordinator

Appendix II
Counselor Measures

Counselor Evaluation of In-person Session

Immediately after completing each in-person session identify whether or not you engaged in each activity below and discuss your rational for not doing so. This is not a right or wrong evaluation, but simply a review of what happened in each session and your rationale for choosing to or not to engage in an activity.

Activity	Yes	No	Reason for not engaging in this activity
Present a menu of options for which to receive feedback			
Elicit which piece of feedback participant wants to learn most about			
Present assessment data piece by piece			
Use elicit – provide – elicit in providing feedback			
Explore pros/cons of changing behavior			
Help clarify exercising goals/values			
Assessed readiness to change			
Assessed importance of changing			
Follow up with scaling questions (e.g. why a 5 and not a 3)			
Present participant a menu of change options (use menu handout)			
Elicit which change option may be most appealing			
Develop/revise change plan			
Elicit participant commitment to plan			

Therapist Evaluation of Motivational Interview (TEMI) Data Enrollment Forms

[TO BE COMPLETED BY THE THERAPIST/COUNSELOR]

Please rate each response on the scale below relating to your **recent MI session.**

[1] Not At All
[2] Only a Little
[3] Some
[4] A Great Deal

In your session, how much did you:

|___|	TEMI01.	focus only on client weaknesses.
|___|	TEMI02.	help the client to talk about changing their behavior.
|___|	TEMI03.	act as a partner in the client's behavior change.
|___|	TEMI04.	helped the client discuss their need to change their behavior.
|___|	TEMI05.	make the client feel distrustful of you.
|___|	TEMI06.	help the client examine the pros and cons of changing their behavior.
|___|	TEMI07.	help the client to feel hopeful about changing their behavior.
|___|	TEMI08.	argue with the client to change their behavior
|___|	TEMI09.	change the topic when the client became upset about changing their behavior.
|___|	TEMI10.	push forward when the client became unwilling to talk about an issue further.
|___|	TEMI11.	act as an authority on the client's life.
|___|	TEMI12.	tell the client what to do.
|___|	TEMI13.	argue with the client about needing to be 100% ready to change their behavior.
|___|	TEMI14.	show the client that you believe in their ability to change their behavior.
|___|	TEMI15.	help the client to feel confident in their ability to change their behavior.
|___|	TEMI16.	help the client to feel hopeful about changing their behavior.

Motivational Interviewing Supervision & Training Scale - R

HELPER STATEMENT	Open Questions	Simple Reflection	Complex Reflection	Affirming	Summarization	Missed Opportunity	Closed Question	Interpretation	Confrontation	Information/Advice	COMMENTS
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
10.											
11.											
12.											
13.											
14.											
15.											
16.											
17.											
18.											
19.											
20.											

Motivational Interviewing Supervision and Training Scale

1. Questions

1 Relies on closed questions for information gathering	2	3	4 Balanced use of questions, but timing and wording do not fully facilitate client exploration	5	6	7 Good facilitation of client exploration through the use of primarily open questions

2. Simple Reflection

1 Primarily repeats client's statements to keep client talking	2	3	4 Mainly uses paraphrase to clarify information	5	6	7 Used to reinforce and emphasize important statements

3. Complex Reflection

1 Adds no meaning to what client said	2	3	4 Adds some, but not substantial meaning	5	6	7 Adds substantial meaning to what client has said

4. Affirming

1 Focuses solely on client weaknesses and problems	2	3	4 Acknowledges strengths but still emphasizes problems and weaknesses	5	6	7 Appropriately elicits and reinforces strengths

5. Summarization

1 Used simply to clarify information	2	3	4 Primarily used to track the session	5	6	7 Used to link and reinforce material that has been discussed during and between sessions

6. Engaging client in the intervention process

1	2	3	4	5	6	7
Fails to establish rapport			Establishes some rapport, but environment not conducive to active client participation			Creates an environment in which the client can actively participate in therapy

7. Elicits change talk

1	2	3	4	5	6	7
Does not entice the client to voice change talk			Acknowledges change talk but in a manner that does not facilitate exploration, awareness, or further change talk			Evokes client to voice change talk

8. Addresses client ambivalence

1	2	3	4	5	6	7
Confronts ambivalence as denial			Acknowledges client ambivalence without working to resolve it			Works actively to help client resolve ambivalence

9. Rolling with resistance

1	2	3	4	5	6	7
Argues with the client in favor of change			Notes client resistance without a change in own behavior/focus of session			Changes behavior/focus of session in order to reduce client resistance

10. Collaborating

1	2	3	4	5	6	7
Assumes an expert/authoritarian role			Vacillates between expert and collaborative approach			Adopts an collaborative approach

11. Supports Client Self Efficacy

1	2	3	4	5	6	7
Fails to communicate belief in client's abilities to change			Misses opportunities to recognize and reinforce client strengths/abilities			Communicates belief in the client's ability to change

12. Communicating Hope

1	2	3	4	5	6	7
Fails attempts at communicating a sense of hope			Partially communicates a sense of hope			Effectively communicates a sense of optimism/hope about client change

13. Acceptance

1	2	3	4	5	6	7
Appears judgmental and/or non-accepting			Acceptance is inconsistent			Appears non-judgmental and accepting of client

14. Respect

1	2	3	4	5	6	7
Fails to communicate respect for client experience			Respect appears conditional			Communicates respect for client experience

15. Use of active listening skills

1	2	3	4	5	6	7
Relies on one type of skill			Relies on 3 or 4 skills			Effectively integrates all skills to facilitate MI

16. Appropriate sequence of MI skills (OARS)

1	2	3	4	5	6	7
Inappropriate sequencing and/or timing			Misses opportunities to reflect, affirm and summarize			Skills effectively used to develop motivational themes

17. Overall Spirit of MI

1	2	3	4	5	6	7
Displays behavior inconsistent with the MI spirit			Missed some opportunities to exhibit spirit of MI			Displays behaviors consistent with MI spirit

18. Overall response of client

1	2	3	4	5	6	7
Disengaged from process of change			Moderately engaged in change process			Fully engaged in change process

19. General effectiveness of therapist

1	2	3	4	5	6	7
Not effective in facilitating MI			Moderately effective in facilitating MI			Extremely effective in facilitating MI

20. Overall Missed MI Opportunities

1	2	3	4	5	6	7
Frequently misses opportunities			Misses some opportunities			Takes full advantage of opportunities

Appendix II
Session Materials

Know Your Numbers Card

	Healthy Range	1st Numbers	2nd Numbers	3rd Numbers	4th Numbers	5th Numbers	6th Numbers	7th Numbers
Systolic Blood Pressure	< 120 mmHg							
Diastolic Blood Pressure	< 80 mmHg							
Waist Circumference (inches)	Men < 40 Women < 35							
Body Mass Index	18.5-24.9							
Weight	Varies							
Height	Varies							
Total Cholesterol	<200 mg/dL							
LDL (Bad) Cholesterol	<100 mg/dL							
HDL (Good) Cholesterol	Men >40 mg/dL Women >50 mg/dL							
Blood Glucose	Pre-meal Glucose: 70-130 mg/dL Post-meal Glucose: <180 mg/dL							
Diet: Fruits & Vegetables	4-5 cups							
Diet: Fiber	≥25g/day							

Diet: Sugar	~2tsp/day (5 Tbs/week)							
Diet: Calcium	1000 mg/day							
Diet: Dairy	2 to 3 cups							
Med: Blood Pressure	Y/N and I.D.S.							
Med: Blood Sugar	Y/N and I.D.S.							
Med: Cholesterol	Y/N and I.D.S.							

Menu of Options

Health Behavior Change Options

?

?

?

Change Plan Worksheet
The changes I plan to make are:
The most important reasons I want to make these changes are:
My goals for making these changes are:
I plan to do these things *Plan of action* *When*:
The first steps I plan to take in changing are:
Some things that could interfere with my plan are:
Other people could help me in changing in these ways: *Person* *Ways they can help*
I hope that my plan will have these results:
I will know my plan is working if:

Adapted from SAMSHA (1999)

Appendix III

Session Flow Charts

Participant #:

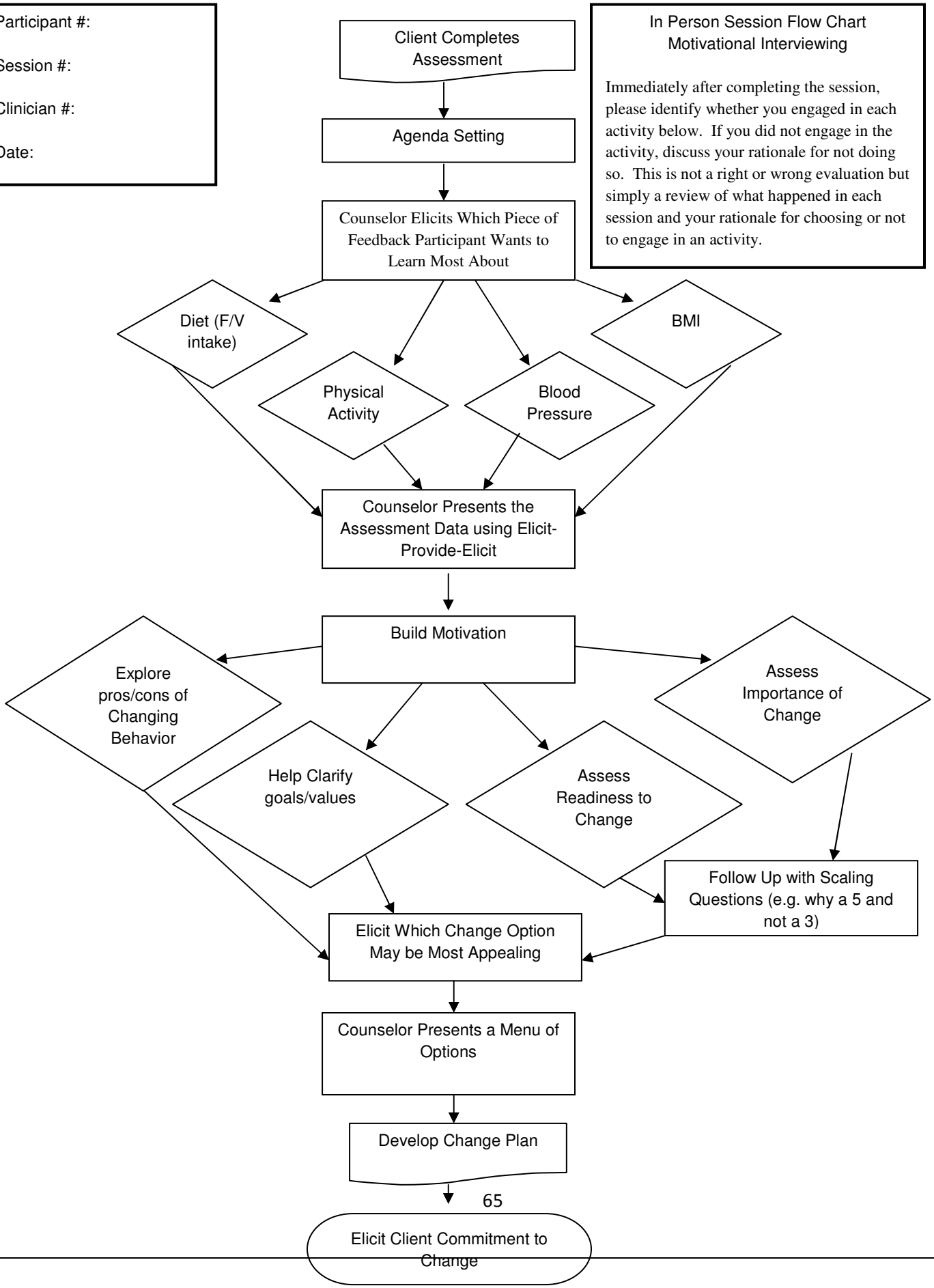
Session #:

Clinician #:

Date:

In Person Session Flow Chart
Motivational Interviewing

Immediately after completing the session, please identify whether you engaged in each activity below. If you did not engage in the activity, discuss your rationale for not doing so. This is not a right or wrong evaluation but simply a review of what happened in each session and your rationale for choosing or not to engage in an activity.



In-Person Follow Up Flow Chart

Participant #:

FU Session #:

Clinician #:

Assessment Completed

Review Assessment Results

Review Behavior Change Plan and Current Activities

Have any changes been made?

None or minimal, inconsistent changes

Yes changes made

In Person Session Flow Chart
Motivational Interviewing

Immediately after completing the session, please identify whether you engaged in each activity below. If you did not engage in the activity, discuss your rationale for not doing so. This is not a right or wrong evaluation but simply a review of what happened in each session and your rationale for choosing or not to engage in an activity.

These individuals may be unaware of the problem or have limited knowledge of personal risk. It is necessary to individualize the risk

Consciousness raising:
Elicit from client importance of the need to change and hazards of not changing**.** Individualize the risk of the behavior, making problems specific to the client's current lifestyle

Self-reevaluation:
Have the client examine current behaviors to see how the mismatch between current behavior & desired behavior (Decisional Balance)

Environmental Barriers:
Help to examine the environment in which the client lives and identify those factors that will either enable or discourage the necessary change

Personal barriers:
Elicit from client methods to overcome those obstacles that the client lists as reasons for not changing

Increase self-efficacy:
Help the client to set small, realistic goals that are easy to achieve. Once these goals are met, allow the patient to reward his or her efforts and set new goals

Comments related to implementation of change plan and readiness to change (changes made to plan, observations):

Prevent relapse/ problem solve:
Recognize those situations that may cause the client to resume old behaviors and develop a plan to overcome these obstacles

Cope with relapse:
Explain to the client that relapse is common and it is not considered failure. Elicit exceptions from client. Elicit what client learned from relapse

Helping relationships:
Elicit from the client ways to establish relationships that will help to support and continue the change

Stimulus control:
Help the client to identify unhealthy behaviors and to replace them with healthy behaviors. Help to identify and remove cues in the environment that lead to unhealthy behavior

Enhance Benefits:
Elicit from client the benefits of the change and list any additional benefits the client may not have originally recognized

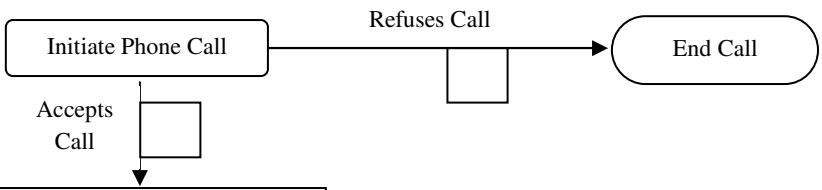
Increase self-efficacy:
Encourage an overall feeling of confidence in the client's ability to maintain the change. Continue to set and encourage goals in order for the client to be successful

Other Comments:

Participant #:

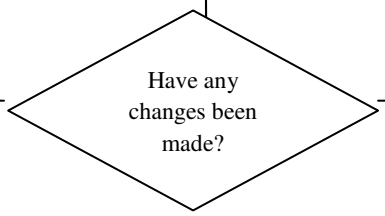
Session #:

Clinician #:



Accepts Call

Review Behavior Change Plan and Current Activities



None or minimal, inconsistent changes

These individuals may be unaware of the problem or have limited knowledge of personal risk. It is necessary to individualize the risk

Comments related to implementation of change plan and readiness to change:

Consciousness raising: Elicit from client importance of the need to change and hazards of not changing**.** Individualize the risk of the behavior, making problems specific to the client's current lifestyle

Self-reevaluation: Have the client examine current behaviors to see how the mismatch between current behavior & desired behavior (Decisional Balance)

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Stimulus control: Help the client to identify unhealthy behaviors and to replace them with healthy behaviors. Help to identify and remove cues in the environment that lead to unhealthy behavior

Enhance Benefits: Elicit from client the benefits of the change and list any additional benefits the client may not have originally recognized

Increase self-efficacy: Encourage an overall feeling of confidence in the client's ability to maintain the change. Continue to set and encourage goals in order for the client to be successful

Other Comments: