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Motivational Interviewing

*An evidence-based approach to counseling
helps patients follow treatment
recommendations.*

Overview:

Motivational interviewing is an evidenced-based counseling approach that health care providers can use to help patients adhere to treatment recommendations. It emphasizes using a directive, patient-centered style of interaction to promote behavioral change by helping patients explore and resolve ambivalence. This article will help nurses learn how to use motivational interviewing to encourage patients to adhere to treatment recommendations. The basic theoretical underpinnings, principles, and methods of motivational interviewing are discussed, with an emphasis on acting in accordance with the "spirit" of the approach.

There's no way I'm going to remember to take these pills." Many nurses have met with such resistance when encouraging patients to follow through on treatment recommendations. Indeed, common treatment recommendations, such as keeping appointments, following a dietary or exercise regimen, or reducing substance use, involve changing established routines. Although many patients recognize that making these sorts of behavioral changes will benefit their health, they're also aware that it may come at a cost. This ambivalence can lead patients to follow through incompletely, if at all.

In a review of the literature, Christensen found that rates of non-adherence to treatment recommendations are 20% to 40% for acute illness, 30% to 60% for chronic illness, and 80% for prevention.¹ Often the result is reduced treatment effectiveness and poor health outcomes, as well as increased financial and social costs.^{2,3}

Motivating patients to make behavioral changes is an important nursing task, and promising work has been done in developing and evaluating methods of promoting treatment adherence. (For an overview of the methods currently in use, see *Promoting Treatment Adherence: A Practical Handbook for Health Care Providers*, edited by two of us [WTO and ERL].) In particular, motivational interviewing, introduced in 1983 by William Miller, has shown promise as a counseling method for promoting change. Its developers describe the



photo by Susan Garland

motivational interviewing has promising effects on lifestyle change and health outcomes when compared with standard approaches, such as patient education, risk reduction interventions, nonspecific counseling, and treatment contracts.^{5,9,10}

technique as “a directive, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence.”⁴ Initially developed for the treatment of addictions, motivational interviewing has been widely adapted to facilitate change across a range of patient health behaviors, including those related to the management and prevention of chronic diseases. Motivational interviewing is well suited for use in many health care settings because it can be applied in very brief (10-to-15-minute) patient encounters.^{5,6}

A recent metaanalysis by Hettema and colleagues evaluated 72 published clinical trials of motivational interviewing and its adaptations.⁷ According to the researchers, “the strongest support by far for [motivational interviewing’s] efficacy is in the area for which it was originally designed: altering substance use.”⁷ But they also found at least modest effects in a variety of conditions, including treatment adherence, HIV risk reduction, diet and exercise, and health safety practices—behavioral changes that are among the most difficult to make. A metaanalysis by Rubak and colleagues found that motivational interviewing “outperforms traditional advice giving in the treatment of a broad range of behavioural problems and diseases. Large-scale studies are now needed to prove that motivational interviewing can be implemented into daily clinical work in primary and secondary health care.”⁸ Research on the effectiveness of motivational interviewing in medical health care populations and settings is in the relatively early stages, consisting primarily of pilot studies. But several randomized controlled trials have found that

Woollard and colleagues evaluated the efficacy of motivational interviewing as part of a “lifestyle change intervention” for improving health outcomes in 166 patients with hypertension who were being treated at general medical practices.¹¹ Patients were randomly assigned to receive standard care along with either a high or low level of the intervention; a control group received standard care only. The motivational interviewing interventions were delivered by nurse counselors and focused on reducing alcohol, dietary fat, and salt consumption; losing weight; quitting smoking; and increasing physical activity. The high-level intervention consisted of six face-to-face sessions, whereas the low-level intervention consisted of a single face-to-face session and five brief follow-up telephone contacts. At the 18-week follow-up measurement, the patients who received the high-level intervention had significantly decreased blood pressure and body weight and those who received the low-level intervention had significantly decreased salt and alcohol consumption, as compared with the standard-care controls. There were no significant differences in health outcomes between patients who received the two levels of motivational interviewing intervention.

In another study, Borrelli and colleagues randomly assigned 98 home health care nurses to provide their 273 patients who smoked with either an adaptation of motivational interviewing for smoking cessation (motivational interviewing in addition to a self-help smoking cessation manual and feedback on carbon monoxide levels) or standard care (in which the provider engaged the patient in “the five As” of quitting—ask, assess, advise, assist, and arrange follow-up—in addition to a self-help smoking ces-

sation manual).¹² The motivational interviewing-based intervention was delivered during three visits and one follow-up phone call. The standard care intervention was provided in one visit; however, the nurses provided additional support at subsequent visits if patients wanted it. At the two-, six-, and 12-month follow-up visits, patients who received the motivational interviewing intervention reported they had made more attempts to quit smoking and had significantly reduced the number of cigarettes they smoked, compared with those who received standard care. Biochemically verified abstinence rates (based on carbon monoxide measurements) were also higher at each of the follow-up visits in patients given the motivational interviewing adaptation, but these differences were found not to be statistically significant.

THEORETICAL BASIS

Motivational interviewing derives from Prochaska and DiClemente's transtheoretical model of change.¹³ This model explains behavioral change as a process in which individuals pass through five stages: precontemplation, contemplation, preparation, action, and maintenance.

A patient in the precontemplation stage doesn't believe that her or his current behavior (for example, smoking, poor diet, or lack of physical exercise) is a significant problem and doesn't intend to change the behavior anytime in the near future. In the contemplation stage, a patient begins to see that the behavior is a problem and considers making a change but is ambivalent about doing so because she or he also sees reason to keep things as they are (for example, smoking can be relaxing and enjoyable, and preparing healthy foods and going to the gym can be time-consuming). A patient in the preparation stage has decided to make a behavioral change and has a specific plan for doing so in the near future. In the action stage, a patient carries out a behavioral change plan and begins making the desired change. Finally, in the maintenance stage, a patient has made the behavioral change and works to avoid relapsing into the original behavior.

The transtheoretical model of change assumes that as people progress through these stages, they will experience normal fluctuations in ambivalence, problem recognition, and willingness to take action, and that most people will relapse and progress through the stages several times before successfully maintaining a behavioral change. Furthermore, some people may not pass through these stages in a linear fashion; instead, they may skip stages or regress to previous stages as they attempt to make and maintain behavioral changes.

This model is relevant to efforts to facilitate behavioral change because it orients the clinician first to understanding the patient's level of readiness to change and then to working toward successful movement through the stages. In this way the model helps clinicians work with patients "where they're at" in terms of readiness for change, thereby promoting collaboration and reducing resistance.

OVERCOMING AMBIVALENCE

Many patients faced with recommendations for behavioral change experience ambivalence, the simultaneous holding of contradictory feelings or attitudes. When patients are ambivalent about making recommended changes (such as taking a prescribed medication, stopping smoking, or modifying their diet or physical activity level), providers may try to persuade them using logic and problem solving, emphasizing the importance of making the change and describing ways in which the change might be implemented. If the recommendations are not followed, as is frequently the case, providers may "turn up the volume" by reiterating the importance of following the recommendations or sometimes confronting the patient out of concern or frustration. Other providers avoid this struggle, assuming that patients will make recommended behavioral changes only when they are ready and that providers can do little to motivate patients. These providers may simply present patients with a brief description of what is to be done and then hope for the best. Important questions emerge here: Why are methods of persuasion and confrontation so ineffective in promoting change? Why isn't the threat of poor health enough to persuade a patient to quit smoking, begin exercising, change her or his diet, or take medication? Is there a more effective way to evoke behavioral change?

Motivational interviewing offers an alternative response to ambivalence. The approach is grounded in the assumptions that struggles with ambivalence are a normal part of the process of change and that patient motivation and readiness to change are not static traits, but rather dynamic states that can be greatly influenced by interactions between provider and patient. In motivational interviewing, the provider refrains from persuading and confronting. Motivational interviewing is not a "fixing method" in which the provider says "I have what you need," but rather an "evocative method" in which the provider says "You have what you need." Specific counseling skills are used to elicit and reinforce the patient's motivation and readiness to change health behaviors, as well as to facilitate discussion and awareness of how these changes are

linked to important personal values and beliefs.

In motivational interviewing, the provider acknowledges and respects the patient's autonomy, recognizing that it is up to the patient to decide whether or not to change. In using this method, the provider resists the natural tendency to try to fix a patient's problems by imposing solutions on the patient, a tendency sometimes called the righting reflex. Instead, the provider works to elicit the patient's own reasons for change and encourages the patient to generate ideas about how to make changes. Additionally, the provider works collaboratively with the patient, making the provider-patient relationship more like a partnership. This is what is meant by the "spirit" of motivational interviewing: being with patients in a way that is simultaneously empathetic and supportive, as well as directive in moving patients toward change by strengthening their own reasons for change.

FOUR PRINCIPLES OF MOTIVATIONAL INTERVIEWING

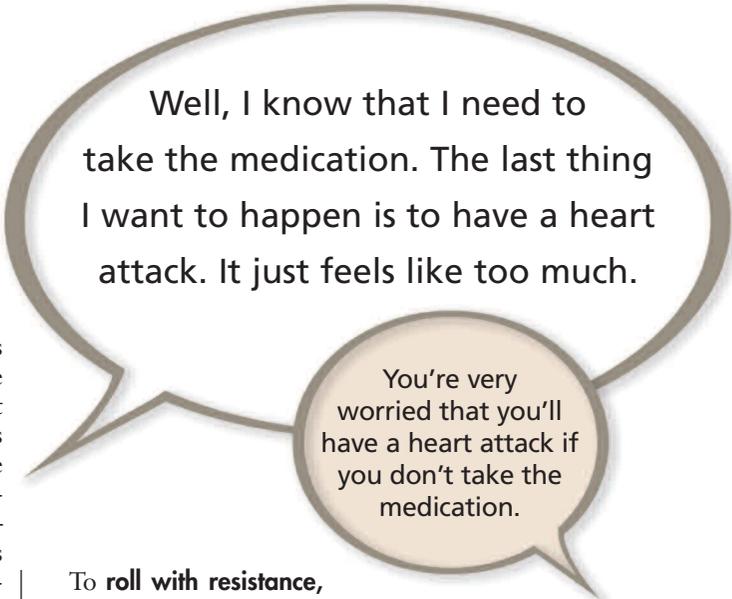
Motivational interviewing is more of a principle-driven counseling style than a set of specific therapeutic techniques. Therefore, it's generally unwise to use a "cookbook" approach to teaching and practicing motivational interviewing. A recent metaanalysis of motivational interviewing studies by Hettema and colleagues echoes this caveat, having found that the use of motivational interviewing manuals was associated with smaller effect sizes.⁷ What appears to be most important in the practice of motivational interviewing is that the clinician be guided by the "spirit" of the approach, rather than adhering to a rigid formula.

Motivational interviewing has four core counseling principles:

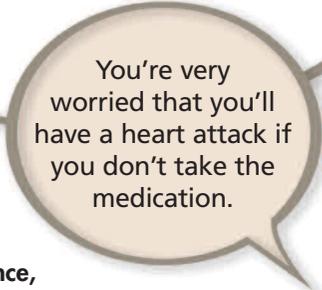
- Express empathy.
- Develop a discrepancy.
- Roll with resistance.
- Support self-efficacy.

To **express empathy**, the provider communicates that she or he understands and accepts the patient's experience, including the patient's ambivalence about change. This differs from expressing sympathy or relating a similar experience in that it is an attempt to see the world through the patient's eyes.

To **develop a discrepancy**, the provider uses the skills described below to enhance the patient's awareness of the inconsistencies between the patient's unhealthy behavior and her or his personal goals and values in order to motivate the patient to change. It's important that the provider refrain from identifying these discrepancies for the patient; rather, the provider should help the patient identify them.



Well, I know that I need to take the medication. The last thing I want to happen is to have a heart attack. It just feels like too much.



You're very worried that you'll have a heart attack if you don't take the medication.

To **roll with resistance**, the provider doesn't directly oppose any resistance displayed by the patient. Instead, the patient must be the primary source of answers and solutions and the provider must invite, not impose, new perspectives.

Finally, to **support self-efficacy**, the provider maintains and expresses to the patient a belief in the possibility of change, emphasizing the patient's ability to choose and carry out a plan to change her or his behavior.

FOUR SKILLS OF MOTIVATIONAL INTERVIEWING

To carry out the four principles described above, there are four basic therapeutic skills or methods used in motivational interviewing:

- reflective listening
- asking open questions
- affirming
- summarizing

Reflective listening involves responding to a patient's statement by stating back to her or him the essence or a specific aspect of the statement. Reflective listening has three primary functions. The first is to ensure that what the provider thinks the patient means is accurate. If the provider reflects something the patient did not mean, the patient can then clarify. The second purpose is to diminish the patient's resistance. Providers often counter patients' resistant statements, such as "I'm just not that into exercise because it's boring," with responses that attempt to solve the problem (for example, "Have you tried exercising outdoors?") or to persuade (for example, "Yes, but it's so good for you."). Such responses are inconsistent with motivational interviewing because they typically result in continued, or increased, resistance. In motivational interviewing, the provider responds to resistant statements by reflecting back to the patient the meaning of what was said (for example, "You've tried all kinds of exercise and don't like anything."), with the goal of

Table 1. Medication Adherence: Sample Exchanges

Speaker	Responses and Motivational Interviewing Principles Used
Patient: <i>I've got way too much going on in my life to remember to take pills two times a day.</i>	This shows the patient's resistance. She's adamant that she's unable to follow the treatment recommendation.
Provider: <i>Right now it's too difficult to fit taking this medication into your busy life. Nevertheless, I'm glad you came here today and are letting me know about this problem. It shows that your health is important to you.</i>	The provider reflects the patient's statement and rolls with her resistance. Although it may be tempting for the provider to respond to the patient's resistance with persuasion or confrontation, such responses often result in greater resistance. The provider then affirms the positive aspects of the patient's behavior, inferring from her attendance that the patient wants to be healthy.
Patient: <i>Yeah, it's important to me to get my blood pressure under control, but my daily routine is insane; I have to get the kids up in the morning and off to school by 8 AM, and then I have to get myself ready for work and out the door by 8:30. Nights are even crazier. I don't think I can remember to take these pills.</i>	The patient is describing the barriers to taking the medication and is also stating that her health is a priority, revealing her ambivalence. She is becoming less resistant and more willing to converse about the barriers to adherence.
Provider: <i>You're concerned about your health, and have so much going on in your life with your family and work—taking this medication is an extra burden that you don't really need.</i>	Through reflection, the provider highlights both sides of the patient's ambivalence, communicating acceptance.
Patient: <i>Well, I know that I need to take the medication. The last thing I want to happen is to have a heart attack. It just feels like too much.</i>	The patient is now talking about her need to take the medication while still mentioning the difficulty.
Provider: <i>You're very worried that you'll have a heart attack if you don't take the medication.</i>	The provider selectively reflects the patient's statement in favor of taking the medication. This is done to provoke more talk in favor of this behavioral change.
Patient: <i>I need to be around for my kids. I just wish it were easier for me to remember to take the pills.</i>	The patient discusses reasons for taking the medication but also mentions the difficulty of doing so.
Provider: <i>You're feeling stuck. What do you see as a solution to this problem?</i>	The provider reflects the patient's ambivalence and the resultant immobilization and then asks an open question to prompt the patient to explore ways to change.
Patient: <i>Well, my mom takes a lot of pills, and she remembers to take them by leaving them by her toothbrush morning and night.</i>	The patient generates ideas for how she could more easily remember to take her medications.
Provider: <i>It sounds like your mom has found a way to make taking medications work for her. What do you think you'd like to do?</i>	The provider affirms the patient's ability to find a solution and asks an open question to elicit a plan. The provider implies that, while this solution worked for her mother, it isn't the only possible answer and reinforces the patient's autonomy by conveying that it's up to the patient to devise a plan.
Patient: <i>Well, I suppose I could give that a try and see if it helps.</i>	The patient makes a commitment, although a somewhat equivocal one, to a specific plan.
Provider: <i>I think it's great that despite how hard this has been, you are willing to keep trying to make this work. Between your family and your job, you manage a lot in your life, and I believe that you can succeed with this, too.</i>	The provider affirms the patient's willingness to solve this problem and offers a summary that captures the main points the patient has made. The provider further supports self-efficacy by recognizing the patient's ability to succeed in many areas.

diminishing resistance by communicating that the provider understands and acknowledges the patient's thoughts and feelings. The third purpose of reflective listening is to encourage discussion of the patient's reasons for wanting to make changes. This is accomplished by the provider selectively reflecting the statements the patient makes in favor of change, thereby eliciting further statements in favor of change.

Reflections can be as simple as repeating what the patient said or can be made more complex by changing or amplifying the patient's statement. For example, a response to the statement "I'm just not that into exercise because it's boring" could be either the simple reflection "You don't find exercise very much fun" or a reflection that amplifies the patient's meaning, such as "You like to be excited about things and, so far, you haven't found an exercise that keeps your interest." Both allow the patient to correct or elaborate on the provider's reflection, build rapport by giving the patient a feeling of being understood, and facilitate movement in the patient's readiness to change.

Asking open questions elicits discussion of the reasons for making desired changes. Especially in the early phases of motivational interviewing, the patient should do most of the talking while the provider listens carefully and encourages elaboration. The provider stays away from closed questions that invite brief "yes" or "no" answers (for example, "Are you satisfied with your current level of exercise?"); instead, she or he asks open questions whose answers are reasons that the change is necessary or desirable. Here are some examples:

- *What would have to happen for it to become much more important for you to exercise?*
- *What concerns do you have about your obesity?*
- *If you were to stop smoking, what would it be like?*
- *What worries you about your diabetes?*
- *What are the worst things that might happen if you don't take this medication?*
- *What are the best things that might happen if you do take this medication?*

Open questions can also be used to explore the person's short- and long-term goals or guiding values. For instance, "What do you want in life?" or "How does your smoking fit in with your goals or values?" As a general rule, providers offer at least two reflective statements for each open question asked.

Directly affirming and supporting the patient during the interaction is an important way to sup-

Suggested Reading

Miller WR, Rollnick S, editors. *Motivational interviewing: preparing people for change*. 2nd ed. New York: Guilford Press; 2002.

O'Donohue WT, Levensky ER, editors. *Promoting treatment adherence: a practical handbook for health care providers*. Thousand Oaks, CA: Sage Publications; 2006. (See especially, Bisono AM, et al. Promoting treatment adherence through motivational interviewing. p. 71-84.)

Rollnick S, et al. *Health behavior change: a guide for practitioners*. New York: Churchill Livingstone; 1999.

Also see: www.motivationalinterview.org.

port the patient's self-efficacy, build rapport, reinforce the patient's efforts, and encourage open exploration. Affirmations can be as simple as complimenting the patient for making an effort ("Thanks for coming in today"), acknowledging small successes ("It's great that you were able to take your medicine almost every day this week"), or stating appreciation or understanding ("I appreciate that you were so honest with me by telling me you haven't taken your meds this week").

Summary statements link and reinforce material that has been discussed. Summaries are presented throughout the process of exploration and continue rather than interrupt the patient's narrative. As a patient begins to offer the provider statements indicating the desire to change ("Part of me wants to change this"), the ability to change ("I might be able to"), reasons for wanting to change ("I don't want to set the wrong example for my kids"), and the need for change ("I have to clean up my act"), the provider mentally collects them and offers them back to the patient in a two- or three-sentence summary. It's helpful to end summary statements with an open question such as "What else?" to invite the patient to continue the narrative. The following is an example of a clinician providing a motivational interviewing summary to a patient:

You've told me that you're somewhat worried about the possible long-term effects of being overweight if you don't start to do something about it. Having high blood pressure really scares you, and it is hard to hear that you are at risk for a heart

attack or stroke. On the other hand, you're young, you enjoy eating what you like, and the long-term consequences seem far away. What else?

The motivational interviewing principles and skills described above are focused on building patients' intrinsic motivation to make behavioral changes. Motivational interviewing also incorporates specific skills for working with patients to develop a change plan and for strengthening their commitment to that plan. These include skills for recognizing a patient's readiness for change, avoiding behavior (on the part of the provider) that impedes change, arriving at a specific plan, and eliciting a commitment. Although a description of these "phase II" motivational interviewing skills is beyond the scope of this article, a thorough discussion of them was compiled by Miller and Rollnick.¹⁴

PROVIDING INFORMATION TO PATIENTS

As part of standard nursing practice, providers often share with patients information such as the cause, nature, and typical progression of specific illnesses; the need for treatment and how it would work; the importance of adherence; and the consequences of specific behaviors, both harmful and healthful. In cases in which a patient's health is at risk, providers may also need to prescribe or proscribe specific health-related behaviors. To present patients with information and recommendations in a way that's consistent with the spirit of motivational interviewing, an "ask–provide–ask formula" is appropriate. First, the provider asks the patient what she or he already knows about the topic that the provider would like to discuss. Examples of this first "ask" step include the following:

- *Tell me what you already know about type II diabetes and how it is managed.*
- *What information have you been given about the impact of alcohol use on your liver?*
- *It's often difficult for people to remember to take medications more than once a day. What are your thoughts about how you will remember to do this?*
- *What have you been told already about the importance of taking this medication exactly as prescribed?*

When a patient appears to need additional information, the next step is for the clinician to ask for permission to impart it. If the patient grants permission, the information is provided without judgment. If the patient doesn't grant permission (which is very rare), the clinician refrains from providing the information and moves on to another topic, or may use reflective listening, open questions, affirmation, and summa-

rization to learn more about the patient's resistance and possibly reduce it. The following are examples of questions introducing the "provide" step:

- *It sounds like you know that drinking is not good for your liver. I have some specific information about the ways that alcohol affects your body that I'd like to share. Is that all right with you?*
- *I'd like to share some more information with you about what diabetes is and how it can be most effectively managed. Would that be okay with you?*
- *There are several strategies that many patients have used to help them remember to take their medications. Can I share these with you?*
- *There are some very specific effects of taking your medication as prescribed and of not taking it as prescribed. Can I tell you about these?*

The final step is for the clinician to ask the patient to discuss her or his thoughts and reactions to the information provided. The clinician then responds to the patient's replies using reflective listening, open questions, affirmation, and summarization. Examples of questions that can begin this final "ask" step include:

- *What are your reactions to what I have told you about the effects of alcohol on your liver?*
- *I've given you a lot of information about diabetes and about managing it. What thoughts or questions do you have about what I have said?*
- *What do you think about these medication-taking strategies I have shared with you?*

COMMON 'TRAPS' WITH UNMOTIVATED PATIENTS

There are a number of "traps" providers can fall into when attempting to facilitate behavioral changes in unmotivated patients. Providers frequently fall into these traps when responding to difficult patient behaviors (such as ignoring the provider, arguing, denying that there's a problem, interrupting, or changing the subject), which often results in patients becoming more resistant to change. Several common traps, as well as strategies that can be used to avoid them, are briefly described below.

Confrontation–denial trap. When a provider presents a patient with reasons for making changes (such as reasons why current behavior is problematic or why specific changes would be beneficial), the patient may respond with reasons why change isn't needed or possible, and the provider then counters with reiteration or additional reasons for changing. For example:

Patient: *To tell you the truth, I really don't see a reason why I should stop smoking.*

Provider: *Well, it's harmful to your health and will shorten your life.*

Patient: *The thing is, I would rather have a shorter life where I can smoke.*

Provider: *Okay, but the quality of your life will be lessened if you smoke.*

Patient: *The quality of my life is lessened if I don't smoke.*

This type of provider–patient interaction usually isn't productive and can easily result in the provider becoming frustrated and the patient arguing more strongly against change. As discussed earlier, in motivational interviewing the provider doesn't present arguments for change but, rather, uses open-ended questions, reflections, affirmations, and summary statements that encourage the patient to argue for change.

Question–answer trap. When a provider asks one question after another, the patient may give a series of brief, uninformative responses. For example:

Provider: *So what do you see as the problem with your diet?*

Patient: *Well, I guess I eat too much.*

Provider: *Why is that a problem for you?*

Patient: *Because I'm too fat.*

Provider: *Okay, why are you concerned about being overweight?*

Patient: *It's not healthy.*

Provider: *What concerns you about being unhealthy?*

Patient: *I might get sick.*

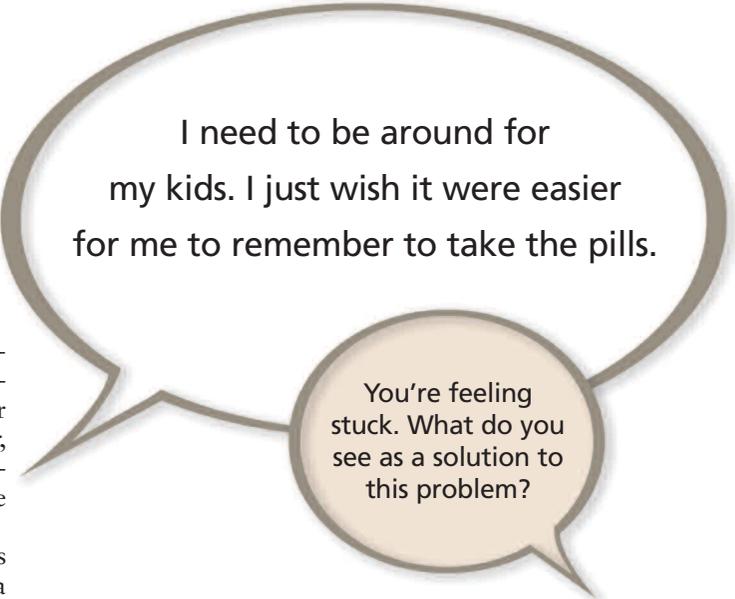
Such exchanges promote passivity on the part of patients and don't stimulate deep exploration of issues. The question–answer trap can be avoided if the provider limits her or his questions and responds to patients more often with reflections that encourage further exploration. A rule of thumb is that the provider should ask no more than two consecutive questions before offering a reflection.

Expert trap. If the provider gives the patient directions, suggestions, solutions, and advice for making changes rather than encouraging the patient to generate her or his own, it tends to foster passivity on the part of the patient and may result in the patient making half-hearted commitments to changing behavior. For example:

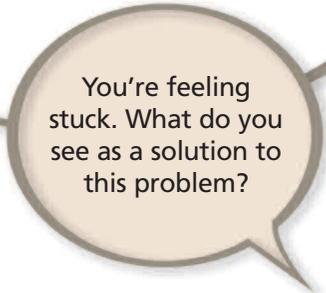
Patient: *I'm not sure I'm going to be able to remember to take this medication every day.*

Provider: *Well, you can leave your medications out where you will see them at your dosing time. You can also set an alarm on your watch or computer if you have one, and it also helps to get and fill a pillbox and keep it with you, okay?*

Patient: *I guess so.*



I need to be around for my kids. I just wish it were easier for me to remember to take the pills.



You're feeling stuck. What do you see as a solution to this problem?

Again, a provider using the motivational interviewing approach may with permission give suggestions or advice, but first should work with the patient to explore, address, and draw upon the patient's own goals, desires, skills, and abilities.

Premature focus trap. The provider may become focused on addressing a specific issue or problem (such as improving medication compliance) without first determining what the patient would like to discuss (such as the need for the medication) or before fully assessing other important issues. For example:

Provider: *I see from your intake questionnaire that you are drinking quite a bit of alcohol on a daily basis.*

Patient: *Yeah, that's true.*

Provider: *Well, I imagine that you are concerned about this. Let's discuss how you can cut down on your drinking.*

Patient: *Actually, I was hoping we could talk about my antidepressant medication; I'm not sure it's working.*

The provider can avoid this trap by beginning with an open-ended question about what the patient would like to discuss during the interaction and then using reflective listening to identify which issue may be the most important one to focus on.

CASE EXAMPLE

The case example in Table 1 shows how the basic principles and skills described in this article can be used in a patient–provider interaction. In a follow-up visit with her provider, a hypertensive patient presents with concerns that she won't be able to continue taking her blood pressure medication because of difficulties with following the regimen (see Table 1, page 54). ▼

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GENERAL PURPOSES: To present registered professional nurses with the theoretical underpinnings, principles, and methods of motivational interviewing, with an emphasis on acting in accordance with the "spirit" of the approach.

LEARNING OBJECTIVES: After reading this article and taking the test on the next page, you will be able to

- explain the concept of motivational interviewing.
- apply the principles of motivational interviewing to various patient-provider interactions.
- give specific examples of the common traps that can be avoided by using motivational interviewing techniques.

TEST INSTRUCTIONS

To take the test online, go to our secure Web site at www.nursingcenter.com/CE/ajnl.

To use the form provided in this issue,

- record your answers in the test answer section of the CE enrollment form between pages 56 and 57. Each question has only one correct answer. You may make copies of the form.
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