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Negotiating behaviour change in medical settings: The development of brief motivational interviewing

STEPHEN ROLLNICK, NICK HEATHER AND ALISON BELL

National Drug & Alcohol Research Centre, University of New South Wales, Sydney, Australia 2033

Abstract

Motivational interviewing was developed in the addictions field for helping people work through ambivalence about behaviour change. This paper describes a brief form of motivational interviewing developed in a medical setting for use in brief consultations. It is based upon the assumption that most patients do not enter the consultation in a state of readiness to change their patterns of drinking, smoking, exercise, diet or drug use; therefore, straightforward advice-giving will be of limited value and will lead to the kind of non-constructive dialogue often encountered in the addictions field: the interviewer's arguments for change are met by resistance from the patient. In contrast, this method aims to help patients articulate for themselves the reasons for concern and the arguments for change. Even if a decision to change is not made in the consultation, this time will be well spent since behaviour change itself could well occur in the near future. The method is based upon the use of a menu of strategies, with the interviewer selecting a strategy to match the degree of readiness to change of the patient. Each strategy takes 5-15 minutes to complete. Information-giving, which forms a central component, is designed as a patient-centered activity which maximizes freedom of choice for the individual. This paper contains an overview of the method and includes details of three strategies taught to trainees. It concludes with a discussion of some implications for training and health care practice.

Introduction

Ambivalence about behaviour change is a common problem encountered in health care consultations. Nurses, doctors and health visitors are used to speaking to patients about the need to take more exercise, drink less, stop smoking, eat less, reduce drug use, and so on. Since the most common form of consultation involves the delivery of medical advice controlled by the practitioner (Roter, 1989), negotiations about behaviour change frequently take the form of an exercise in overt persuasion. But what appears to be a fairly convincing line of reasoning to the practitioner often seems to fall on deaf ears; patients seem reluctant to launch into behaviour change, and might even counter the practitioner's logic with arguments of their own. For example:

Dr: *Have you thought about trying to lose weight so that your blood pressure comes down?*

Pt: *Well yes, but it's not so easy, and I must say, I really like my food.*

Dr: *But it's not a matter of depriving yourself of food. You just need to eat different, healthier foods, if you see what I mean.*

Pt: *Yes I know, I did try to eat less bread and more fruit and that sort of thing, but I never keep going for too long. I always seem to have these eating feasts when I break all my rules, and I just get fat.*

Dr: *What about .....?*

Pt: *Yes but.....*

Giving advice about behaviour change clearly works with some patients, as demonstrated by general practice research among excessive drinkers and smokers (see Wallace et al, 1988; Russell et al, 1979). Appropriate information-giving, for example, can empower patients to make decisions for themselves (Roter, 1989). However, success rates in the published brief intervention studies are not high, and the kind of see-saw dialogue illustrated above is often the outcome of well-intentioned advice-giving. Often, it feels like a fruitless and tiring business. How many doctors adopt this approach, try some form of counselling or simply avoid these negotiations, remains to be clearly established. One study suggests that the majority either do not afford high priority to negotiating behaviour change or believe that they should simply persuade their patients to change (Tuckett et al, 1985). Patients, it appears, have reservations about being "told what to do" by their doctors (see Stott and Pill, 1990).

One problem with giving advice about behaviour is that many patients are not ready to change when they enter the consultation. Advising them about the mechanics of behaviour change (i.e. about what action to take) is thus misdirected and premature because the issue of ambivalence has been ignored. More fundamental is the possibility that direct persuasion per se, whatever the degree of readiness to change, pushes the patient into a position of defensiveness. This could account for evidence which suggests that elements of a more patient-centered approach produce better outcomes among smokers (Ockene et al, 1991), obese patients (Williams et al, in press) and those with other physical problems (Kaplan et al, 1989).

This paper describes a patient-centred brief intervention method which was developed specifically for use among patients with varying degrees of readiness to change. A specialist technique, motivational interviewing for addictive problems, was adapted for use by general health care workers. It was first outlined by Rollnick and Bell (1991) who used it in a research study of excessive drinkers in an Australian hospital setting, and was then taught to other primary and secondary level workers, mostly in workshop format. It is derived from specialist work on motivational interviewing (see Miller, 1983; Miller & Rollnick, 1991; Saunders Wilkinson & Allsop, 1991).

The development of this brief method was guided by a number of principles: it should be useable in time-limited consultations; the training of practitioners should take no more than 12-15 hours; interviewers should be able to raise the subject of behaviour change in a sensitive and respectful manner, and the method itself should be flexible, capable of being used with patients who vary in their degree of readiness to change. The outcome of this work, which is currently being evaluated as part of a larger research project, was a method in which the interviewer uses a menu of strategies, selecting one at a time to suit the degree of readiness to change of the patient. Although focussed upon drinkers in a general hospital setting, its relevance to general behaviour change problems was strik-

ing. Our practitioners were faced with a problem common to many health care consultations: an apparent need to discuss a particular behaviour with patients, many of whom seemed reluctant to launch into decision-making and behaviour change. The example used below is that of substance use, although the principles and method are applicable to other behaviours like exercise, eating, phobic avoidance, and so on.

Rationale

Most patients do not come forward saying they want to change their behaviour. Decisions to change behaviours like eating, smoking, drinking, drug use and exercise are not always easy to make, and are often preceded by fluctuating motivation and feelings of ambivalence. A decision can be made and then reversed before behaviour change takes place. Understanding this process has been aided by the development of the stages of change model (Prochaska and DiClemente, 1986), in which people are said to move through the stages of precontemplation (not thinking about change), contemplation (ambivalent about change) and action. Among smokers, for example, one study found that 35% were in the precontemplation stage, 50% in the contemplation stage, and only 15% in the action stage (Prochaska, DiClemente & Velicer, 1988). Our study of hospitalized excessive drinkers suggested that 29% were in the precontemplation stage, 45% in the contemplation stage, and 26% in the action stage (Rollnick et al, in press).

Talking to patients who vary in their readiness to change clearly demands flexibility from the practitioner. For the minority who have more or less made up their minds, providing information about what to do and how to do it would seem readily appropriate. For the majority who still feel ambivalent or who are not thinking about change, the challenge to the practitioner is greater. It is tempting to simply leave the less ready patients alone. However, this is not always medically advisable (e.g. with the diabetic patient who needs to control his or her diet), and it overlooks the valuable role which could be played in helping people resolve ambivalence. Smokers, for example, move through the stages of change during the course of treatment, and this movement predicts subsequent attempts to give up (Prochaska, DiClemente & Velicer, 1988). Helping someone resolve ambivalence can therefore lead to behaviour change at a later point in time.

These observations provided the rationale for using brief motivational interviewing in a medical setting. Essentially, motivational interviewing is an attempt to find new ways of working with ambivalence and represents something close to the polar opposite of advice-giving. It arose from the observation that overt persuasion of someone who is feeling ambivalent about behaviour change is likely to be counterproductive, leading to some form of resistance. "Don't you think you should....." from the counsellor is likely to result in a "Yes, but....." response from the patient; this was called the confrontation-denial trap by Miller and Rollnick (1991). A possible mechanism underlying this resistance is the phenomenon of psychological reactance (see Brehm & Brehm, 1981), in which a threat to the client's personal freedom is likely to be met with a corresponding assertion of autonomy. The goal of motivational interviewing is to work with this need for autonomy by encouraging the client to explore his or her ambivalence and move towards behaviour change at a more measured pace.

The brief form of motivational interviewing described here was developed during the course of training practitioners. This proved

to be an instructive experience. They reported losing their sense of direction when using the form of motivational interviewing developed within the specialist arena, which relied mostly on using skills like reflective listening. For this reason a set of concrete strategies was developed which provided structure and direction to a session, yet allowed the interviewer ample opportunity to follow the patient's lead. The use of the strategies had to be sensitive to varying degrees of readiness to change among patients. Therefore, the idea of using a menu of strategies, each lasting 5-15 minutes, was devised. A strategy was to be selected from the menu to match the patient's readiness to change. Sometimes, in longer sessions lasting 30 minutes or more, two or three strategies would be used, thus following the patients evolving readiness to consider concerns and the possibility of change. A clear distinction was made between microskills (reflective listening, open questions, etc.) and broader strategies. With limited time available to teach health care workers, most emphasis was placed upon the latter.

In summary, this form of brief motivational interviewing involves moving between directive and nondirective interviewing styles. Although highly structured in parts, it is client-centered, and requires the practice of accurate empathy from the interviewer (Gordon, 1970). Most of the talking is done by the patient. It is therefore compatible with what Tuckett et al (1985) describe as a "meeting between experts" in medical consultations, and with the concept of reciprocity in the consultation (see Roter, 1989).

Two key concepts

The theoretical basis of motivational interviewing and its guiding principles are described in detail by Miller and Rollnick (1991). Attention here will be focussed on two concepts found to be particularly useful when teaching health care workers.

Ambivalence

Ambivalence is a common and normal experience. For people with a substance-use difficulty there is a conflict between indulgence and restraint, each option having pros and cons associated with it. The intensity with which people experience this conflict varies a great deal, and appears to increase as the person approaches decision-making.

The goal of motivational interviewing is to explore this conflict and to encourage patients to express their reasons for concern and the arguments for change. The interviewer's role is simply to elicit this material, thereby building motivation in a more constructive way. The interviewer does not argue in favour of change or restraint, but rather helps patients to do this for themselves.

Readiness to change

This concept is conveyed to trainees using a simple linear continuum rather than the discreet stages presented in Prochaska & DiClemente's (1986) model. At the left-hand end are patients who are not at all ready to consider change. Towards the right-hand end are those in the processes of decision-making and actual behaviour change, while those in the middle are in a state of ambivalence about their behaviour. A number of basic observations are then made to trainees. First, that people can move backwards and forwards along this continuum. Helping them move forward, even if they do not reach decision-making, let alone behaviour change itself, is an acceptable outcome of a consultation. Also, that, if an interviewer talks to a patient as if they were further along the line than they really are, resistance will be the likely outcome. The first task for the inter-

viewer is therefore to establish the patient's degree of readiness to change, and to then select a strategy appropriate to this level of motivation. The decision about which one to use next is based upon progress with the previous one. Readiness to move forward along the continuum usually emerges as a natural part of the interview process.

Some of the strategies described below serve the purpose of assessing readiness to change (see 'a typical day' & 'good things, less good things'). As part of our research effort we also used a questionnaire for this purpose (Rollnick et al, in press).

The use of microskills and strategies

When training health care workers, we make a distinction between microskills, like open questions, reflective listening, summarizing and affirmation on the one hand, and broader strategies on the other. The microskills are used all the time, but the way in which they are used will depend on the strategy being employed. A new strategy will usually start with an open question, followed by the use of all the microskills, and end with a summary, and so on. Initial direction is provided by the choice of strategy; once this takes place, the interviewer uses the nondirective microskills to elicit relevant material.

The menu of strategies

What follows is a description of a menu of selected strategies, each of which takes 5-15 minutes to work through. More than one strategy can be used in a given interview, depending on the time available and the progress made by the patient. For illustration purposes, three of these are presented in full below (see Tables 2,3 & 4), in the form in which they are used in training health care workers.

Table 1. Motivational interviewing strategies

The menu of strategies
1. Opening Strategy: lifestyle, stresses and substance use
2. Opening Strategy: health and substance use
3. A typical day/session
4. The good things and the less good things
5. Providing information
6. The future and the present
7. Exploring concerns
8. Helping with decision-making

As noted above, the choice of strategy from the menu depends on readiness to change. We found it helpful to order the menu according to degree of readiness to change. As one moved down the menu, so the strategies required greater readiness to change from the patient. It follows, therefore, that while strategies towards the top can be used with almost all patients, those towards the bottom can only be used with the smaller number who are entering decision-making. With most patients we usually started close to the top of the menu, using either "A typical day" or "The good things/less good things". This provided a solid platform of rapport and helped the interviewer understand the patient's life circumstances. Further progress down the menu depended upon readiness to change. If the patient openly expressed concern we usually moved down to "Exploring concerns" (no.7). However, if he or she appeared unconcerned about the behaviour we usually only got as far as "Providing Information" (no.5). Our interviewers thus soon became familiar with the need to be flexible in their choice of strategies and to avoid going too far down the menu if the patient was not ready for it. Some

found it helpful initially to have the menu available (see table 1) on a small card for easy reference during interviews. The list of strategies described below is by no means exhaustive, but simply summarises those thought to be particularly useful in health care settings.

It is obviously essential to establish some degree of rapport with the patient to begin with and, most important, to agree about the value of exploring behaviour change in the first place. Patients are not necessarily expecting or wanting to receive lifestyle advice when they enter the consultation (Stott and Pill, 1990). If other problems are more pressing, then these need to be given priority. Sometimes the subject can be raised with a neutral and non-judgemental question like, "How do you feel about us talking about your use of —, how do you see things, and how does this fit into your everyday life?" References to "your problem", for example, are best avoided. If it feels difficult to broach the subject, use of either of the first two "opening strategies" below can help to bridge this gap, bearing in mind that reluctance from the patient should be respected, even if this means dropping the subject altogether. On the other hand, if it proves easy to raise the subject, we encourage trainees to start with "A typical day" (No. 3) or "The good things..." (No. 4).

1. Opening strategy: lifestyle, stresses and substance use

This strategy involves talking generally about the person's current lifestyle and stresses, and then raising the subject of substance use with an open question like, "Where does your use of — fit in?". People then usually point to the genuinely positive aspects of substance use. This helps the interviewer understand the context in which the substance is used.

2. Opening strategy: health and substance use

Particularly useful in health settings when one thinks that substance use is causing health problems, a general enquiry about health is followed by a simple open question like, "Where does your use of — fit in?" or "How does your use of — affect your health?".

3. A typical day/session

The functions of this strategy are to build rapport, to help the patient talk about current behaviour in detail within a non-pathological framework, and to assess in more detail the degree of readiness to change. Because the interviewer makes no reference to "problems" or "concerns", it is particulary useful with patients who seem not ready to consider change (i.e. the precontemplators). It is also a useful starting point for other more ready patients, since it helps the interviewer understand the context of the behaviour in question, and can produce a wealth of information relevant to assessment.

A typical and recent day or session is carefully pinpointed and the interviewer begins as follows: "Can we spend the next 5-10 minutes going through this day from beginning to end. What happened, how did you feel, and where did your use of — fit in? Let's start at the beginning..." The goal is simply to follow the patient through a sequence of events, focussing on both behaviour and feelings, with simple open questions being the main input from the interviewer.

Pacing is important with this strategy; the interviewer needs to push ahead if the pace is too slow or backtrack if it is too fast. Trainees are advised not to inject any of their own hypotheses about problems. So too, if the patient raises a specific problem, trainees are encouraged to acknowledge this, possibly agreeing to return to it later, and to carry on with the strategy.

4. The good things and the less good things"

This strategy, which is illustrated in Table 2, is often used as an alternative to the strategy described above. It helps to build rapport, provides important information about context, and enables an assessment of readiness to change to be made. Crucially however, it approaches the exploration of concerns even though it avoids using terms like "problem" or "concern". It is therefore suitable for most patients. However, the patient who is not ready to consider change at all will

Table 2:

Strategy outline: "Good things, less good things"

Aim

To explore patients' feelings about the behaviour in question, without imposing on them any assumptions about it being problematic. They, rather than you, identify problem areas or reasons for concern.

Functions

Often used soon after first raising the subject, this strategy serves the following functions:

1. Useful for building rapport, and for understanding context of substance use.
2. Useful with patients who seem unconcerned, or when you are unsure about what they feel about their substance use. Resistance is minimized because:
   - You start with the positive things about person's substance use.
   - You talk about "less good things" rather than "concerns". This allows the patient to identify problem areas without feeling that these are being labelled as problematic.

How to Do It

1. Ask the key question:
   "What are some of the good things about your use of —?"
   These usually emerge quite quickly. Summarize them, if necessary.
2. Ask:
   "What are some of the less good things about your use of —?"
   Elicit these one by one, with the aim of finding out why this patient thinks these are "less good things". Open questions are useful here, for example, " How does this affect you" or "What don't you like about it?"
3. Summarize the good things and the less good things, in "you" language, as succinctly as possible, and leave the person time to react. For example:
   "So, using alcohol helps you relax... you enjoy doing this with friends, and it helps when you are really feeling fed-up. On the other hand, you say you sometimes feel controlled by the stuff and that on Monday mornings you find it difficult to do anything at work."

Note

- Avoid using words like "problem" or "concern", unless the patient does. If this happens, consider moving soon on to the "Exploring Concerns" strategy. Don't assume that "a less good thing" is a cause for concern to patient.
- Keep to task at hand, and avoid raising new topics or hypotheses of your own.
- An alternative format is to ask, "What do you like/dislike about your use of —?".

resist at the point where the "less good things" about behaviour is raised. Under these circumstances the interviewer will be left with little room to move in; the choice will be either to leave the matter to rest for the time being, or to see if the patient is interested in receiving information.

5. Providing information

Giving patents information is a routine part of health care consultations. It can be done with most patients, perhaps with the exception of those who are clearly not ready to consider change. Crucially, however, the way in which information is exchanged can affect the responsiveness of the patient and the outcome of the exercise. This strategy is outlined in Table 3, where emphasis is placed upon three phases of information giving: the readiness of the patient to receive information, its provision in a neutral and nonpersonal way, followed by eliciting the patient's reac-

Table 3:

Strategy outline: Providing information

Aim

To provide information about substance-use in a sensitive manner.

How Not to Do It!

The worst way to provide information is to "wag your finger" at the patient, for example, "You are ....., and if you are not careful, you will....., and then you will find that.....".
With a moralistic tone to your voice, you risk pushing the patient into a corner. They will have no choice but either to agree with you (or pretend to) or to disagree.

How to Do It

1. Choose the right moment and ask permission.
   - Best when patient seems curious, actually asks for information, or is at least not in a defensive frame of mind.
   - Your voice tone should be neutral. If the patient decides not to receive information, that's their choice.
   - Ask permission, for example:
     "I wonder, would you be interested in knowing more about the effect of — on — ?"
2. Provide information in a neutral and non-personal way, referring generally to "what happens to people" rather than to this particular person. Also useful to refer to what experts think, rather than yourself.
3. When finished, ask:
   "I wonder, what do you make of all this? How does it tie in with your use of —?"

Note

- Take your time when discussing the personal implications in Step 3 above.
- Some people don't need or want information: because they already know the facts, or because they are not ready to receive them. That's why it's important to ask permission and gauge their reaction first.
- Giving people potentially "frightening" information does not necessarily motivate them to change. It can have the opposite effect.

tion with an open question like, "What do you make of this?"

6. The future and the present

This strategy can only be used with patients who are at least concerned to some degree about the behaviour in question, i.e towards the right-hand end of the readiness to change continuum. A focus upon the contrast between the patient's present circumstances and the way he or she would like to be in the future often elicits a discrepancy, which can be a powerful motivating force. A useful opening question is, "How would you like things to be different in the future?". This is better than asking clients about their ideal future scenario which is, almost by definition, unachieveable.

After helping the patient to clarify future aspirations, the interviewer can then focus on the present; for example: "What's stopping you doing these things you would like to do?". This will serve to pinpoint areas of dissatisfaction with present circumstances, and it allows the interviewer to ask: "How does your use of — affect you at the moment?" This often leads directly to an exploration of concerns about substance use and the issue of behaviour change.

A similar strategy can be constructed around a comparison between the past and present; here, the aim would be to see whether substance use is contributing to current dissatisfactions.

7. Exploring concerns

This is the most important strategy of all, since it provides a framework for pursuing the goal of motivational interviewing, that of eliciting from the patient their reasons for concern about substance use (see table 4). Obviously, it can only be used with patients who do have concerns. It involves listening carefully to what they are saying, following their lead, and intervening at appropriate moments to nudge the discussion a step forward. The opening question assumes that the patient does have concerns to talk about, and therefore cannot be used with someone who is not contemplating change (table 4).

After following the patient's answers to the opening question, this strategy simply involves summarizing the first concern and then asking, "What else, what other concerns, do you have?", and so on until all concerns have been covered. The strategy ends with a summary which highlights not only these concerns but also the positive benefits of substance use; this is done to bring out the contrasting elements of the patient's ambivalence conflict.

Part of this conflict usually involves wondering what it would be like if a change in behaviour were to take place. Therefore, a near-identical strategy can be constructed around concerns about behaviour change. The opening question would simply be something like: "What concerns do you have about no longer using —?".

8. Helping with decision-making

This strategy can only be used with patients who indicate some desire to make a decision to change. It is often used following strategy No 7 above, when conflict about ambivalence is clearly manifest. This will usually be accompanied by a noticeable change in mood, and the person will seem close to decision-making. At this delicate stage, a push too far from the interviewer will produce a retreat from the patient. Therefore an opening question like, "Where does this leave you now?", being neutrally-worded, is more useful than a question like, "What are you going to do now?".

The dialogue that follows this kind of question should be characterized by reciprocity, in which the interviewer allows the patient to

Table 4:

Strategy outline: "Exploring concerns"

Aim

To help patients express for themselves what concerns they have about their substance use.

Functions

This is a key strategy, often the foundation for building motivation. It highlights elements of the ambivalence conflict, and can lead to the generation of discrepancy - a sense of discomfort - which often precedes the decision to make a change. It can only be used with patients who are concerned about their behaviour.

What To Do

1. Ask the key question:
   "What concerns do you have about your use of —?"
   * Explore in detail whatever concern is raised. (If more than one concern is raised simultaneously, take them one at a time). Use open questions and reflective listening.
   * Summarize this concern (in "you" language). Highlight contrast with the "good things" about substance use for this person.
2. Ask:
   "What other concerns do you have about your use of —?"
   * Explore in detail, as above.
   * Summarize both this and the first concern, and highlight the "good things" as well (if appropriate).
3. Ask:
   "What else, what other concerns do you have....?"
   * Explore, as above.
   * Having covered all concerns, summarize them and highlight contrast with good things about drinking.

Reminders

* Don't rush. Use simple open questions to encourage patient: e.g. "Why does this concern you?", "Can you give me an example?", "What concerns you the most about this?".
* Don't move too far away from exploring concerns.
* Highlighting discrepancy, often most evident after using this strategy, can lead to discomfort. Be supportive, and don't rush the person into a decision to change. Let them raise this topic.

move back and forth between contemplating change and staying the same. Care should be taken to offer support and information without falling into the "expert problem-solver trap", in which the interviewer, often relieved that the patient is ready to change, harnesses his or her wisdom and expertise and simply tells the patient what to do and how to do it. It is possible to provide information and concrete advice without undermining the patient's autonomy. To this end, we encourage trainees to adhere to eight key guidelines when helping with decision-making (Table 5).

Table 5:

Guidelines for helping with decision-making
* Do not rush patients into decision-making. * Present options for the future rather than a single course of action. * Describe what other patients have done in a similar situation. * Emphasize that "you are the best judge of what will be best for you". * Provide information in a neutral, non-personal manner. * Failure to reach a decision to change is not a failed consultation. * Resolutions to change often break down. Make sure that patients understand this and do not avoid future contact if things go wrong. * Commitment to change is likely to fluctuate. Expect this to happen and empathize with the patient's predicament.

The training of health care workers

Whatever its length, training in using the above menu of strategies has involved providing an overview of the method, followed by supervised practice of selected strategies in role-play. After outlining and demonstrating the strategy, trainees then practice in a small supervised group, ideally with only 3-5 people in the group, followed by feedback, more practice, and so on. Sometimes the size of a group is unavoidably large, in which case a variant of the "fishbowl technique" is employed in which a team of interviewers work together on a role-play patient under the supervision of the trainer (see Miller and Rollnick, 1991).

The provision of a one-off training course has serious limitations. The gap between learning in role-play and everyday clinical practice is better bridged by spreading the training over a series of 2-3 hour sessions covering a number of weeks. This allows trainees to practise with real patients, and to review progress and problems accordingly.

Implications for health care practice

This method has been criticised by specialists for being too simple and prescriptive, and by general health care workers for being too complex! The gulf between specialist technique and general health care practice is thus a large one, and there is little room for dogmatism about how best to fill it, since this is a new area of work. It is not intended here to present brief motivational interviewing as the best or only way to fill this particular gap. The concern about complexity can be dealt with by replacing the strategies with a series of useful questions to ask of patients, which at least ensures that the consultation remains patient-centred (see examples in Richmond et al, 1991; Williams et al, 1991). Concern about the method being too prescriptive could be based on a misunderstanding of the role of the strategies illustrated in this paper. They are used in training in a sharp and clear form so as to maximize the likelihood of transfer to everyday practice. Having practised these strategies trainees are actively encouraged to adapt them to suit their own needs.

Some trainees say that they prefer to use a simpler approach based on straightforward advice-giving. In teaching we try to avoid polarizing matters by pointing out, for example, that the "Typical Day" strategy can be easily used alongside a more directive approach. So too, we find most trainees generally responsive to the observations that patients vary in their degree of readiness to change, that decision-making is a process rather than an all-or-nothing event, and that flexibility is an important component of good interviewing.

One ever-present issue is that of limited time to receive training and to spend with patients. Both the training package and the approach itself are amenable to simplification in the interests of time. However, one could argue that the concern about time is misplaced. Practitoners who spend so much of their working lives negotiating behaviour change on so many levels should be properly trained in the sensitive use of behaviour change techniques. Seen in this light, 12-15 hours of training is far from adequate. So too, when it comes to their patients, we believe that 5-15 minutes of carefully-used time, preparing someone for the possibility of behaviour change, could lead to better outcomes and, in fact, save time compared with the often rushed attempts to give advice to patients who are not ready to receive it.

A criticism sometimes aired is that this method is so unstraightforward as to be downright manipulative. We would acknowledge that, handled badly, without the practice of empathy which is fundamental to motivational interviewing, the interviewer might indeed end up pushing and prodding the reluctant patient. If this were to happen, the patient would understandably resist, and we teach our trainees to pay careful attention to resistance. In general, however, we believe that if empathy is practised, and if the interviewer remains neutral and continually aware of the patient's degree of readiness to change, then this method is a sensitive way of dealing with the difficult business of negotiating behaviour change.

Increasing emphasis is being placed upon health promotion in primary health care settings. In the United Kingdom, for example, general practitoners are now being paid additional bonuses for doing this work, much of which is probably carried out using some variant of advice-giving. In the absence of training and the careful evaluation of patient satisfaction and outcome, the obvious danger is that quality is sacrificed in the interests of simply taking patients through the system.

Whether brief motivational interviewing leads to better outcomes than simple advice-giving is yet to be clearly established. Insofar as it is compatible with patient-centred interviewing styles found to be related to good outcome (see Kaplan et al, 1989; Ockene et al, 1991; Stewart & Roter, 1989), there are certainly good grounds for testing this hypothesis. Patient satisfaction with the consultation should be one of the key outcome measures used. Our own research is currently looking at a comparison between this method and a skills-based approach among hospitalized excessive drinkers.

One new development will be the extension of this method to use with patients who have passed through decision-making into the "action stage". These people often experience fluctuating commitment which might need attention. A menu of strategies linked to the action stage would enable commitment problems to be tackled and would also ensure that concrete action plans remain client - rather than practitioner - directed.

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Reprints from Mr. S. Rollnick currently based at the Department of Clinical Psychology, Whitchurch Hospital, Cardiff, Wales.