MOTIVATIONAL PRACTICE
PROMOTING HEALTHY HABITS AND SELF-CARE OF CHRONIC DISEASES

Richard J. Botelho, B.Med.Sci., B.M., B.S., M.R.C.G.P. (UK)
Professor of Family Medicine and Nursing,
University of Rochester School of Medicine and Dentistry
Rochester, New York

Contributing Author (Chapters 1, 6 and 7)
Harvey Skinner, Ph.D.
Chair and Professor of Public Health Sciences
Department of Public Health Sciences
Toronto, Ontario

MHH Publications

Richard J. Botelho
University of Rochester School of Medicine and Dentistry
Rochester, New York 14620 USA

First edition published 2002
(Beyond Advice: 1.Becoming a Motivational Practitioner and 2.Developing Motivational Skills.)
Second edition 2004.
(This edition appears as a new title and is based on the above book series.)
Printed in the United States of America

Visit www.MotivateHealthyHabits.com to obtain contact information and

- *Learn more and get more support from a newsletter*
- *Listen to audio or watch videos*
- *Inquire about training programs, online courses and consultations*
- *Learn about the books for practitioners and lay health coaches*

CONTENTS

Tables

Figures

Learning Exercises

PREFACE

I am a British-trained general practitioner who has been teaching academic family medicine in the United States for over 20 years. During the past 10 years, I have done research and development in process improvement work on health behavior change. This work is part of my never-ending journey of learning how to change practitioner and patient behavior, with the goal of promoting healthy habits and self-care of chronic diseases. I hope that this book will expand my network of colleagues who share a passion for advancing and integrating this marginalized field into mainstream health care.

Students and practitioners can use this book to learn when and how to change from the advice-giving (fix-it) role to a motivational role. To assist them with this process, I have synthesized evidence, experience and wisdom from multiple sources—patients, students, colleagues, health care practitioners and expert educators, as well as integrated pragmatic approaches from selected theories, models and concepts together with research evidence from different disciplines. These eclectic resources are organized within a six-step, problem-solving approach to provide some coherence to a complex field. This clinical framework can assist practitioners with initiating the lifelong learning process of enhancing their ability to engage patients in change dialogues.

However, the magnitude of unhealthy behaviors in the general population is far too big for the health care system alone to treat everyone. Mutual aid and self-help (MASH) approaches are needed. I have also written a MASH guidebook, *Motivate Healthy Habits: Stepping Stones to Lasting Change,* to assist your patients with self-directed change (with or) without your professional assistance. This book taps into the most important yet underutilized resources: families and friends working on health behavior change in a grassroots manner.

In Foreword 1 of this book, Dr. Ian McWhinney describes the importance of learning about the therapeutic value of dialogue in helping patients change. In Foreword 2, Dr. Kirsti Lonka describes the introspective process of "higher learning" with respect to the personal and professional context of motivating behavior change.

ACKNOWLEDGMENTS

I would like to thank Ceil Goldman and Barbara Coster for their editorial support, Steve Marcus for his secretarial support, Hilliard Jason and Jane Westberg for their educational expertise, and my patients, students and professional colleagues, who contributed in countless different ways over many years.

FOREWORD 1
How to Motivate Healthy Behaviors

The information and advice we convey to our patients is often ineffective. A knowledge of risk factors alone seldom dissuades people from smoking, excessive alcohol consumption, overeating, high-risk sexual behavior or substance abuse. Knowledge itself does not change behavior. Type 2 diabetes, for example, is increasing in many Western countries, driven by epidemic obesity and physical inactivity. Yet in clinical trials, lifestyle changes (exercise, diet and weight reduction) in people with impaired glucose tolerance can reduce the incidence of type 2 diabetes by 50-66%.[1]

Why is it so difficult to apply our knowledge? The guidelines are available and quite straightforward. If results can be obtained in the tightly controlled world of the randomized trial, why can they not also be obtained in the world outside? It is tempting to blame primary care physicians, their patients or both. But let us at least consider that the way medicine is being practiced and taught is part of the problem. We practice a medicine based on the metaphor of the body as machine. Our logic is of linear, unidirectional causal chains, and our notion of therapy is a technology of control. The mechanistic approach to medicine extends not only to treatment but also to behavior modification based on control, reinforcement, conditioning and social engineering—an approach that overlooks human decision-making and autonomy. Not surprisingly, this approach has significant limitations when it comes to promoting healthy behavior and the self-care of chronic disease.

Most guidelines are the product of linear logic. Problems arise when linear logic meets complexity in the form of patients with their thoughts, beliefs, assumptions, expectations, emotions and relationships. This complexity is the reality of medical practice, and Rick Botelho's motivational approach is designed to deal with this reality. His groundbreaking book springs from advances in psychology and moves beyond the linear logic of control and behavior modification.

The sciences of complexity and organization provide a context for understanding the nonlinear process of change for both practitioners and patients. The work also challenges the simplistic notion of a unidirectional translation of research into practice, thus transcending the research-practice divide. This book liberates practitioners from the constraints of evidence-based guidelines without ignoring the guidelines' significant contributions.

We cannot continue to think only in terms of single causes, single-point interventions and predictable outcomes. When linear logic meets the nonlinear logic of complexity, meanings must also be considered. As Dr. Botelho says, giving advice (the "fix-it" role) is not enough. Patients have to be engaged where they live. It is not easy to

change oneself: there have to be good reasons, and the motivation to change has to come from the heart as well as the head. We are all—practitioners and patients—very good at self-deception, at finding reasons (rationalizations) for avoiding change.

For practitioners educated in the fix-it role, adopting a motivational role requires a major shift from "doing" to "being" with patients. As Dr. Botelho so rightly says, going through behavior change ourselves can help us to empathize with patients facing similar changes. The self-knowledge that comes from reflection on experience can help us to sense the appropriate role for us to adopt for a particular patient at a particular time. In adopting the motivational role, we acknowledge that, for all of us, change has to come from within. We cannot enforce change in our patients, but we can, with their agreement, help them to work through the process, clarifying their thoughts and expectations, identifying sources of resistance, pointing out inconsistencies and correcting misconceptions.

We are fortunate in having a body of knowledge on motivation and behavioral change from other disciplines, and Dr. Botelho makes very good use of this knowledge. There are skills here that can be learned, and the format of the book helps by being that of a workbook. A step-by-step approach takes the reader through the process of motivational practice, using many case examples, strategies and exercises. This book lends itself to being studied alongside clinical practice. I visualize the reflective practitioner changing gradually as he or she goes from patient to book and back to patient, until mastery is achieved, the knowledge and skills internalized and a lasting transformation accomplished.

The book has great relevance for the patient-centered clinical method, recently conceived and developed as a successor to the method that has dominated modern medicine.[2] The previous method laid its greatest emphasis on diagnosis, as exemplified by the clinical-pathological conference. A clinician is presented with a case report and develops a differential diagnosis, which is then confirmed or otherwise by the pathologist. The injunction given to clinicians is "Either make a physical diagnosis or exclude organic pathology." With its predictive and inferential power based on organic pathology, the method has great strength. On the other hand, it makes the tacit assumption that therapy follows naturally from diagnosis. Although such is often the case, the method has little to say about the complexities of management or about the many situations in which no conventional diagnosis is appropriate. For many people, their health status is the outcome of many interrelated, complex factors, including economic, social, cultural, educational and attitudinal issues that intersect with their biological condition.

The patient-centered clinical method is designed to deal with complexity. Like the previous method, it gives clinicians a number of injunctions.[3] "Ascertain the patient's expectations" recognizes the importance of knowing why the patient has come.

"Understand and respond to the patient's feelings" acknowledges the crucial importance of the emotions. "Make or exclude a clinical diagnosis" recognizes the continuing power of correct classification. "Listen to the patient's story" recognizes the importance of narrative and context. "Seek common ground" enjoins the physician to mobilize the patient's own powers of healing. Seeking common ground is the key to therapeutic success: the method requires it but does not indicate the skills required to achieve it. With this book, Rick Botelho has fulfilled this purpose.

Pedro Lain Entralgo,[4] one of the foremost scholars of the history of clinical method, has reminded us that a part of the Hippocratic tradition was a "therapy of the word," whereby the physician tried to influence the patient to take the measures necessary to recover from his or her illness. The therapy called for all the physician's skill in rhetoric. Far from being an exercise in coercion, this was based on the skill of helping the patient to see what was in his or her own interest. Rhetoric at one time was regarded as one of the foremost and most difficult arts, worthy of its place in a classical education and in the curriculum of the medieval university, before the term and its meaning became debased in our own time. Dr. Botelho is teaching us a new therapy of the word.

I. R. McWhinney, O.C., M.D., F.R.C.G.P, F.C.F.P, F.R.C.P
Professor Emeritus
Department of Family Medicine
The University of Western Ontario
London, Ontario, Canada

REFERENCES

1. Pinkney J. Prevention and cure of type 2 diabetes. British Medical Journal 2002;325: 232-233
2. Stewart M, Brown JB, Weston WW, et al. Patient-centered medicine: Transforming the clinical method. Thousand Oaks, CA: Sage Publications; 1995
3. McWhinney IR. Textbook of family medicine, 2nd ed. New York: Oxford University Press; 1997
4. Entralgo P. The therapy of the word in classical antiquity. New Haven, CT: Yale University Press. 1961

FOREWORD 2
How to Motivate Healthy Learning

Knowledge about the best evidence does not necessarily change our professional behavior.[1;2] Even when we use evidence-based interventions (such as providing information and advice), our patients do not necessarily change their behaviors. Most of us are not well educated in how to motivate patients who resist these interventions.

The process of developing motivational skills involves higher learning about ourselves and our patients. It involves reflecting about assumptions, perceptions, mental maps (ways of thinking), and exploring our feelings and differences in values. To initiate this process of continuing professional development (CPD), you can use this book and the accompanying guidebook (described below) to address personal and professional changes that underpin the lifelong learning process of enhancing motivational skills.

- ***Personal change.*** Learn how to change yourself before helping others. The mutual aid and self-help guidebook *Motivate Healthy Habits: Stepping Stones to Lasting Change* invites you to change one of your own health behaviors. This book guides you through an experiential process of learning about change concepts that you can then use to help others.

- ***Professional change***. Learn how to change your professional role from being a fix-it health adviser to being a motivational practitioner. This book describes a six-step approach that can help you to transform your professional role and to develop the art of dialogue with patients.

This process of higher learning prepares you to address the challenges and complexities of change when collaborating with your patients to create shared learning opportunities. Let me clarify how these books use two strategies synergistically in groundbreaking ways that epitomize what higher learning is all about.

Strategy 1. Use introspective journaling as part of your learning portfolio

In this information overload age, continuing professional education predominantly focuses on keeping up-to-date with the latest scientific discoveries. The major focus is on providing content. The self or the inner experience of the individual learner is at risk of drowning in a sea of overwhelming content. The neglect of self dehumanizes learners and places them at high risk of professional burnout, thereby losing the heart and soul of caring. Increasing considerations are given to our professional and personal growth.[3;4] We also need to develop process skills to help patients learn how to improve their health.[5]

This book integrates improvement cycles as part of the journaling process for creating your learning portfolio (a compilation of personal evidence about your ongoing

professional development).[6-8] Each chapter offers you the opportunity to write a brief summary about what learning was new for you and how this new learning will change what you do. These assignments encourage you to find your personal voice by writing in the first person (I) rather than in the third person (he, she or it).

Research shows that writing is a powerful tool for this kind of higher learning.[9] However, introspective journaling goes against traditional education in health care, and students and practitioners are reluctant to engage in such a learning opportunity. And yet, it is one of the most potent ways of enhancing their continuing professional development.

Strategy 2. This book inverts the traditional hierarchy of learning

European researchers have developed a hierarchy of learning categories, ranging from superficial to deep.[10-12] A reformulation of these categories, as they relate to behavior change, is as follows:

- ***Passive***. Learners remember new facts and information from external sources
- ***Active.*** Learners acquire knowledge from external sources and reformulate the information in a personalized way
- ***Applied.*** Learners acquire knowledge, principles and ideas for a practical purpose, such as solving problems
- ***Meaningful.*** Learners discover new perspectives and ideas to understand the complexity underlying the change process
- ***Interpretative.*** Learners reflect about and change their attitudes and views through the process of reconstructing their mental maps

As lifelong learners, we can continually refine our mental maps to deepen our understanding about the complexities of our clinical work, including the change process. The transformation from a novice to an expert on behavior change involves a continuous improvement process[13-15] as well as the development of emotional awareness when working with patients.[3;5] Such a learning process can enhance our capacities to help our patients find their own motives to sustain constructive behavior change.

A deeper level of learning has been added to the categories described above: *personal and professional change.*[16] Ideally, we should undergo deep change as the consequence of engaging in any significant learning process. The self-awareness process that is encouraged in this book series involves reflecting about ourselves and our patients in ways that can enable us to work with them most effectively.[4;5]

This orientation and approach are what I find particularly appealing about Dr. Botelho's work. These books incorporate the principles of modern learning theories. The CPD process used in these books begins with self-focused change, both in your personal and your professional life. Then you learn a method to expand your range of skills as a motivational coach. To work in patient-centered ways, you can use your expanded range

of skills to understand better your patients' thoughts, feelings, perceptions and values and to develop an individualized process of engaging patients in the change process over time.

This "process" textbook is an invaluable resource. After reading this book, you can refer back to appropriate sections when you get stuck while working with a patient. Section IV provides key content and specific suggestions for initiating dialogues with patients about tobacco cessation, alcohol risk and harm reduction and self-care of chronic diseases, as illustrative examples, but this process can be expanded to any unhealthy behavior. You will probably find that it works best to use this book as part of an ongoing learning process, using improvement cycles (see Introduction) repeatedly over time by incorporating specific suggestions into your practice. The book can also help you initiate a learning portfolio, so that you can gather evidence about the impact of this learning process on your CPD and your work with patients.

I had the pleasure of participating in one of Dr. Botelho's workshops. I have seldom observed how the application of educational principles and methods fits so well with modern learning theories. (View the videotape used in this workshop at www.MotivateHealthyHabits.com.) He is also developing online courses based on his books, so that professional bodies and educational institutions can develop formal curricula to address this major deficiency in professional education. Ideally, students and practitioners need longitudinal curricula and continuing professional development opportunities to become better motivational coaches. This increases the chances for us to develop a learning organization, where professionals create a shared vision about patient care.[17]

This book on motivational practice captures what higher learning is all about: the cognitive, emotional, perceptual and ethical aspects of personal change. Health care professionals of the 21st century can use this book and the guidebook to assist themselves and their patients in the change process. Dr. Botelho's work gives us all hope that it is truly possible to make modern learning theories work in action, for both practitioners and patients.

Kirsti Lonka, Ph.D.,
Professor of Medical Education
Karolinska Institute, Stockholm, Sweden

REFERENCES

1. Davis DA, Thomson MA, Oxman AD, et al. Changing physician performance. A systematic review of the effect of continuing medical education strategies. Journal of the American Medical Association 1995;274: 700-705
2. Davis D, Evans M, Jadad A, et al. The case for knowledge translation: Shortening the journey from evidence to effect. British Medical Journal 2003;327: 33-35
3. Hager P, Gonczi A. What is competence? Medical Teacher 1996;18: 15-18
4. Schon DA. Educating the reflective practitioner. Toward a new design for teaching and learning in the professions. San Francisco: Jossey-Bass Publishers; 1987
5. Makoul G. The interplay between education and research about patient-provider communication. Patient Education and Counseling 2003;50: 79-84
6. Lonka K, Slotte V, Halttunen M, et al. Portfolios as a learning tool in obstetrics and gynaecology undergraduate training. Medical Education 2001;35: 1125-1130
7. Parbooshingh J. Learning portfolios: Potential to assist health professionals with self-directed learning. The Journal of Continuing Education 1996;16: 75-81
8. Snadden D, Thomas M. The use of portfolio learning in medical education. Medical Teacher 1998;20: 192-199
9. Tynjala P, Mason L, Lonka K. Writing as a learning tool: Integrating theory and practice. Studies in Writing, Vol. 7. Dordreth, The Netherlands: Kluwer Academic Publishers; 2001
10. Entwistle N, Ramsey P. Understanding student learning. London: Croom Helm; 1983
11. Lonka K, Joram E, Bryson M. Conceptions of learning and knowledge: Does training make a difference? Contemporary Educational Psychology 1996;21: 240-260
12. Lonka K, Ahola K. Activating instructions. How to foster study and thinking skills in higher education. European Journal of Psychology of Education 1995;10: 351-368
13. Chi MTH, Glaser R, Farr MJ. The nature of expertise. Hillsdale, NJ: Erlbaum; 1988
14. Glaser R, Bassok M. Learning-theory and the study of instruction. Annual Review of Psychology 1989;40: 631-666
15. Schmidt HG, Boshuizen HPA. On acquiring expertise in medicine. Educational Psychology Review 1995;5: 205-221
16. Marton F, Dall'Alba G, Beaty E. Conceptions of learning. International Journal of Educational Research 1993;19: 277-300
17. Senge PM. The fifth discipline: The art and practice of the learning organization. New York: Doubleday; 1990

INTRODUCTION

Let's use the tobacco pandemic as the leading example of how health care systems and the scientific community underestimate the complexity of changing behavior. The tobacco pandemic will reach its peak in 20 to 30 years and kill one in eight persons worldwide (20 million to 30 million deaths per year), with 70% of these deaths occurring in the developing countries. This global threat far exceeds the negative impact of all acts of wars and terrorism, alcoholism, drug abuse and HIV disease combined. Yet, despite these shocking facts, young people are still relentlessly initiating this addictive, lifelong habit. We provide inadequate guidance to our youth in how to deal with the manipulative influences of the tobacco companies, popular media and negative peer influences.

How do tobacco marketers take this deadly product and sell it as a pleasure? They use sophisticated methods to manipulate human beliefs (e.g., smokers deceive themselves into believing that tobacco relieves their stress, when in fact nicotine addiction adds to it).

So, what is the power of the tobacco industry's emotional appeals? They exploit human vulnerability by creating positive biases toward tobacco—associating images of pleasure, sexuality and/or attractive identities with smoking and targeting this association to an individual's needs, wants, desires, vanities, aspirations and/or fantasies in an implicit and meaningful way. They hook youth on tobacco during their vulnerable stages of development. They masterfully develop dynamic approaches with new angles on positive biases to influence health beliefs and to promote smoking behaviors. They produce spectacular results in the real world, without generating any hard evidence from randomized controlled trials about how marketing actually works.

In contrast, the scientific approach in health care is based on the premise of minimizing or removing biases in research studies: in effect, taking a neutral, factual and skeptical stance, in sharp contrast to tobacco marketers. The scientific community develops hard evidence from randomized controlled trials, but this evidence does not translate into significant results at a population-based level. For example, the smoking cessation guideline that uses the five A's model (ask, advise, assist, assess and arrange follow-up) relies on practitioners providing information and advice to patients. The impact of this guideline on cessation rates varies from 2-10%, depending on the duration of the intervention. But this guideline doesn't use sophisticated emotional appeals and negative biases against tobacco use, a strategy that goes against the grain of scientific impartiality of being bias-neutral. Because the factual evidence does not support it, the guideline provides little assistance in how practitioners can

- Work with adolescent smokers
- Help smokers in precontemplation
- Motivate patients who do not respond to the five A's approach

Many practitioners tire of or stop using this guideline protocol in any systematic way, for a variety of legitimate reasons. What we need are new, dynamic and innovative ways of engaging all smokers in the change process, using the best available evidence and state-of the-art practices. In particular, we can use emotional appeals and biases that marketers use for tobacco initiation and apply them in the opposite direction to help patients work on the emotional aspects of tobacco cessation. But these techniques alone are not sufficient, because tobacco cessation is far more complex than its initiation. In addition to treating nicotine addiction, we need more sophisticated behavioral interventions. One approach (based on multiple methods) can be found in motivational practice. This approach provides practitioners with a wide range of interventions to address smoking cessation and other behaviors such as

- *Risk behaviors:* excessive alcohol use, illegal drug use, obesity, unhealthy diets, lack of exercise, unsafe sex and unwanted pregnancies
- *Disease management*: nonadherence to medication and treatment recommendations, suboptimal self-care of chronic diseases and failure to attend follow-up appointments
- *Preventive measures*: immunizations, mammogram and pap smears and injury prevention

WHAT IS MOTIVATIONAL PRACTICE?

This interdisciplinary book addresses how practitioners can learn to develop individualized interventions that meet patients' changing needs over time. The clinical approach of motivational practice builds on the shoulders of these trailblazers:

- Self-efficacy theory: A. Bandura[1-4]
- Transtheoretical model of change: J. Prochaska and C. DiClemente[5-7]
- Motivational interviewing: W. Miller and S. Rollnick[8;9]
- Self-determination theory: E. Deci and R. Ryan[10]
- Relapse prevention: G. Marlatt and J.Gordon[11]
- Solution-based therapy: S. De Shazer[12-15]
- Patient-centered approaches: M. Steward and colleagues[16]

No single theory, model or clinical approach has a monopoly on clinical effectiveness in predicting positive outcomes, but clearly some clinical approaches peak in popularity, and some fade over time as the field advances. The concept of self-efficacy has shown some durability but it has limitations (as described in Chapter 7). A systematic review (www.ncchta.org/fullmono/mon624.pdf) of interventions based on the stages of change model has questioned its effectiveness in promoting behavior change. Motivational interviewing has gained stature and popularity with a supportive foundation of evidence.

(For those interested in exploring different perspectives on evidence and the concept of translational research, go to www.MotivateHealthyHabits.com to download two chapters that address these issues in more detail.)

To assist you with the limitations of current evidence, this book incorporates state-of-the art clinical practices and learning processes that involve

- Using continuous innovation, testing and evaluation of individualized interventions
- Applying motivational principles for overcoming the knowledge-behavior gap (e.g., "I know what to do but I don't do it")
- Developing the art of dialogue (nonlinear, dynamic processes) to address cognitive-emotional dissonance (e.g., "I think I should change but don't feel like it") and so-called irrational behavior
- Incorporating learning portfolios (e.g., gathering personal evidence about developing motivational skills) into your continuing professional development

Consider exploring your professional role, mental maps (ways of thinking) and assumptions before developing your motivational skills. This premise may help you learn how to work more effectively and efficiently with patients. You may even have to unlearn some of your training-of-origin perspectives so that you can expand your repertoire of skills. This process can challenge your assumptions and evoke emotional reactions, such as ambivalence or even resistance to the introspective process.

Instead of imposing a concept/model/theory-driven worldview on patients, you learn how to work from the patients' worldviews and select theories and models that fit into their worldviews rather than the other way around—making patients fit into a particular mould. This learning process can help you develop individualized interventions that activate patients to become researchers of their own behavior change and learn new ways of acting in their best interest.

Do not quench your inspiration and your imagination;
do not become the slave of your model
—Vincent Van Gogh

May this quotation inspire your creativity and sustain your enthusiasm for lifelong learning on how to help patients change.

AN OVERVIEW OF WHAT YOU COULD LEARN

Section I explores how cultural, personal and professional issues affect the change process in patients. Scientific rationality lacks sophistication in addressing human irrationality and in dealing with otherwise knowledgeable patients who lack the critical factor: motivation. Chapter 1 highlights the limitations of the rational, scientific approach in providing health information and advice to patients about changing their unhealthy behaviors, and explores key concepts, models and ideas for addressing common, everyday situations. Chapter 2 offers a case study that contrasts the advice-giving or fix-it approach with a motivational one. The aim here is to highlight the merits of adopting a motivational role. Chapter 3 explores the implications for patient change based on which role you adopt—the fix-it, preventive or motivational one. Each of these roles is defined according to its characteristics, functions and boundaries to examine how they differ in helping patients change their behavior. Chapter 4 examines how assumptions can help or hinder the change process for the patient.

Section II is an overview for understanding and facilitating individual change. Using a Forces of Change model, you learn how both individual and systems factors can generate positive and negative forces for change (Chapter 5). More specific attention is then given to understanding the individual dynamics of resistance (Chapter 6) and motivation (Chapter 7) from different perspectives. These three chapters help you become familiar with the key theories, models and concepts that have shaped the development and practical applications of the six-step approach. To prepare for using the materials in Section III, Chapter 8 is an overview of the six-step approach with an example of a practitioner-patient partnership working toward behavior change and using this approach as a mental map for thinking about how to motivate behavior change.

Section III describes in detail the six-step, interdisciplinary approach for negotiating behavior change with patients. A chapter is devoted to each of the six steps, describing micro skills that you can use for addressing a broad range of health behaviors in health promotion (e.g., physical activity), disease prevention (e.g., smoking cessation, regular mammograms), chronic disease management (e.g., diabetes) and injury prevention (e.g., the use of car safety belts). Though you will become familiar with a wide range of micro skills used in this method, you still need to learn how to use these skills in an effective, patient-centered way.

Section IV specifically addresses tobacco use, excessive alcohol intake and self-care of diabetes. Consider doing an in-depth study of a specific behavior so that you can learn how to generalize this approach to other behaviors. You can also use these chapters when you get stuck with patients to identify new ideas for interventions.

An interdisciplinary note

I use the term *practitioner* to describe all professionals who help patients to change: physicians, physician assistants, nurse practitioners, nurses, psychologists, therapists, community and public health workers, social workers and allied health professionals. All members of your health care team can benefit from learning how to become motivational practitioners and can adopt a variety of roles when working with patients. In the examples and stories in this book, I have used the abbreviations FP, PP or MP (and Dr. F., Dr. P. or Dr. M) to represent the fix-it, preventive or motivational role for practitioners (and physicians).

In the text of this book, I have used the first person (we) and second person (you) to describe the fix-it and motivational roles, respectively. As practitioners, we all assume the fix-it role, but when it is not working, you can opt for adopting a motivational role. This personal style of writing sets a tone that aims to engage you in the change process in ways that you may replicate with your patients.

HOW TO USE THIS BOOK

Motivational skills are fundamental core competencies for all health care practitioners. Yet this topic is inadequately or poorly addressed in health care education. Instead, you are left to learn on the job. This book could have a cascade of positive benefits on your continuing professional development by

- Reducing your frustration in working with so-called resistant patients
- Enjoying engaging patients in dialogues about change over time
- Developing individualized approaches to meet patients' changing needs
- Enhancing patients' readiness to change
- Improving patient outcomes

Ideally, you would use a variety of ongoing learning opportunities to enhance your motivational skills over time: self-directed learning; online group learning (see www.MotivateHealthyHabits.com); longitudinal skills-based training opportunities in small groups led by supervisors or facilitators; direct observation with simulated and actual patients with feedback and evaluation; and in-depth learning experiences working with a small number of patients on behavior change over one to two years.

You can use this book to initiate the process of creating a learning portfolio. The story about the race between the turtle and hare is an apt analogy for understanding different ways of using the book. If you race through this book (like the hare), you may only gain a superficial understanding about individualizing interventions for patient care, and that limited understanding may constrain your ability to enhance motivational skills.

On the other hand, you can use the way of the turtle: take your time in reading this book and learn more from your journey as you go along. Experiment in applying new ideas and concepts in your clinical work and learn from those experiences. Introspective journaling can further enhance your continuing professional development. This process of higher learning (as described by Dr. Lonka in Foreword 2) can help you gain an in-depth understanding about how to enhance your ability to engage patients in change dialogues. However, many practitioners are reluctant to engage in such a learning process because it takes hard work to change (just like our patients).

To assist you with this learning process, each chapter begins with a question or brief statement that helps you focus on what you can learn from reading this chapter. Case examples and learning exercises are provided throughout to help you better understand key concepts, principles, strategies and interventions for motivating change. Questions are also posed at the end of each chapter with space given for writing a summary about your new learning and its potential impact on working with your patients. This book invites you to journal your learning process about changes in yourself and in your clinical work. Consider using the PARE improvement cycle as you read (and hopefully revisit) chapters of this book over time.

- **P**repare: Set a flexible timetable for reading these chapters that gives you time to experiment in applying new ideas and concepts in your clinical work.
- **A**ct: Consider highlighting areas with a yellow marker and making notes in the margins to help you write summaries for the next phases of the learning cycle.
- **R**eflect: Write a summary (in 200 words or so) about what you learned that was new for you. Write in the first person (I) about your internal reactions to the material rather than reiterating the text of the book (it).
- **E**nhance: Write down your ideas (in 100 words or so) about how your new learning could improve what you do with your patients.

These notes will help you gather personal evidence about your continuing professional development.[17] For example, your notes may refer to changes in your mental maps, your understanding about your assumptions and roles and the potential application of new ideas, metaphors, concepts, models and theories. You can add these notes to build your learning portfolio. Whether or not you are willing to make a commitment to this journaling process, you can still assess whether you gained any of the benefits mentioned on the previous page. Whatever you decide, this learning process needs to be considered within a much larger context.

AN ECOLOGICAL PERSPECTIVE

An ecological approach to engaging and activating individuals, families, organizations, communities and systems is needed to promote healthy habits and self-care of chronic diseases at multiple levels. Such an approach integrates macro (policy), meso

(organizational) and micro (individual) strategies with multimodal methods to generate synergistic collaboration among the top-down (political and administrative), side-to-side (intersectoral) and bottom-up (grassroots) processes.[18] A brief description of these strategies provides a wider context to understand the complexities of disseminating motivational practice into health care and the contributions of this book toward this overarching goal.

MACRO STRATEGIES

Changes in political vision, leadership and public policies establish national organizations to

- Shift the health care agenda and resources from an acute cure paradigm toward health promotion, disease prevention and disease management
- Enforce national and international laws and policies to reduce risk behaviors (e.g., the Framework Convention on Tobacco Control)
- Align financial incentives to quality improvement initiatives in health promotion, disease prevention and disease management
- Develop clinical information technology systems to analyze how process improves outcomes at population-based levels
- Provide data about improvements in performance at organizational and practitioner levels
- Use marketing strategies to promote the transformation from a disease-producing to a health-promoting society
- Foster the development of intersectoral approaches, community mobilization and grassroots programs

MESO STRATEGIES

Changes in public policies provide the necessary learning resources to support the continuing professional and organizational development that is needed to enhance health promotion, disease prevention and disease management programs across health care settings, schools and work sites. Such programs enable practitioners to learn how to

- Contribute toward a continuous improvement of their comprehensive programs
- Change from the fix-it, advice-giving role to the motivational role
- Enhance their motivational skills over time
- Link up with community mobilization initiatives and grassroots movements

MICRO STRATEGIES

Changes in the organizational setting, teamwork, professional roles, workflow and clinical information systems are developed to

- Use a spectrum of methods (as described at the beginning of this section) and develop individualized interventions to meet patients' changing needs.
- Use a variety of delivery methods (e.g., individual encounters, group visits, telephonic support and online learning programs)

- Encourage the general public to systematically use mutual aid and self-help (MASH) approaches to behavior change, with or without professional support

Even with ideal political leadership and public policies supporting this ecological approach, individuals ultimately determine the impact of any systematic approach. The quality and effectiveness of the individualized interventions will determine the ultimate success of any program. We cannot wait until such ideal public policies exist before learning how to motivate patients to change their unhealthy habits.

REFERENCES

1. Bandura A. Self-efficacy: The exercise of control. New York: W.H. Freeman; 1997
2. Bandura A. Self-efficacy in changing societies. New York: Cambridge University Press; 1995
3. Bandura A. Social foundations of thought and action. Englewood Cliffs, NJ: Prentice Hall; 1986
4. Bandura A. Self-efficacy: Toward a unifying theory of behavior change. Psychological Review 1977;84: 191-215
5. Prochaska JO, DiClemente CC. Toward a comprehensive model of change. In: Miller WR, Heather N, eds. Treating addictive behaviors: Processes of change. New York: Plenum Press; 1986:3-276.
6. Prochaska JO, DiClemente CC. The transtheoretical approach: Crossing traditional boundaries of therapy. Homewood, IL: Dow Jones/Irwin; 1984
7. Prochaska JO, DiClemente CC. Transtheoretical therapy: Toward a more integrative model of change. Psychotherapy Theory, Research and Practice 1982;19: 276-288
8. Miller WR, Rollnick S. Motivational interviewing: Preparing people to change addictive behavior. New York: Guilford Press; 1991
9. Miller W, Rollnick S, Conforti K. Motivational interviewing, 2nd Edition: Preparing People for Change. New York: Guilford Press; 2002
10. Deci EL, Ryan RM. Intrinsic motivation and self-determination in human behavior. New York: Plenum Press; 1985
11. Marlatt GA, Gordon JR. Determinants of relapse: Implications for the maintenance of behavior change. In: Davidson P, Davidson S, eds. Behavioral medicine: Changing health lifestyles. New York: Brunner/Mezel, Inc.; 1980:410-452
12. De Shazer S. Words were originally magic. New York: W.W. Norton & Co.; 1994
13. De Shazer S. Putting difference to work. New York: W.W. Norton & Co.; 1991
14. De Shazer S. Clues: Investigating solutions in brief therapy. New York: W.W. Norton & Co.; 1988
15. De Shazer S. Keys to solutions in brief therapy. New York: W.W. Norton & Co.; 1985
16. Stewart M, Brown JB, Weston WW, et al. Patient-centered medicine: Transforming the clinical method. Thousand Oaks, CA: Sage Publications; 1995
17. Sweeney KG, MacAuley D, Gray DP. Personal significance: the third dimension. Lancet 1998;351: 134-136
18. Noncommunicable Diseases and Mental Health, World Health Organization. Innovative care for chronic conditions: Building blocks for action. Geneva, Switzerland, World Health Organization: 2002.

SECTION I

CONSIDER CHANGING YOURSELF BEFORE HELPING OTHERS

Chapter 1 invites you to learn about improving your own health behaviors and transforming your professional role before learning how to help patients change. A case study in Chapter 2 contrasts how a fix-it and a motivational practitioner deal with the same patient. The purpose of this example is to emphasize the advantages of a new role rather than to illustrate the limitations of the traditional role for addressing behavior change. Chapter 3 describes a conceptual framework for better understanding how you can adapt your role to meet patients' needs. Chapter 4 explores how assumptions can either hinder or facilitate the change process for patients and their families. Over time, you can discover for yourself whether this premise (change yourself before helping others) helped you become a more effective and efficient motivational practitioner.

CHAPTER 1
WHEN GIVING HEALTH INFORMATION AND ADVICE DOESN'T WORK

FOR REFLECTION

What do you do when patients do not change their unhealthy behaviors in response to your health information and advice?

OVERVIEW

When we use only a hammer (provide advice), we treat patients' unhealthy behaviors as nails. Most patients and their behaviors, however, are more like nuts and bolts rusted together. Hammering away can damage the threads of the bolt, so the nut never comes off. With advice only, patients may become more resistant and less likely to consider change.

Do you keep hammering away, give up the advice-giving approach altogether, or do you learn from your clinical experiences about how to work with patients in alternative ways?

Mere knowledge about the negative consequences of risk behaviors is insufficient to motivate most patients to change. Even when individuals know what is good for them and have the skills to change, many do not. Resistant patients work against our attempts to help them change. Unmotivated ones are indifferent to change. Ambivalent patients have mixed thoughts and feelings about change.

Thus, most patients are not ready to change their unhealthy behaviors. They may or may not even be thinking about change.[1;2] Not surprisingly, health information and advice do not help most patients to change. We need to develop skills to help our patients work on changing over time.

This book invites you to consider learning about how you change yourself as you learn how to help patients change. It encourages you to consider

- Analyzing your health behaviors, professional roles and assumptions
- Internalizing the six-step approach (described in Sections II and III) as a mental map for working with patients over time
- Initiating the process of gathering a learning portfolio for your continuing professional development
- Learning micro skills to address tobacco use and excessive alcohol intake

If you are curious about why patients do or do not change, this book may assist you on a journey of lifelong learning about motivating health behavior change.

LIMITATIONS OF GIVING INFORMATION AND ADVICE

What is the impact of giving health information and advice to patients, in relation to the overall magnitude of unhealthy behaviors and their consequences? (Section IV in this book and the Web sites listed in the tables and footnotes provide additional evidence for using such interventions.[abcd]) Such approaches are the first step in helping *patients* change their unhealthy behaviors, but they benefit only 5-20% of patients.[3-10] Let's briefly focus on the tobacco issue again, because it is the single greatest preventable contributor to disease and premature death internationally. In community surveys conducted in the

a. For information about smoking, alcohol, dietary practices, physical activity, cardiovascular disease, diabetes and asthma, check out the Center for the Advancement of Healthy www.cfah.org and click on Publications.
b. For evidence about preventive and behavioral health interventions, check out the Cochrane Database of Systematic Reviews and the database of abstracts of reviews of effectiveness at www.update-software.com/cochrane/abstract.htm.
c. For information about clinical prevention guidelines for smoking and related health behaviors, check out the Agency for Healthcare Research and Quality www.update-software.com/cochrane/abstract.htm.
d. For evidence and approaches for improving chronic diseases, check out the Improving Chronic Illness Care Web site at www.improvingchroniccare.org.

United States, 40% of smokers are not thinking about quitting, and 40% of smokers are thinking about it.[11-14] Giving information and advice may be appropriate for only 20% of smokers who are ready to quit. This approach helps 2.3-12.8% of smokers to quit, depending on the time length of the session, the total number of sessions and the number of different clinicians involved in delivering interventions.[3]

Consider this fact in relation to the tobacco pandemic, as described in the Introduction. The report *Trust Us: We're the Tobacco Industry* helps us to understand how the tobacco industry contributed toward creating this pandemic.[e] To counteract these disease-promoting practices, the World Health Organization's Tobacco Free Initiative (http://www.who.int/toh) and the Framework Convention on Tobacco control aim to decrease global tobacco consumption. Yet in spite of our knowledge about this problem, tobacco use will remain the leading cause of death worldwide for the foreseeable future.

Giving information and advice does not always change behavior. Furthermore, this seemingly helpful approach can have negative consequences that may or may not be apparent.[15;16] For example, increases in depression, anxiety and overall disability occurred at three months after physicians advised patients to quit smoking, but this finding was not found with medication-related or dietary change advice.[15;16] Two examples highlight this issue from a practitioner and patient perspective:

> Dr. N., a general practitioner from Nepal, was treating a patient who was a smoker and a doctor. Dr. N. advised his patient to quit smoking on three separate occasions over time. The patient got fed up with Dr. N. and decided to see another doctor, a doctor who smoked cigarettes and would not advise him to quit smoking. Dr. N. felt rejected and wished that he could have been more helpful to his patient. He was interested in learning more about how to work with smokers in alternative ways.

> Mrs. D. was an overweight middle-aged woman who had diabetes. Her overweight endocrinologist repeatedly advised her to change her eating habits, to lose weight and to exercise more. She could not live up to her doctor's expectations and had resigned herself that she would need to rely on her medications to control her diabetes. Mrs. D. had mixed feelings about continuing to see the endocrinologist because he made her feel guilty, but she also respected him and depended on him for her ongoing care. Mrs. D. resented his lack of empathy, given that he was also overweight, and wished that he was better trained in how to understand her situation.

Michael Balint once stated that doctors are the most commonly prescribed drug in general practice.[17] This drug metaphor has merit in acknowledging the psychotherapeutic impact of the doctor, but its literal interpretation highlights how we fail to resolve

e. You can download the full report (html version) from www.ash.org.uk/html/conduct/html/trustus.html or the pdf format from tobaccofreekids.org/campaign/global/framework/docs/TrustUs.pdf.

behavior change issues effectively with our patients. Giving rational advice to patients about changing unhealthy behaviors is on a par with the placebo impact of 19th-century drugs. The use of this "drug" over and over again, when it is clearly not working, could be regarded as a form of medical error.

LIMITATIONS OF THE BEST EVIDENCE

In helping our patients change, we should always use the best available evidence from randomized controlled trials (RCTs). However, most behavioral RCTs conducted in primary care provide limited guidance in how to help patients change, because they use only one or two health information and advice-giving interventions with patients, with time-limited follow-up, for a year or so. Such rational interventions are the most frequently studied for tobacco cessation in primary care.[4;6;18-21] Doctors are encouraged to use these approaches routinely and repeatedly with all smokers at each visit, but this does not happen in practice.

Doctors prefer to give advice to patients who have smoking-related problems or who are ready to quit; conversely, they avoid confronting patients who do not fit into this group.[22-25] Such avoidance has some justification: patients react negatively or prefer not to get such advice.[26;27] For these and other reasons, the feasibility of implementing these guidelines has been questioned.[28]

Furthermore, rational interventions do not work for the majority of patients because they are simply not ready to take action. Evidence-based tobacco cessation guidelines tell us what works, but they don't tell us how to work with people when proven interventions fail. Something is missing in the conduct of RCTs in terms of dealing with the full spectrum of patients. RCTs rarely address the internal process of why change did or did not occur. They do not tell us the whole story about change, either from the practitioner's or the patient's perspective. Instead, they provide a very limited view for understanding human experience and behavior change.

With unhealthy behaviors, emotions often supersede reason. Patients frequently decide that the short-term emotional benefits (e.g., smoking to relax) are more important than the long-term quantifiable benefits (e.g., live longer). They make so-called "irrational" decisions. Recommendations from RCTs provide no guidance on how to deal with human emotions, perceptions and values. Scientific rationality lacks sophistication in dealing with human irrationality and otherwise knowledgeable patients who lack the critical factor: motivation.

ADOPTING NEW METAPHORS

Metaphors can help us understand better the gaps between scientific evidence and the complexity of dealing with individual patients' unhealthy behaviors. Here is a visual metaphor to illustrate the gaps in our understanding: RCTs are tiny square pegs in a large round hole. The hole (gaps in our understanding) simply gets bigger with each additional peg. No matter how many pegs are put into the hole, the gaps in our understanding will remain between rational evidence and the emotional complexity of issues affecting behavior change. Evidence-based medicine alone will never close all the gaps.

Metaphors that shape our professional behavior toward patients are embedded in our everyday language.[29] Here are some metaphors that make explicit our fix-it approach toward our patients: "Medical care is a high-tech machine in a competitive market manufacturing magic bullets [e.g., drugs] to cure diseases."[30;31] These mechanistic metaphors suggest objectivity, predictability, beating the competition, winning, cure, war, control and death.

Here, as a complementary worldview, are ecological metaphors that expand the narrow focus of medical care:[30] "Health care is an endangered plant in a threatened ecosystem that needs environmental restoration; in addition to the fix-it role, we adopt a motivational role and become 'gardeners': cultivating the soil, fertilizing the ground, and planting seeds." These organismic metaphors suggest subjectivity, unpredictability, sharing interdependence, collaboration, care, growth, nurture and quality of life. Changing the dominant metaphors in medical care, however, is a major paradigm shift and no simple task. Metaphors can act as weapons against change, as well as agents for change. The underlying value system of the mechanistic metaphors in health care that work against mainstreaming organismic ones are summarized in Table 1.1.

Table 1.1. Comparing Medical and Behavioral Worldviews and Value Systems

Quick-fix: Treating Diseases	Long Haul: Motivating Healthy Behaviors
1. Address complicated, decontextualized tasks Use "closed system" approach	1. Address complex, contextualized tasks Use "open system" approach
2. Focus on objectivity and entities	2. Focus on subjectivity and context
3. Use mechanistic thinking "Technicians using tools"	3. Use organismic thinking "Gardeners planting seeds"
4. Use reductionist and linear approaches Apply scientific rationality	4. Use holistic and nonlinear approaches Address human irrationality
5. Intervene in symptomatic phase Patients depend on their practitioners	5. Intervene in asymptomatic phase Patients start thinking about change
6. Control and cure diseases Practitioners save lives	6. Support autonomy to influence behavior Activate patients to take charge
7. Focus on harms, deficits and pathology	7. Address emotions, perceptions and values
8. Use high-tech treatments (drugs and surgery) Static, prescribed interventions	8. Employ low-tech interventions (dialogue) Dynamic, changing interventions
9. Produce dramatic results Immediate benefits	9. Foster incremental change Delayed benefits

THE NEED FOR A COMPLEMENTARY APPROACH

Modern drug research emphasizes purposeful nonvariation, that is, developing highly specific drugs to target particular enzymes, receptor sites or genes to treat and cure diseases. Unlike the development of drugs, purposeful variation is needed to design highly individualized behavioral interventions to enhance their potency and impact on patients. The "receptor site" is not only different for each patient but also for each of his or her unhealthy behaviors. In spite of the diversity of patient needs, we tend to fall into the trap of using the one-size-fits-all approach.

For this reason, the top-down, "from research to practice," rational choice model, while important in determining what works in some circumstances,[32] has a limited impact, because evidence-based guidelines don't teach practitioners how to attend to the diversity of emotions, perceptions and values that affect patients' health behaviors.[33] With the top-down approach, researchers often try to make patients fit a particular theory: in effect, a controlling method. The researcher is the principal investigator, and practitioners are coinvestigators ostensibly working with patients but in effect telling them what to do. The following quotation provides another perspective about the limitation of this approach.

> *Rational planning and decision-making are doomed to failure in the face of the remarkable complexity of human motivation, encompassing interlocking hurts, disappointments,, confusions, affections and aspirations.*[34]

We need to use a bottom-up, "from practice to research" approach if we are to help our patients close the large gap between evidence and practice and to work with the discrepancy between so-called rationality and their emotions. With the bottom-up approach, the patient is the principal investigator researching his or her health behavior change, and the practitioner is the coinvestigator working with researchers to select theories that fit the particular needs of the patient.

We should also move beyond hierarchy (the top-down, one-way-street approach) and toward partnerships if we want to develop innovative approaches to health care and behavior change. It is vitally important that researchers, theorists and practitioners collaborate in a two-way street to develop partnerships with patients. Patient-centered approaches can help to develop such partnerships and enhance the process and outcome of health care.[35;36] The motivational approach described in this book adds to the patient-centered concept, which addresses concerns, feelings, expectations and consequences relevant to episodes about their care and describes how to develop individualized interventions that help patients change their perceptions and values. To encourage such partnerships, this approach has been developed from state-of-the-art clinical practices (working with patients, students and health care practitioners), research evidence and different theories and models (described in Chapters 6 and 7) about health behavior

change.[37-39] Emerging research findings and clinical reviews provide some encouraging evidence to justify using motivational approaches.[40-72] (Some Web sites to help you keep abreast of this developing field are listed below.[f])

For those of us working with providing continuity of care to our patients, we have many opportunities to adopt a motivational approach and deliver individualized interventions that meet their changing needs over several years. Effective training methods can help us move beyond standard question-and-answer clinical interviews to engage patients in "change dialogues" so they not only adopt healthy behaviors but maintain these changes. [37-39;73] (The Web site www.MotivateHealthyHabits.com is under continuous development to improve the training methods for helping both practitioners and patients learn how to work more efficiently on this change process.)

LIMITATIONS OF THE FIX-IT ROLE

Clinical experience can teach us a lot about the shortcomings of our professional training and the limitations of the advice-giving, or fix-it, approach. When we adopt this approach, we impose our own values and perceptions about healthy behavior without knowing what our patients think. We give answers rather than ask questions.

The following account provided by Dr. W., a family physician, reveals the limitations of the fix-it approach and highlights the advantages of a motivational approach. Over a nine-year period, Dr. W. struggled before figuring out how best to work with resistant patients. He shared this account of his professional experience after attending a workshop on motivating health behavior change.

> After graduating from a family practice residency program, I spent the first three years getting frustrated with patients when dealing with their risk behaviors and the next three years confused about what I should do with them. For the next three years, I really took the time to listen to my patients and learn from them about what it would take for them to change. After being in practice for nine years, I don't go home worrying about any patient's self-destructive behavior.
>
> This kind of workshop could have helped me learn much earlier about how to individualize my approach in working with patients over time. I wish I had had this training in medical school. It could have prevented many years of frustration and confusion because I would not have given the same kind of health education and advice messages over and over again to patients.

f. For motivational Web sites about research publications, refer to the Motivational Interviewing site at http://www.motivationalinterview.org and the Cancer Prevention Research Center at http://www.uri.edu/research/cprc. To learn more about a Behavioral Change Consortium at the National Institutes of Health, go to http://www1.od.nih.gov/behaviorchange. For information about Project PACE for promoting exercise, refer to http://www.paceproject.org or e-mail project.pace@sdsu.edu.

Dr. W. first assumed a fix-it role and acted as though he could make patients change their risk behaviors. This take-charge approach works well for treating diseases, but it plays a limited role in addressing risk behaviors; directive or controlling advice works with only a minority of patients. Dr. W.'s clinical experiences taught him a lesson: trying to control patients' behavior usually does not work. A version of the Serenity Prayer by Reinhold Niebuhr—a Protestant theologian and social critic born in 1892—reinforces the lesson that experience taught Dr. W.:

> *Grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.*[74]

Dr. W. typifies how most of us have been trained to adopt a fix-it role for working with resistant patients. This educational shortcoming handicaps our professional development and creates a blind spot in our learning. Clinical experiences after completing his training taught Dr. W. how to adopt a motivational approach. He did this by carefully listening to, and learning from, his patients. By doing this, he became more effective at helping them change their behavior.

The key differences between fix-it and motivational approaches to behavior change are summarized in Table 1.2.[38;75] Fix-it practitioners, for example, erroneously assume that they can control patients' behavior, whereas motivational practitioners realize that only patients can take charge of their health. Motivational practitioners thus help patients explore the possibility of change, rather than try to control the patient.

Table 1.2. Contrasting Assumptions about Patients

Fix-it Approaches	Motivational Approaches
Patients need to act now. They lack knowledge about the need to change. Education will convince patients to change. They need advice to change.	Patients may not yet be ready for action. They lack motivation to change. They have knowledge and skills to change. Most patients are willing to explore change.

MOTIVATING CHANGE

Opportunities for motivating healthy behaviors occur in almost every patient encounter.[76] Yet most of us are poorly trained to take advantage of such opportunities. Furthermore, the development of simple yet sophisticated interventions for motivating healthy behaviors over time (particularly in nonspecialist, time-pressured health care settings) has lagged far behind the advances in drug treatment of diseases. This lag is especially significant, given that an estimated 50% of preventable mortality is due to unhealthy behaviors.[77]

Carl Rogers, a seminal thinker about human psychology, captures an essential ingredient for motivating change—listening:

> *We think we listen, but very rarely do we listen with real understanding, true empathy. Yet listening, of this very special kind, is one of the most potent forces for change that I know.*[78]

In many instances, listening with empathy is a prerequisite for helping patients to change. Paolo Freire, a radical contemporary educator, builds on this fundamental principle by emphasizing another critical ingredient needed to work toward effective action:[79;80]

Listening *precedes* ***Dialogue,*** *which precedes* ***Action.***

Freire's aphorism highlights the need to engage patients in constructive dialogue about change in order to motivate them to action.

Motivational practitioners appreciate that each person is unique in what might motivate him or her to change. These practitioners use motivational principles (see Table 1.3) as a guide to engaging patients in the change process over time and work through the three phases of Freire's aphorism (listening, dialogue, action), whereas fix-it practitioners jump in at the action phase.

Table 1.3.

Motivational Principles
• Develop empathic relationships with patients
• Clarify roles and responsibilities for health behavior change
• Gain consent from patients to address behavior change
• Respect patients' autonomy—use influence, not control, to effect change
• Work at a pace sensitive to the patients' needs and their readiness to change
• Help patients explore and understand better their values and perceptions
• Help patients decide whether to change their values and perceptions
• Focus on strengths, successes and health, not weaknesses, failures and pathology
• Focus on solutions rather than on problems
• Enhance patients' confidence and competence to change (self-efficacy)
• Negotiate reasonable goals for change
• Help patients believe that healthy outcomes are possible
• Help patients increase their supports and reduce their barriers to change.
• Develop plans to prevent relapses and use so-called failures as learning opportunities

Attempts to force patients to act in healthy ways when they are not ready can sometimes have the opposite effect.[81;82] For example, if you are a parent, consider the last

time that you gave strong, directive advice to your children (especially teenagers) about changing their behavior. Or recollect when you were a teenager and were told not to do something by your parents or teachers. Sometimes you did it anyway! Years later, you realized that their advice was right, but how did you feel about the advice at the time it was given? Controlling or threatening messages, such as providing highly directive advice—"Do this . . . you should . . . or else"—often proves counterproductive. Individuals may become even more resistant in response to such controlling advice. Strong unsolicited advice, even if logical, can bring out the rebellious teenager in all of us.

We must move beyond the idea of control,[83] that is, beyond trying to control our patients or having patients control themselves, to the idea of autonomy.[84] Patients are more likely to adopt healthy behaviors if they *want to* rather than if they *ought to* or *have to* change. Over time, patients are more likely to behave in *healthy* ways if we openly acknowledge their choice to engage in an unhealthy behavior rather than trying to make them change. Autonomy-supportive approaches (offering choices) are more effective in helping patients change than are coercive measures.[84] Examples of the distinctions between controlling and autonomy-supportive approaches are interspersed throughout this book.[85]

CONSIDER CHANGING YOURSELF

Consider taking a step back from changing patients' behaviors to focus on your own health behaviors, professional roles and assumptions. Learning from your attempts to change your personal and professional behaviors may help you empathize and work more effectively with your patients. This suggestion is important for another reason. Our health habits affect how we work with patients. Physicians with healthy behaviors (e.g., nonsmoking, low-risk drinking or abstinence, regular exercise) are more likely to counsel patients about the same behaviors.[86-90] In a few countries, an overall decline in the smoking rate was preceded by a decline in the smoking rate among physicians. Yet the smoking rate among health care professionals remains high in many countries. Perhaps the health care professions can indeed do a better job of helping its members develop healthier habits. No one, of course, is perfect. We all have something that we could do to improve our health (healthy diets, weight reduction and more exercise).

Mohandas K. Gandhi emphasized the importance of beginning with oneself when addressing change:

> *Be the change that you want to see in the world.*

> *I have only three enemies. My favorite enemy, the one most easily influenced for the better, is the British Empire. My second enemy, the Indian people, is far more difficult. But my most formidable opponent is a man named Mohandas K. Gandhi. With him I seem to have very little influence.*

An important take-home message is that you may find it easier to influence patients to change than to change your own family members, or even yourself.

The inner process of learning how to change your health behaviors and how to become a motivational practitioner can accelerate the outer process of expanding your depth and range of motivational skills and of developing individualized interventions to meet your patients' changing needs. This premise, however, can be threatening or seem irrelevant or unnecessary to some practitioners, so they avoid exploring personal or professional issues about self-change. As you read through the next section of this chapter, assess your internal reactions about the extent to which you have positive, negative or mixed responses to different aspects of this premise or this chapter. In what ways are your internal reactions similar or different from some of your patients?

> **Practitioner Example of Internal "Mixed" Reactions:** A general practitioner from Bergen, Norway, felt that this chapter was persuasive about promoting healthy habits but also expressed concerns about practitioners "overdoing it" with their patients and acting as health care imperialists.
>
> **Commentary:** These concerns speak to a crucial issue about the differences between autonomy-supportiveness and behaviorally controlling ways. This chapter introduces the motivational principle of autonomy-supportiveness, but some practitioners may not fully understand how to put this principle into practice and may unknowingly act in controlling ways that are antithetical to this principle. In effect, they fall into the trap of health care imperialism. At the other extreme, we fall into the enabling trap—acting as our patients' unconditional advocates to support their choice to do as they please, without setting any limits. As a middle way between these extremes, we can support patients' autonomy without either of us abandoning or imposing our health care values. Instead of becoming immobilized by this ethical dilemma, we can respect, explore and work with our differences in values with our patients, all, of course, with their explicit consent or implicitly based on mutual trust.

Now, if you wish, consider identifying a professional or personal issue that you want to change. Much can be learned from your attempt to unravel the individual and contextual factors that shape this behavior—doing so may help both you and your patients. Kurt Lewin succinctly captures the essence of this kind of learning opportunity:

> *If you want to understand something, try to change it.*[91]

Personal Change: Your Health Behaviors and Life Situation

Personal health habits influence our professional behavior. Practitioners with unhealthy behaviors (e.g., lack of exercise, unhealthy diet and overeating, causing obesity) are less likely to counsel patients who have the same behaviors. This is yet another reason why it's important to address change by beginning with yourself. Learning Exercise 1.1 helps you reflect about changing yourself as a way to understanding yourself. Such self-understanding can help you become a more effective motivational practitioner with patients. Find out where you stand by completing the exercise.

Learning Exercise 1.1. Assess your overall health behaviors and life issues

Complete the questionnaires for 10 Health Behaviors and 10 Life issues. Circle N or Y for each health decision.

***N** = Not applicable to me.*

***Y** = Yes. For each yes response, use this readiness-to-change" scale:*

***1**= not thinking about change **2** = thinking about change **3** = preparing to change*

Health Behaviors and Life Issues

A Self-evaluation	Self-assessment	Readiness to change
1. Tobacco use	N Y	1 2 3
2. Eating habits	N Y	1 2 3
3. Weight	N Y	1 2 3
4. Physical activity	N Y	1 2 3
5. Alcohol use	N Y	1 2 3
6. Illegal drug use	N Y	1 2 3
7. Safe sex practices	N Y	1 2 3
8. Contraception to prevent pregnancy	N Y	1 2 3
9. Regular use of prescribed drugs	N Y	1 2 3
10. Safety belt use and bicycle helmets	N Y	1 2 3
11. Social relationships	N Y	1 2 3
12. Job satisfaction	N Y	1 2 3
13. Financial situation	N Y	1 2 3
14. Work/family/social balance	N Y	1 2 3
15. Professional/personal overfunctioning	N Y	1 2 3
16. Physical and sexual abuse	N Y	1 2 3
17. Emotional health	N Y	1 2 3
18. Coping with stress	N Y	1 2 3
19. Environmental health (work/home)	N Y	1 2 3
20. Spiritual health	N Y	1 2 3

- *For each health behavior and life situation of concern (those circled "Y"), complete the scale of your readiness to change. Look at each concern where you're not thinking about change or are thinking about it but are unsure what to do.* ***Questions to Ponder:*** *How long have you been thinking about change? What is holding you back? What is keeping your foot nailed to the floor in addressing change?*
- *Think about a recent time when someone did not follow your advice to address a health concern.* ***Question to Ponder:*** *How does your previous analysis of difficulties in changing your own behavior help you understand why it can be so difficult for someone else to change, especially when it is an issue that is not a concern for you personally?*
- *Think about the occasions when a health issue came up with someone you know: a patient, colleague, family member or friend.* ***Questions to Ponder:*** *How was your behavior in this interaction influenced by your own health choices? Can you see any positive or negative patterns in the ways that you interact with others, for better or worse?*

You may even need some additional assistance to address some behaviors such as lack of exercise, unhealthy diet or even overwork. If so, you may find it helpful to use *Motivate Healthy Habits: Stepping Stones to Lasting Change* (a self-guided change version of this book) to work on your behaviors.[92] Your personal experience of using it can then help you to help your patients learn how to use this guidebook with or without your ongoing support.

Professional Change: Roles, Perspectives and Mental Models

We need to incorporate new similes and metaphors into well-established ones. The mechanistic similes (hammer and nails, nuts and bolts) used at the beginning of this chapter only tell practitioners to stop using the fix-it role when health information and advice doesn't work. As previously noted, the machine and gardener metaphors characterize the fix-it and motivational roles respectively. Organic metaphors can help us move beyond the toolbox metaphors; it is not just a question of picking up a new tool. These metaphors more aptly capture how we need to work in addressing health behavior change with our patients. This process also involves professional change: changing your roles appropriately, learning about different perspectives on resistance and motivation and using mental maps for developing individualized interventions to meet your patients' changing needs over time.

Changing roles

An understanding about different roles (motivational, preventive and fix-it) lays the foundation for learning how to enhance your skills at motivating behavior change. (Chapters 2-4 present these three roles in detail and describe how different roles can have both positive and negative impacts on our work with patients.) A brief description about the distinctions between these roles will help you to understand why it is important to change your role before developing new skills.

The term *agent of change* is used figuratively to clarify different roles that you may assume in working with patients. Practitioner-centered advice is the agent of change for fix-it roles. Such advice is based on what practitioners think patients should be given, rather than on what patients may prefer or need. In a preventive role, education tailored to the needs of patients becomes the agent of change. In a motivational role, you work with, rather than against, indifferent or resistant patients. Your dialogue with patients becomes the agency of change. You use such dialogue (together with a motivational assessment) to help develop individualized interventions to meet patients' changing needs over time.

The fix-it role is more appropriate for treating diseases *caused by* risk behaviors (e.g., giving antibiotics for acute bronchitis) than it is for helping patients *change* risk behaviors (e.g., giving advice to quit smoking). If we remain in a fix-it role, we may persist in providing more information and advice to resistant, indifferent and ambivalent patients than they want. This situation can evoke mutual frustration in addition to possible anger and guilt and become such a negative experience that patients may avoid us or fail to seek appropriate care.

Learning about resistance and motivation

Patient resistance is a normal and expected phenomenon, but it is also a learning opportunity to understand why patients resist change in spite of our good intentions to help them. We are often on different wavelengths from our patients. Unless we change our wavelength, we cancel out each other's energy, so nothing happens but perpetual inertia and wariness. How can you motivate these patients to change? First, learn how to adapt your role to meet patients' needs. Different perspectives on resistance and motivation (Chapters 5-7) can help you learn how to work with resistance, rather than work against it. Then you are in a better position to help patients redirect their energy in healthy directions.

Internalizing the six-step approach as a mental map

A mental map is a framework or way of thinking derived from internalizing a model. You can use the six-step approach (summarized in Table 1.4 and explained in Chapters 8-14) as a mental map for negotiating about behavior change with patients. Even if you internalize this map, it does not mean that you are skillful in navigating the territory—in this case, the patient's world. Always keep in mind that the map is not the territory.[93] It is just a guide, but it can help you learn to negotiate an appropriate rate at which to work through the change process with your patients.[94] In addition, a mental map can help you learn how to use words, language and dialogue more effectively in working with your patients. With repeated practice in using this guide, you can become more effective over time in developing individualized interventions for your patients.

Table 1.4. Six-step Approach for Negotiating Change

Mental Map for Negotiating Change	Desired Impact on Patients
Step 1: Building a partnership Step 2: Negotiating an agenda	Helps patients move from not thinking about change to thinking about it.
Step 3: Assessing resistance and motivation Step 4: Enhancing mutual understanding	Helps patients move from thinking about change to preparing to change.
Step 5: Implementing a plan	Helps patients move from preparing to change to taking action.
Step 6: Following through	Helps patients move from taking action to maintaining change.

Patients have good reasons for their health decisions, but you may disagree with their logic. To work with the so-called irrationality, you need to work with patients at the level of their perceptions and values. A decision balance (used in Step 3) is a simple tool that can help you do this. This tool can help your patients organize their thoughts about staying the same (resistance) versus changing (motivation), and uncover what lies beneath their thoughts about change: emotions, perceptions and values. If you understand how their values affect their perceptions, and in turn their behaviors, you will at least understand their decision-making process. The example below illustrates how you can use this tool to understand so-called human irrationality when seeing your patients in your office.

> **Resistance to the Practice of Safe Sex:** Mrs. S., a 45-year-old woman, came to her family physician (Dr. M.) for a follow-up to her HIV test. Two years ago, she remarried after being divorced for many years. She had recently moved back to her hometown after her husband broke his parole and was returned to jail. Mr. and Mrs. S. had regularly attended an HIV clinic because Mr. S. was HIV-positive. Even though Mrs. S. knew how to put a condom on her husband, he did not want to wear one. Fortunately, she remained HIV-negative even without practicing safe sex. The doctor at the HIV clinic had advised Mrs. S. to have an HIV test done every three months. Dr. M. ordered the HIV test and asked her if she would be willing to fill out a decision balance in order to better understand why she did not want to use condoms. Dr. M. saw another patient while Mrs. S. completed this task, and then returned to see what she had written.

Learning Exercise 1.2. Reflect on Mrs. S.'s decision balance

Reflect on the following questions as you read Mrs. S.'s decision balance.

- *How does she perceive her reasons to stay the same versus her reasons to change, based on how she thinks and feels?*
- *What does she feel about her husband?*
- *What does she feel about herself?*
- *How does she value her relationship as compared to herself and her own family?*

Then analyze her decision balance. The left column represents Mrs. S.'s reasons to stay the same, and the right column represents her reasons to change.

Mrs. S.'s Decision Balance about Safe Sex

Reasons not to use condoms (resistance)	Reasons to use condoms (motivation)
1. Benefits of not using condoms Not make him feel he is failing at being sexually competent. He feels secure that I'll stay with him.	2. Concerns about not using condoms Don't want HIV. Don't want my family hurt. Maybe people will think he doesn't care to protect me.
3. Concerns about using condoms He will have erection problems and it will make him sad. He will wish he were with his ex-girlfriend (who is HIV) so he won't have to use them.	4. Benefits of using condoms Won't get HIV so won't upset family. Won't get sick myself so I can take care of him when he gets sicker. Will feel that he cares enough about me and will not allow me to get sick.
Resistance Score = 9 Feeling score = 9 Think score = 6	Motivation Score = 4 Feeling score = 4 Think score = 8

Assessing Mrs. S.'s perceptions about her resistance and motivation: When Dr. M. reentered the room, he read what Mrs. S. wrote and first pointed to the left-hand column of her decision balance. He asked her to use a scale from 0 to 10 (0 = not important and 10 = very important) to rate her overall reasons for not using condoms. Mrs. S. gave a resistance score of 9. Dr. M. then asked to rate her reasons for using them. She gave a motivation score of 4. Dr. M. asked her whether her scores were based on her feelings or her thoughts. Mrs. S stated that her scores were based on her feelings. Dr. M. then asked her to rate her overall reasons to stay the same versus her reasons to change based on what she thought about it. Mrs. S. gave 6 for her resistance score and 8 for her motivation score. This process helped her understand much better how much her heart ruled her head in making decisions. Emotionally, she felt that she should stay the same, but rationally she thought she should protect herself.

Assessing Mrs. S's emotions and values: Looking over her decision balance again, Dr. M. reflected back to Mrs. S. that she must really love her husband. Mrs. S. smiled in total agreement and expressed devotion to her husband, stating that she wanted to care for him when he gets terminally ill. Dr. M. asked her how she valued her relationship with her husband in comparison to herself and the relationship to her own family. Mrs. S. loved her husband so much that she was willing to sacrifice her life for him, but admitted to having mixed feelings when thinking about her own children from her first marriage. Her adult children did not know about her current situation. Mrs. S. stated she came from an abusive family and has suffered from chronic low self-esteem since childhood.

This example demonstrates how you can begin to engage patients in dialogue about change and to develop individualized interventions during a 15-minute

appointment. Over time, effective interventions can assist your patients in deciding whether to change their values and perceptions in ways that motivate them to take charge of changing their behavior. The six-step approach described in Section III can help you learn how to use words, language and dialogue more effectively with your patients. With repeated practice in using this approach, you could become a more effective and efficient motivational practitioner.

CONTINUING PROFESSIONAL DEVELOPMENT

A continuing professional development (CPD) curriculum on motivating health behavior change must revisit topics at increasing levels of complexity to foster lifelong learning, enrich professional development and improve clinical performance. Such a dynamic curriculum could help us develop skills at self-directed learning as well as provide opportunities for small group learning, individual supervision and/or a longitudinal relationship with a mentor throughout our formal education and career. Given that such ideal curricula are rare, however, it is important to take charge of your own CPD. Whatever your level of clinical experience, you can use this book to prepare for and design a learning plan for your ongoing professional development.

Taking Charge of Your Professional Development

Even if you were not trained in how to motivate behavior change, you can use self-directed learning methods, ideally working with patients over time. Section IV in this book describes how you can develop skills for initiating dialogues with patients in addressing specific behaviors. If available, workshops can also help you enhance your motivational skills. Dr. S.'s written evaluation of such a workshop captures the merits of such training:

> Although it has been 15 years since I have done any role-playing, I found it extremely captivating. Afterward, I found that I was immediately applying in the office what I had learned in role-playing. I became consciously aware of resistance during patient interviews and was more apt to closely examine patients' agendas, as well as their perceptions. Patients appear9.3aE1(t)-4(i)-4((l)-.4(y)1827( )-10g)1827E1(t)-a(

take more time and even slow you down, but in time you will expand your range and depth of motivational skills. However, you can develop a learning plan for continuing professional development so that you can monitor your progress, whatever your starting point or level of clinical experience, on your journey from a novice to a master. Becoming a master is not a destination but a journey without end.

YOUR SUMMARY

Reflect: *write a note (in 200 words or so) summarizing how this chapter helped you understand better the potential benefits of exploring your own health behaviors, professional roles and assumptions, as you learn about how to develop motivation skills. Which aspects of this premise, if any, evoke some resistance in you? What have you learned that was new for you?*

Enhance*: write down your ideas about how your new learning could improve your interactions with patients. Add your notes to your learning portfolio.*

_____
_____
_____
_____
_____
_____
_____

REFERENCES

1. Prochaska JO, DiClemente CC. Transtheoretical therapy: Toward a more integrative model of change. Psychotherapy Theory, Research and Practice 1982;19: 276-288
2. Prochaska JO, DiClemente CC. The transtheoretical approach: Crossing traditional boundaries of therapy. Homewood, IL: Dow Jones/Irwin; 1984
3. A clinical practice guideline for treating tobacco use and dependence: A US Public Health Service report. The Tobacco Use and Dependence Clinical Practice Guideline Panel, Staff, and Consortium Representatives. Journal of the American Medical Association 2000;283: 3244-3254
4. Law M, Tang JL. An analysis of the effectiveness of interventions intended to help people stop smoking. Archives of Internal Medicine 1995;155: 1933-1941
5. Ritvo PG, Irvine MJ, Lindsay EA, et al. A critical review of research related to family physician-assisted smoking cessation interventions. Cancer Prevention and Control 1997;1: 289-303
6. Kottke TE, Battista RN, DeFriese GH, et al. Attributes of successful smoking cessation interventions in medical practice. A meta-analysis of 39 controlled trials. Journal of the American Medical Association 1988;259: 2883-2889
7. Kahan M, Wilson L, Becker L. Effectiveness of physician-based interventions with problem drinkers: A review. Canadian Medical Association Journal 1995;152: 851-859
8. Brunner E, White I, Thorogood M, et al. Can dietary interventions change diet and cardiovascular risk factors? A meta-analysis of randomized controlled trials [see comments]. American Journal of Public Health 1997;87: 1415-1422
9. Ashenden R, Silagy C, Weller D. A systematic review of the effectiveness of promoting lifestyle change in general practice. [Review] [51 refs]. Family Practice 1997;14: 160-176
10. Ebrahim S, Smith GD. Systematic review of randomized controlled trials of multiple risk factor interventions for preventing coronary heart disease. British Medical Journal 1997;314: 1666-1674
11. Velicer W, Fava J, and Prochaska J. Distribution of smokers by stage. Cancer Prevention Research Center, 1-26. 1995
12. Velicer WF, DiClemente CC. Understanding and intervening with the total population of smokers. Tobacco Control 1993;2: 95-96
13. Kaplan RM, Pierce JP, Gilpin EA, et al. Stages of smoking cessation: The 1990 California Tobacco Survey. Tobacco Control 1993;2: 139-144
14. Burns D, Pierce JP. Tobacco use in California 1990-1991. Sacramento: California Department of Health Services; 1992
15. Butler CC, Pill R, Stott NCH. Qualitative study of patients' perceptions of doctors' advice to quit smoking: Implications for opportunistic health promotion. British Medical Journal 1998;316: 1878-1881

16. Bowman MA, Dignan M, Crandall S, et al. Changes in functional status related to health maintenance visits to family physicians [see comments]. Journal of Family Practice 2000;49: 428-433
17. Balint M. The doctor, his patient, and the illness. New York: International Universities Press; 1977
18. Simons-Mortin DG, Mullen PD, Mains DA, et al. Characteristics of controlled studies of patient education and counseling for preventive health behaviors. Patient Education and Counseling 1992;19: 175-204
19. Fiore MC. Treating tobacco use and dependence: An introduction to the U.S. Public Health Service Clinical Practice Guideline. Respiratory Care 2000;45: 1196-1199
20. Silagy C, Ketteridge S. The effectiveness of physician advice to aid smoking cessation. In: Lancaster T, Silagy C, eds. Tobacco addiction module of the Cochrane database of systematic reviews [updated 2 December 1996]. Oxford; 1996
21. West R, McNeill A, Raw M. Smoking cessation guidelines for health professionals: An update. Health Education Authority. Thorax 2000;55: 987-999
22. Coleman T, Murphy E, Cheater F. Factors influencing discussion of smoking between general practitioners and patients who smoke: a qualitative study. British Journal of General Practice 2000;50: 207-210
23. Coulter A, Schofield T. Prevention in general practice: The views of doctors in the Oxford region. British Journal of General Practice 1991;41: 140-143
24. Coleman T, Wilson A. Anti-smoking advice in general practice consultations: General practitioners' attitudes, reported practice and perceived problems. British Journal of General Practice 1996;46: 87-91
25. Tapper-Jones L, Smail S, Pill R, et al. Doctors' attitudes towards patient education in the primary care consultation. Health Education Journal 1990;49: 47-50
26. Stott NC, Pill RM. "Advise yes, dictate no": Patients' views on health promotion in the consultation. Family Practice 1990;7: 125-131
27. Kviz FJ, Clark MA, Hope H, et al. Patients' perceptions of their physician's role in smoking cessation by age and readiness to stop smoking. Preventive Medicine 1997;26: 340-349
28. Coleman T, Wilson A. Anti-smoking advice from general practitioners: Is a population-based approach to advice-giving feasible? British Journal of General Practice 2000;50: 1001-1004
29. Lakoff G, Johnson M. Metaphors we live by. Chicago: University of Chicago Press; 1980
30. Royston G, Dick P. Healthcare ecology. British Journal of Health Care Management 1998;4: 238-241
31. Dick P. The NHS as an ecosystem. British Journal of General Practice 2001;51: 248-249
32. Boudon R. The limitations of rational choice theory. American Journal of Sociology 1998;104: 817-828
33. Goldman L. Enlightened individual choice vs the public's health: Rational prevention from whose perspective? Journal of General Internal Medicine 1995;10: 147-150
34. Somekh B, Thaler M. Contradictions of management theory, organizational cultures and the self. Education Action Research 1997;5: 141-160
35. Stewart M, Brown JB, Weston WW. Patient-centered medicine. Thousand Oaks, CA: Sage Publications; 1995
36. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. Journal of Family Practice 2000;49: 796-804

37. Botelho RJ, Novak SJ. Dealing with substance misuse, abuse, and dependency. Primary Care 1993;20(1): 51-70
38. Botelho RJ, Skinner HA. Motivating change in health behavior: Implications for health promotion and disease prevention. Primary Care (Saunders) 1995;22: 565-589
39. Botelho RJ, Skinner HA, Williams GC, et al. Patients with alcohol problems in primary care: Understanding their resistance and motivating change. In: Stuart MR, Lieberman IJA, eds. Primary care: Clinics in office practice. Philadelphia: W.B. Saunders Company; 1999:279-298
40. Harackiewicz JM, Sansone C, Blair LW, et al. Attributional processes in behavior change and maintenance: Smoking cessation and continued abstinence. Journal of Consulting and Clinical Psychology 1987;55: 372-378
41. Ockene JK, Kristeller J, Goldberg R, et al. Increasing the efficacy of physician-delivered smoking interventions: A randomized clinical trial [see comments]. Journal of General Internal Medicine 1991;6: 1-8
42. Currie CE, Amos A, Hunt SM. The dynamics and processes of behavioral change in five classes of health-related behavior-findings from qualitative research. Health Education Research 1991;6: 443-453
43. Ryan RM, Plant RW, O'Malley S. Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement, and dropout. Addictive Behaviors 1995;20: 279-297
44. Williams GC, Grow VM, Freedman ZR, et al. Motivational predictors of weight loss and weight-loss maintenance. Journal of Personality and Social Psychology 1996;70(1): 115-126
45. Williams GC, Rodin GC, Ryan RM, et al. Autonomous regulation and long-term medication adherence in adult outpatients. Health Psychology 1998;17: 269-276
46. Perz CA, DiClemente CC, Carbonari JP. Doing the right thing at the right time? The interaction of stages and processes of change in successful smoking cessation. Health Psychology 1996;15: 462-468
47. Patrick K, Sallis J, Long B, et al. A new tool for encouraging activity: The physician and sports medicine 1994;22
48. Calfas KJ, Long BJ, Sallis JF, et al. A controlled trial of physician counseling to promote the adoption of physical activity. Preventive Medicine 1996;25: 225-233
49. Long BJ, Calfas KJ, Wooten W, et al. A multisite field test of the acceptability of physical activity counseling in primary care: project PACE. American Journal of Preventive Medicine 1996;12: 73-81
50. Sutton S. Can "stage of change" provide guidance in the treatment of addictions? A critical examination of Prochaska and DiClemente's model. In: Edwards G, Dare C, eds. Psychotherapy, psychological treatments and the addictions. New York: Cambridge University Press; 1996
51. Farkas AJ, Pierce JP, Gilpin EA, et al. Is stage-of-change a useful measure of the likelihood of smoking cessation? Annals of Behavioral Medicine 1996;18: 79-86
52. Prochaska JO, Velicer WF. On models, methods and premature conclusions. Addiction 1996;91: 1281-1283
53. Farkas AJ, Pierce JP, Zhu SH, et al. Addiction versus stages of change models in predicting smoking cessation. Addiction 1996;91: 1271-1280

54. Joseph J, Breslin C, Skinner HA. Critical perspective on the transtheoretical model and the stages of change. In: Tucher J, Donovan D, Marlatt A, eds. Changing addictive behavior: Moving beyond therapy assisted change. New York: Guilford Press; 1999:160-190
55. Bien TH, Miller WR, Tonigan JS. Brief interventions for alcohol problems: A review. Addiction 1993;88: 315-335
56. Ershoff DH, Quinn V, Boyd NR, et al. The Kaiser Permanente prenatal smoking-cessation trial: When more isn't better, what is enough? American Journal of Preventive Medicine 1999;17: 161-168
57. Miller WR, Sovereign RG, Krege B. Motivational interviewing with problem drinkers: II. The drinker's check-up as a preventative intervention. Behavioral Psychotherapy 1988;16: 251-268
58. Stephens RS, Roffman RA, Simpson EE. Treating adult marijuana dependence: A test of the relapse prevention model. Journal of Consulting and Clinical Psychology 1994;62: 92-99
59. Baer JS, Marlatt GA. Maintenance of smoking cessation [published erratum appears in Clinical Chest Medicine 1992 Mar;13(1):ix]. Clinical Chest Medicine 1991;12: 793-800
60. Smith DE, Heckmeyer CM, Kratt PP, et al. Motivational interviewing to improve adherence to a behavioral weight-control program for older obese women with NIDDM. Diabetes Care 1997;20: 52-54
61. Brown JM, Miller WR. Impact of motivational interviewing on participation in residential alcoholism treatment. Psychology of Addictive Behaviors 1993;7: 211-218
62. Allsop S, Saunders B, Phillips M, et al. A trial of relapse prevention with severely dependent male problem drinkers. Addiction 1997;92: 61-73
63. Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. Journal of Studies on Alcohol 1997;58: 7-29
64. May WW. Findings from Project MATCH: Fact or artifact? Behavioral Health Management 1998;January/February: 38-39
65. Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. Alcoholism, Clinical and Experimental Research 1998;22: 1300-1311
66. Saunders B, Wilkinson C, Phillips M. The impact of a brief motivational intervention with opiate users attending a methadone programme. Addiction 1995;90: 415-424
67. Heather N, Rollnick S, Bell A, et al. Effects of brief counseling among male heavy drinkers identified on general hospital wards. Drug and Alcohol Review 1996;15: 29-38
68. Woollard J, Beilin L, Lord T, et al. A controlled trial of nurse counseling on lifestyle change for hypertensives treated in general practice: Preliminary results. Clinical and Experimental Pharmacology and Physiology 1995;22: 466-468
69. Butler CC, Rollnick S, Cohen DA, et al. Motivational consulting versus brief advice for smokers in general practice: A randomized trial. British Journal of General Practice 1999;49: 611-616
70. Berg-Smith SM, Stevens VJ, Brown KM, et al. A brief motivational intervention to improve dietary adherence in adolescents. The Dietary Intervention Study in Children (DISC) Research Group. Health Education Research 1999;14: 399-410
71. Lowman C, Allen J, Stout RL. Replication and extension of Marlatt's taxonomy of relapse precipitants: Overview of procedures and results. The Relapse Research Group. Addiction 1996;91: S51-S71

72. Carroll K. Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. Experimental and Clinical Psychopharmacology 1996;4: 46-54
73. Botelho RJ. Negotiating partnerships in healthcare: Contexts and methods. In: Suchman AL, Botelho RJ, Hinton-Walker P, eds. Partnerships in healthcare: Transforming relational process. Rochester, NY: University of Rochester Press; 1998:19-49
74. Bartlett's Familiar Quotations. 14th, rev. and enl. ed. Boston: Little, Brown and Co.; 1968
75. Miller WR, Rollnick S. Motivational interviewing: Preparing people to change addictive behavior. New York: Guilford Press; 1991
76. Rollnick S, Mason P, Butler C. Health behavior change: A guide for practitioners. Edinburgh, Scotland: Churchill Livingstone; 1999
77. McGinnis JM, Foege WH. Actual causes of death in the United States. Journal of the American Medical Association 1993;270: 2207-2212
78. Rogers CR. A way of being. Boston: Houghton Mifflin; 1980
79. Freire P. Education for critical consciousness. New York: Seabury Press; 1973
80. Wallerstein N, Bernstein E. Empowerment education: Freire's ideas adapted to health education. Health Education Quarterly 1988;15: 379-394
81. Brehm JW. A theory of psychological reactance. New York: Academic Press; 1966
82. Brehm SS, Brehm JW. Psychological reactance: A theory of freedom and control. New York: Academic Press; 1981
83. Shapiro DH, Jr., Schwartz CE, Astin JA. Controlling ourselves, controlling our world. American Psychologist 1996;51: 1213-1230
84. Deci EL, Ryan RM. Intrinsic motivation and self-determination in human behavior. New York: Plenum Press; 1985
85. Williams GC, Deci EL, Ryan RM. Building healthcare partnerships by supporting autonomy: Promoting maintained behavior change and positive healthcare outcomes. In: Suchman AL, Botelho RJ, Hinton-Walker P, eds. Partnerships in healthcare: Transforming relational process. Rochester, NY: University of Rochester Press; 1998:67-87
86. Lewis CE, Clancy C, Leake B, et al. The counseling practices of internists. Annals of Internal Medicine 1991;114: 54-58
87. Wells KB, Lewis CE, Leake B, et al. Do physicians preach what they practice? A study of physicians' health habits and counseling practices. Journal of the American Medical Association 1984;252: 2846-2848
88. Schwartz JS, Lewis CE, Clancy C, et al. Internists' practices in health promotion and disease prevention. A survey [see comments]. Annals of Internal Medicine 1991;114: 46-53
89. Frank E, Rothenberg R, Lewis C, et al. Correlates of physicians' prevention-related practices. Findings from the Women Physicians' Health Study. Archives of Family Medicine 2000;9: 359-367
90. Frank E, Breyan J, Elon L. Physician disclosure of healthy personal behaviors improves credibility and ability to motivate. Archives of Family Medicine 2000;9: 287-290
91. Lewin K. Field theory in social science. New York: Harper Torchbooks; 1951
92. Botelho RJ. Motivate healthy habits: Stepping stones to lasting change. Rochester, NY; 2004
93. Bateson G. Mind and nature: A necessary unity. New York: E.P. Dutton; 1979
94. Botelho RJ. A negotiation model for the doctor-patient relationship. Family Practice 1992;9: 210-21