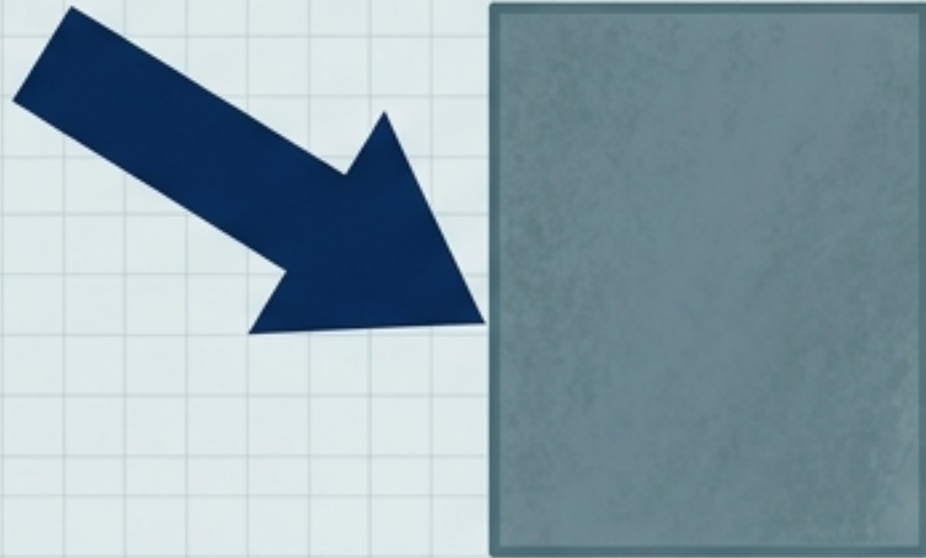


Motivational Interviewing: The Clinical Compass

A foundational stance for behavior change, medication adherence, and intrinsic motivation.

Compliance / Confrontation



Subtext: Generates iatrogenic resistance and reactance.

Collaboration / Evocation

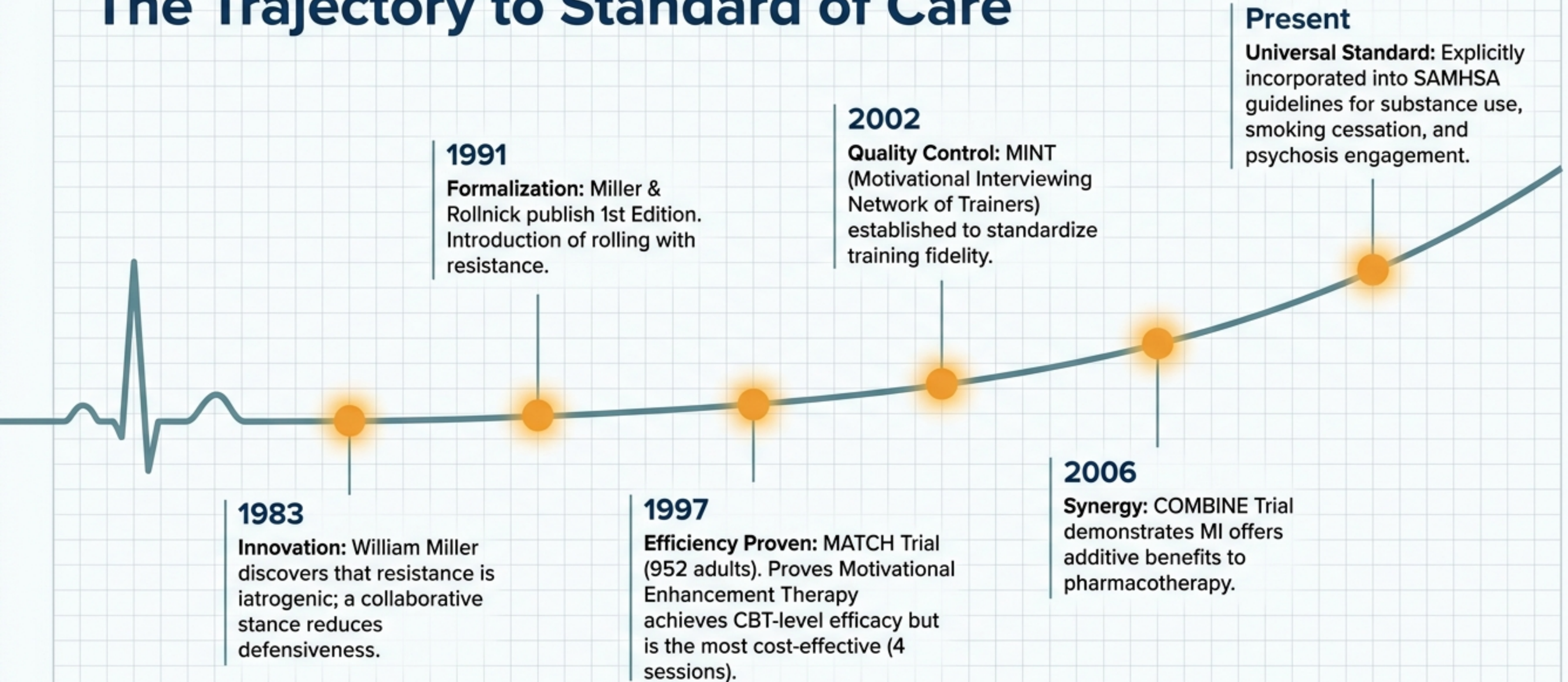


Subtext: Elicits the patient's own reasons for change.

The Paradigm Shift: MI is not a set of techniques to manipulate a patient into compliance. It is a collaborative, patient-centered counseling approach designed to enhance intrinsic motivation and commitment to behavior change.

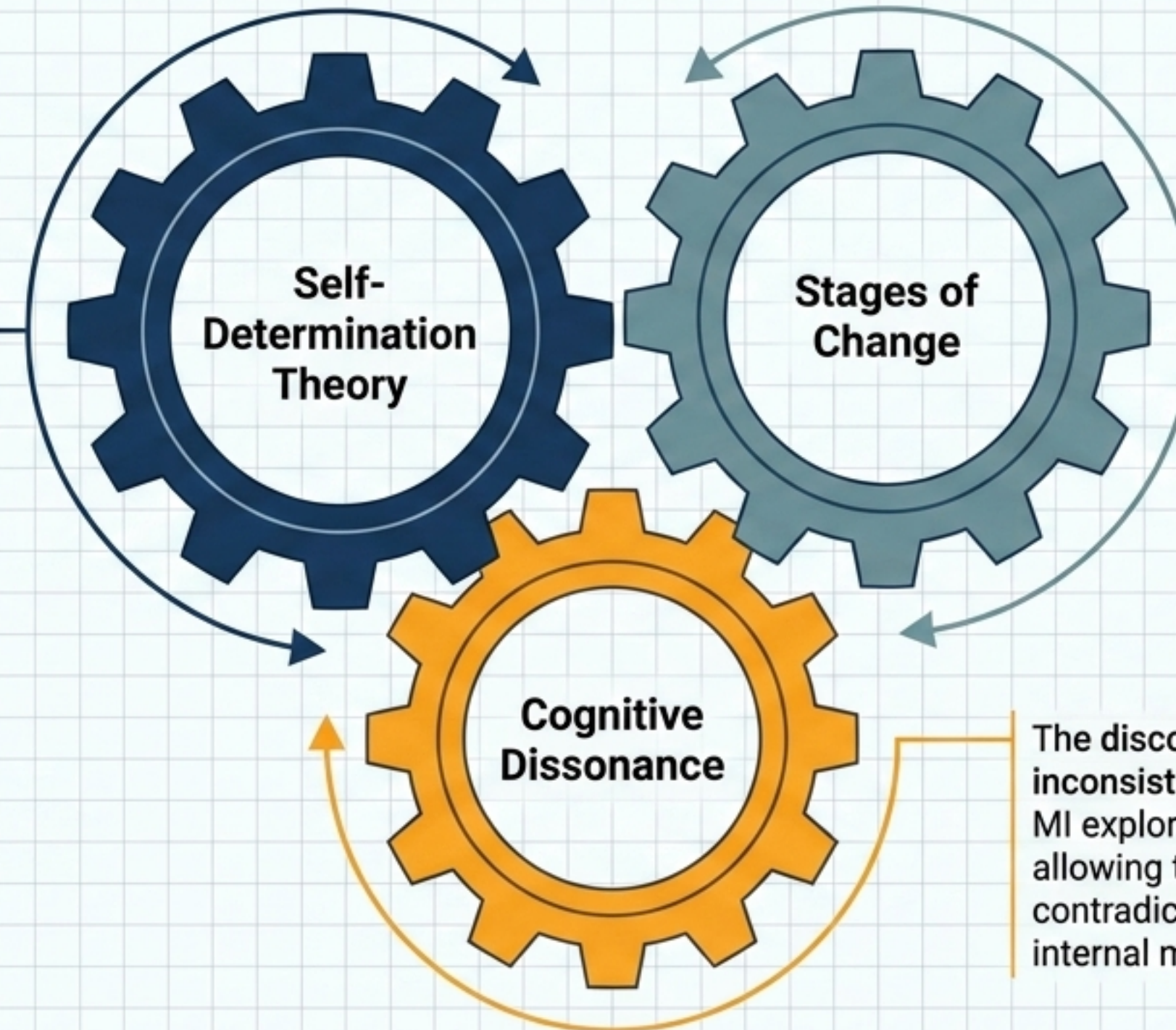
The Core Thesis: You cannot install motivation externally. You must evoke it internally by working with ambivalence rather than against it.

The Trajectory to Standard of Care



The Theoretical Engine of MI

Human motivation requires three psychological needs: Autonomy (volition, not coercion), Competence (belief in success), and Relatedness (connection). MI explicitly satisfies all three.



Patients move non-linearly:
Precontemplation →
Contemplation → Preparation →
Action → Maintenance.

MI calibrates the intervention to the exact stage. Applying action advice to a precontemplator triggers resistance.

The discomfort from holding beliefs inconsistent with behaviors. MI explores this friction naturally, allowing the patient to articulate the contradiction themselves, driving internal motivation.

Intrinsic Motivation

Partnership

Clinician and patient are collaborators. The patient is the expert on their own experience and obstacles.

Language: I wonder if...
or Let's explore...

Acceptance

Absolute worth and respect for the patient's autonomy.

Crucial distinction:
Acceptance is NOT
agreement with harmful
behaviors; it is the
refusal to coerce.

Compassion

An active commitment to
the patient's well-being
and goals,
understanding their
struggles exclusively from
their viewpoint.

Evocation

Drawing out the patient's
own motivations and
values rather than
installing them via
external advice. The
patient must voice the
reasons for change.

The Core Clinical Skills: OARS Matrix



Open-Ended Questions

Invites elaboration beyond yes/no to increase opportunity for change talk.

Instead of:	Say:
Are you drinking too much?	Tell me about your drinking over the past month.



Affirmations

Authentic recognition of strengths to build self-efficacy (competence).

Instead of:	Say:
Good job.	You managed to stay sober for two months under extreme stress—that shows real commitment.



Reflections

Shows understanding of meaning and affect. Not mere paraphrasing.

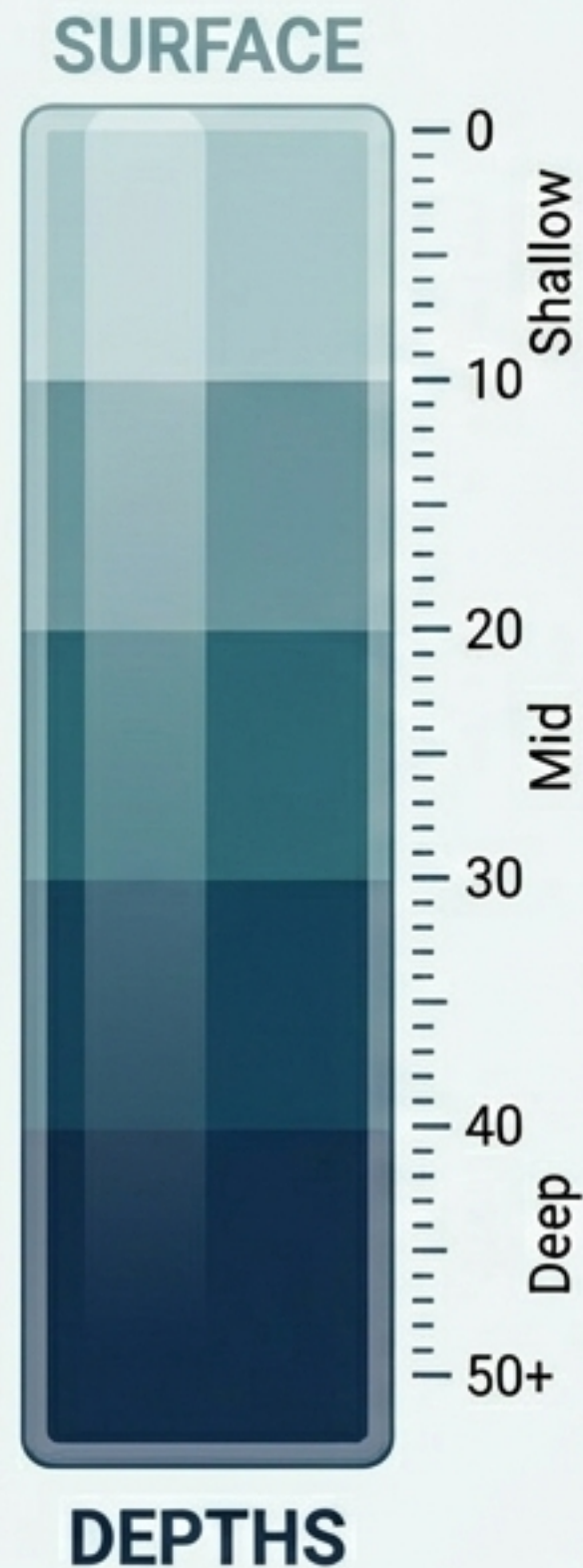
Deep dive on next slide.



Summaries

Consolidates patient thoughts, transitions phases, and strategically increases the prominence of change talk.

Deep Dive: The Power of Reflections



Simple Reflections (The Surface)

Restating what the patient said with slightly different wording to convey active listening.

Patient: I'm overwhelmed with work and family.

Clinician: So it feels like everything's piling on at once.

Complex Reflections (The Depths)

Adding depth by revealing implied emotions, conflicts, or amplifying ambivalence.

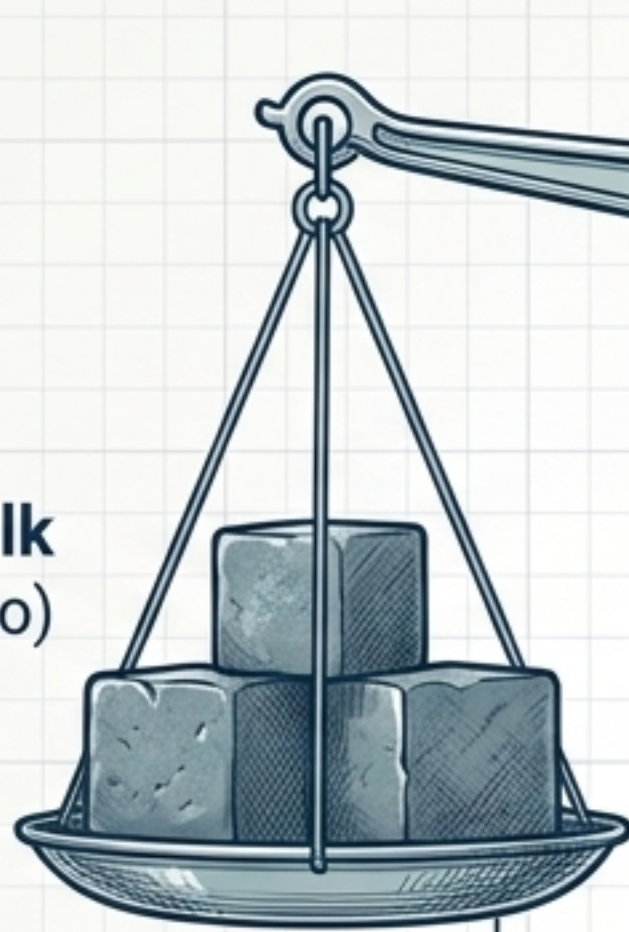
Patient: I know I should quit smoking, but I love smoking.

Clinician: Part of you recognizes smoking isn't helping your health, and another part of you really values the stress relief it gives.

The Paradox: Amplifying and explicitly reflecting ambivalence actually accelerates the patient's ability to resolve it.

Decoding Motivation Signals

Sustain Talk
(The Status Quo)



Change Talk
(The Catalyst)



Language favoring current behavior

Example: I don't think I can quit. Smoking helps me relax.

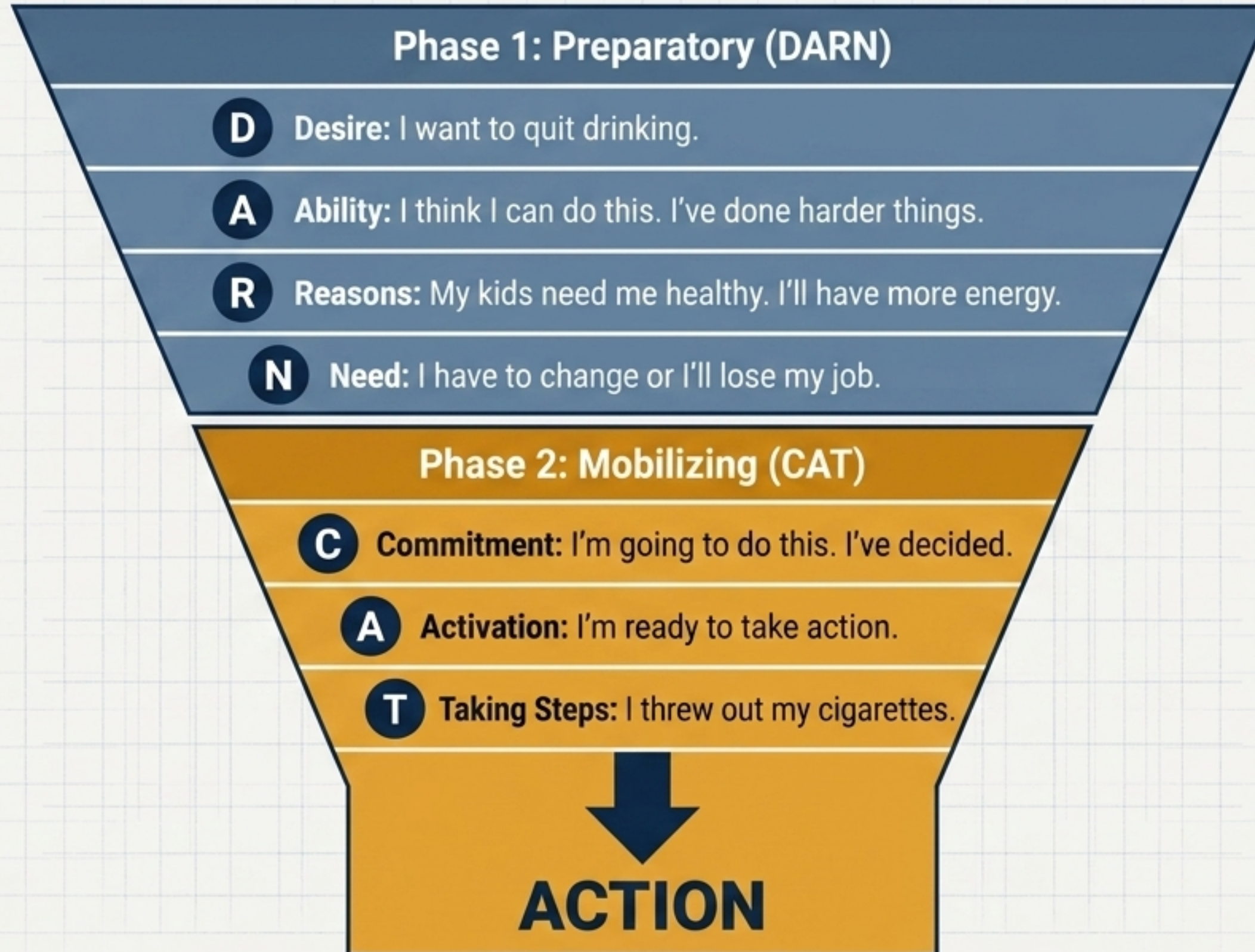
Clinical Strategy: Do NOT argue against it (triggers defensiveness). Acknowledge it, reflect with curiosity, and explore underlying concerns.

Patient-generated language favoring change

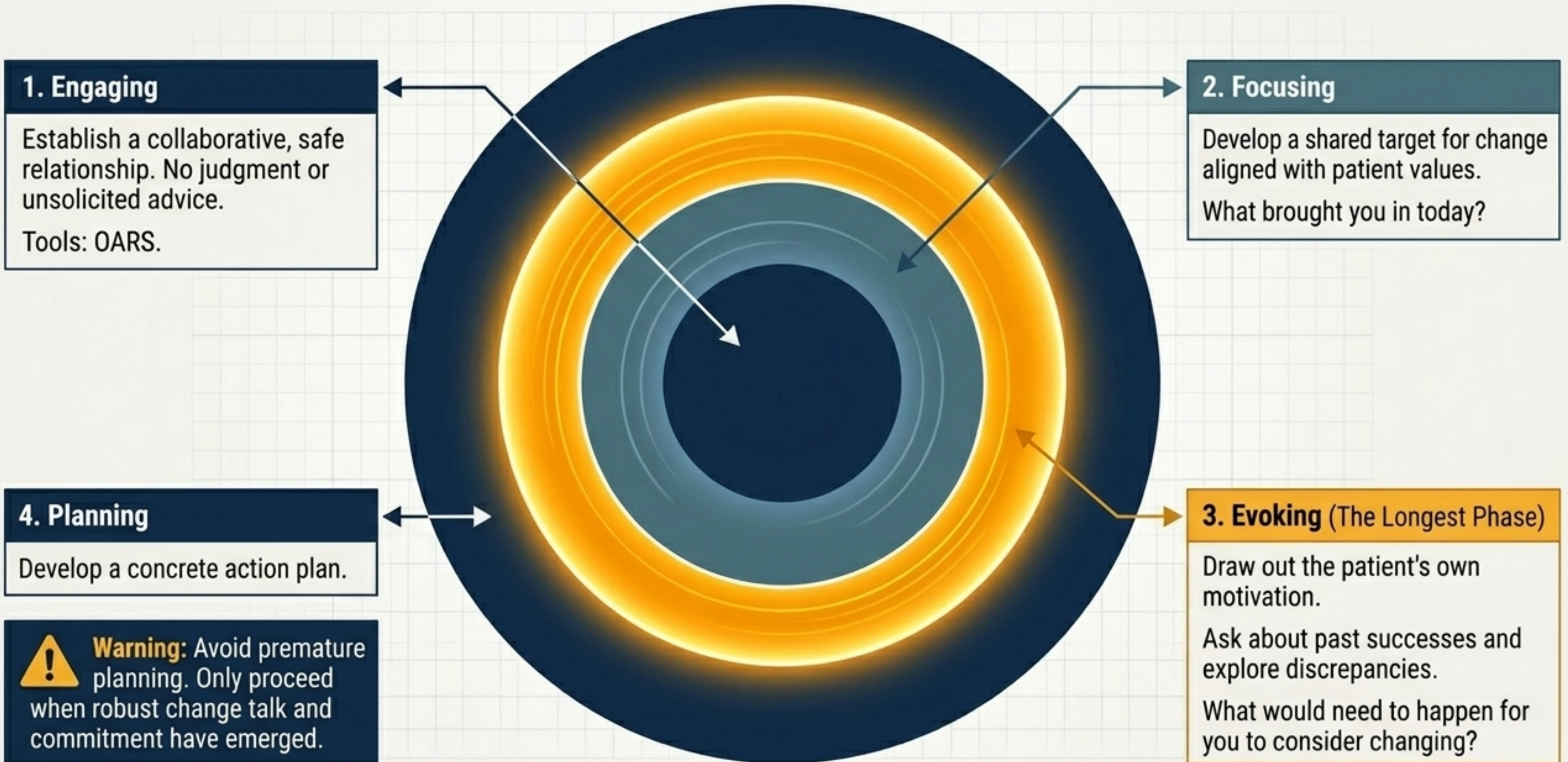
The leading indicator of behavioral success.

Clinical Strategy: The moment you hear it, reinforce it with reflections and requests for elaboration (Tell me more about how that would help).

The Anatomy of Change Talk (DARN-CAT)



The Four Processes of MI



Clinical Pitfalls & The Righting Reflex

The Trap

The Righting Reflex

The well-intentioned instinct to immediately fix the problem with advice.

The Expert Trap

I know what's best for you, which makes patients passive or resistant.

Premature Focusing

Jumping straight to medication adherence or abstinence before understanding the patient's priorities.

Taking Sides in Ambivalence

Arguing solely for change, forcing the patient to unconsciously argue for the status quo.

The MI Antidote

Suppress the reflex.

Ask questions that invite the patient to generate their own solutions first.

Maintain curiosity.

Share information as one perspective among many (Some research suggests... What do you think?).

Take time to align clinician and patient goals early.

Explicitly validate both sides of the ambivalence.

Measuring Competency: The MITI Scale

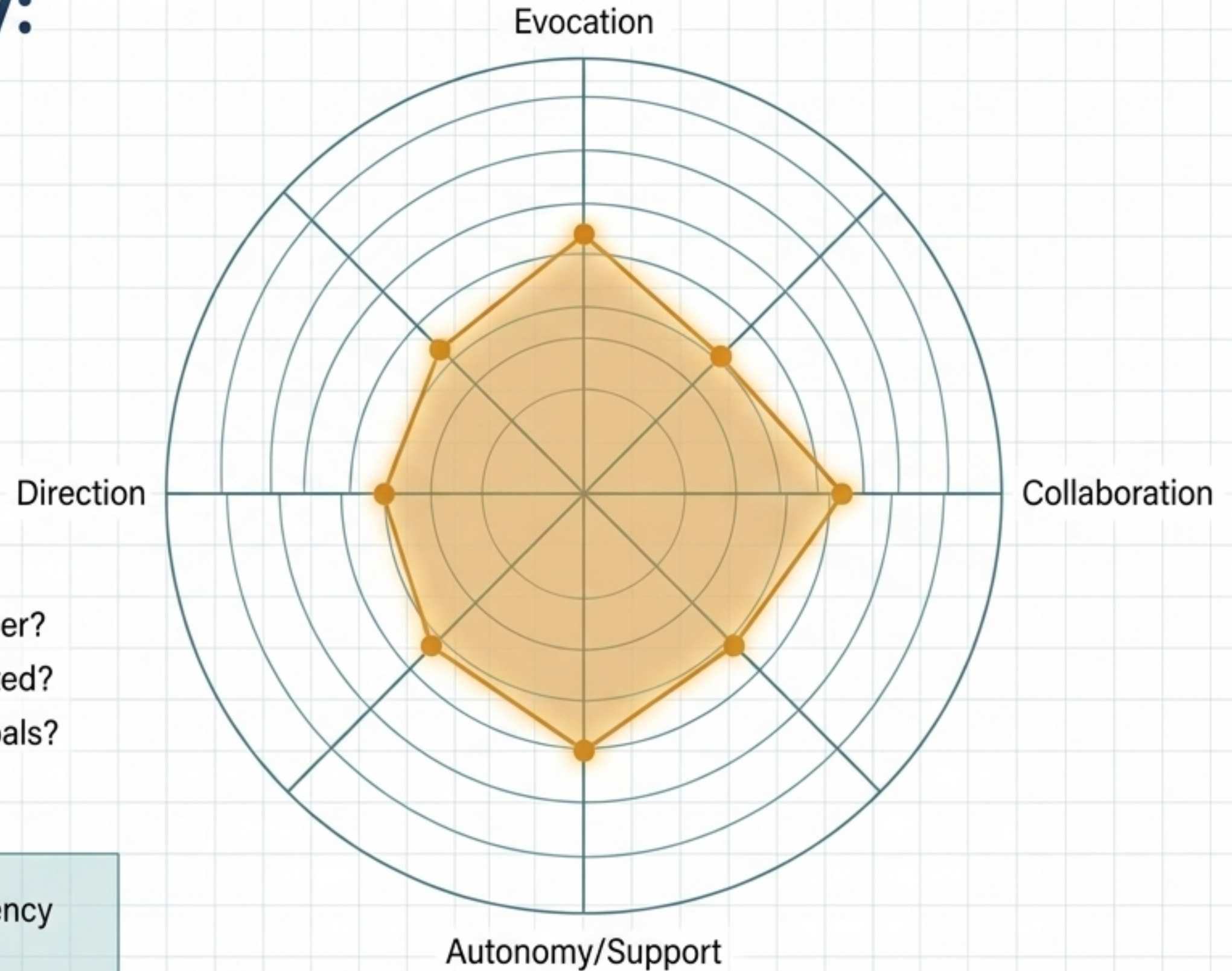
Motivational Interviewing Treatment Integrity (MITI)

The validated coding instrument used to evaluate fidelity to MI in recorded sessions.

4 Metrics of Competency

1. **Evocation:** Does the clinician elicit change talk?
2. **Collaboration:** Is the patient treated as an equal partner?
3. **Autonomy/Support:** Is patient choice actively respected?
4. **Direction:** Is the conversation maintained on target goals?

Note: MINT certification requires demonstrated competency via strict MITI audio coding to prevent clinical drift.



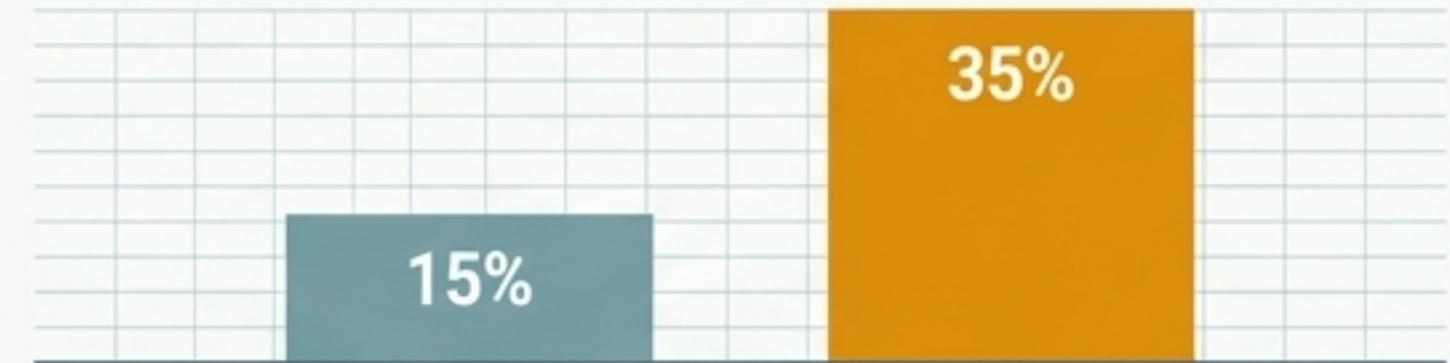
The Evidence Base & Clinical ROI

Substance Use Disorders (SUD)

5–10 Number Needed to Treat (NNT)

First-line SAMHSA treatment. NNT of 5–10 for abstinence/significant use reduction at 6-12 months.

Smoking Cessation



25–35% quit rates with MI. Effect size: $d=0.30-0.50$. Synergy when combined with pharmacotherapy.

Medication Adherence



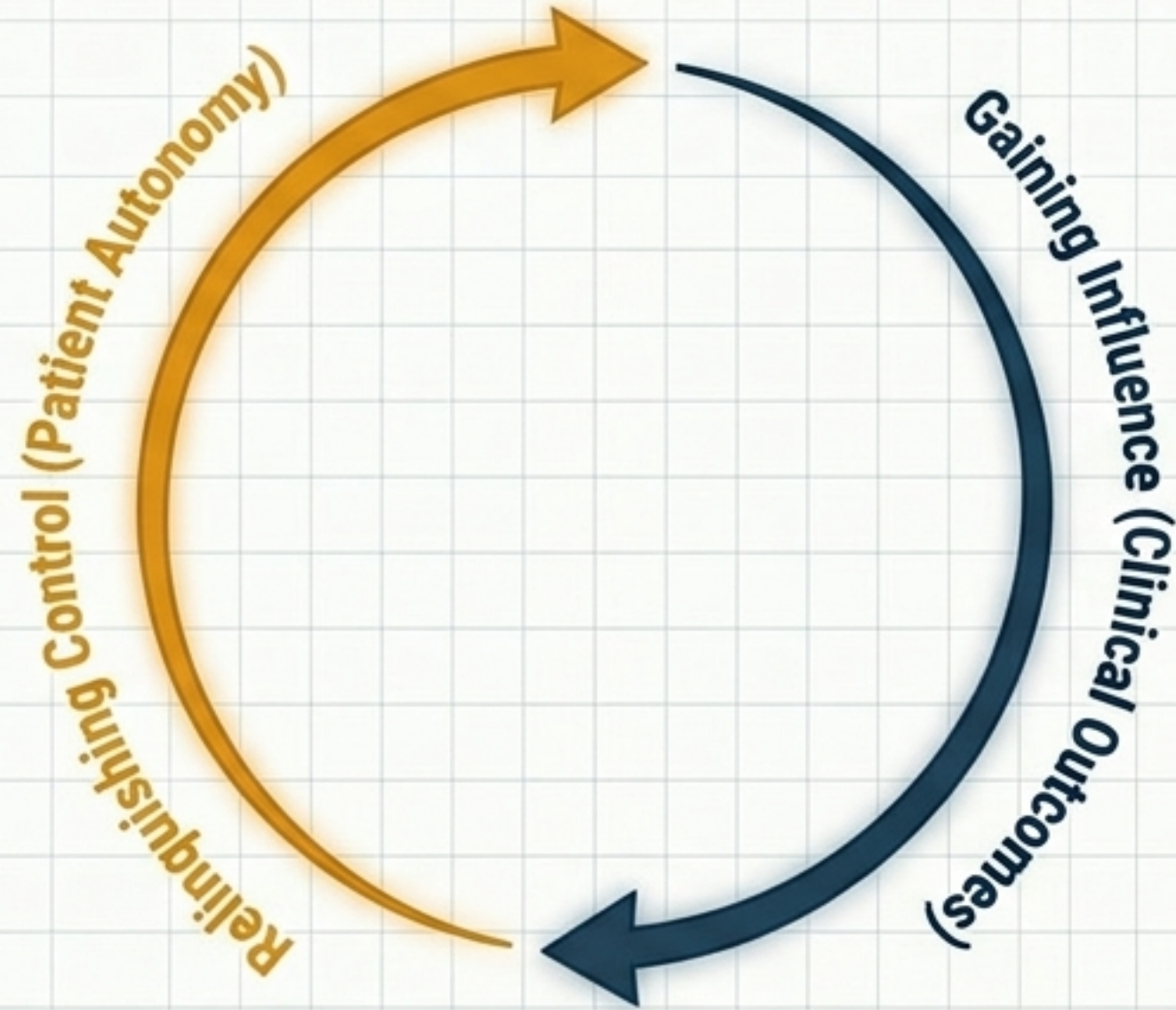
Vastly improves adherence to psychiatric meds (lithium, antipsychotics) by exploring side effect concerns and stigma without judgment.

First-Episode Psychosis



Adapted MI reduces dropout and improves treatment engagement in patients who deny illness, by acknowledging non-normative experiences without forcing diagnostic labels.

Synthesis: The Clinical Paradox



The Ultimate Paradox of MI: By relinquishing coercive control and completely respecting patient autonomy, the clinician actually gains greater influence over positive health outcomes.

The Takeaway: By rolling with resistance and refusing to force change, you create the exact psychological conditions required for the patient to change themselves. Motivation is not prescribed; it is discovered.