



IssueBrief

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Dancing, not wrestling:

Motivational interviewing helps case managers cultivate relationships and elicit change

You cannot “fix” a client.

Of course, every professional case manager knows people cannot be “fixed.” Sometimes, we think we can. But we can’t.

No matter how skilled, passionate and talented board-certified case managers are, they cannot solve all their clients’ problems; patients need to be part of the process. And case managers possess the expertise to guide clients toward finding their own solutions, to give them the tools to self-manage and to make transformative changes.

This truth lies at the heart of motivational interviewing (MI)—collaborative, client-centered conversation that strengthens the client’s own motivation to change. Ultimately, it’s about effective, two-way communication. Communication includes talking *and* listening.

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—CATHERINE M. MULLAHY, RN,
BS, CRRN, CCM, PRESIDENT OF
MULLAHY & ASSOCIATES, LLC.

Why it matters

Communication is essential to effective case management, Mullahy explained. As defined by the Commission for Case Manager Certification, case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services required to meet the client's health and human service needs. (See figure on page 7.) It is characterized by advocacy, communication and resource management, and promotes quality and cost-effective interventions and outcomes.

Communication is necessary to assess needs; establish goals; create an effective care plan; collaborate with clients and their families, providers and payers and others involved in the care; and to optimize potential for improved outcomes and enhanced client satisfaction, Mullahy said.

Poor communication, however, impairs outcomes and increases costs. It creates a stressful environment for clients and their families; it leads to confusion, anger and frustration, and to fragmented care—including unsafe discharges and transition-of-care failures. Poor communication increases errors and complications; it results in less-than-desirable or unanticipated outcomes, all of which result in increased costs due to hospital readmissions, ER visits and other negative outcomes.

the heart of this relationship-based model of care," explained Catherine M. Mullahy, RN, BS, CRRN, CCM, president of Mullahy & Associates, LLC. It comes down to engaging clients one individual at a time, Mullahy said. But that doesn't happen naturally; case managers need to master effective communication techniques and one of the most important, she says, is motivational interviewing.

Motivational interviewing is a clinical method, a guiding process that seeks to bring forth and strengthen a person's own

The technique has gained acceptance across various fields, including public health, health promotion and case management. It is not an intervention itself, but an amalgam of principles and techniques drawn from existing models of psychotherapy and behavior-change theory.¹

MI was first developed to work with substance abuse, Goldstein said. Eventually, it became clear that the set of skills used in the technique was associated with better outcomes, regardless of interventions. A 2005 literature review found significant support for MI's efficacy.²

MI is client-centered, collaborative and fully respectful of the client's autonomy and preferences. It helps clients sort through their thoughts, ideas and often ambivalent feelings about their current situation and possibilities for change.

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That study found the greatest impact came when MI was brought to bear immediately following treatment; the effect was less obvious—but still significant—when used during follow-ups after about a year. Of particular significance, outcomes were better when no manual was used. "The checklist method doesn't work as

¹Resnicow, et. al. Motivational Interviewing in Health Promotion: It Sounds Like Something Is Changing Health Psychology 2002, Vol. 21, No. 5, 444-451

²Hettema, J., et al., Annu Rev Clin Psychol, 1, 91-111, 2005

well," Goldstein explained. MI must be tailored to the needs of a particular client. And that, he said, gets to its spirit.

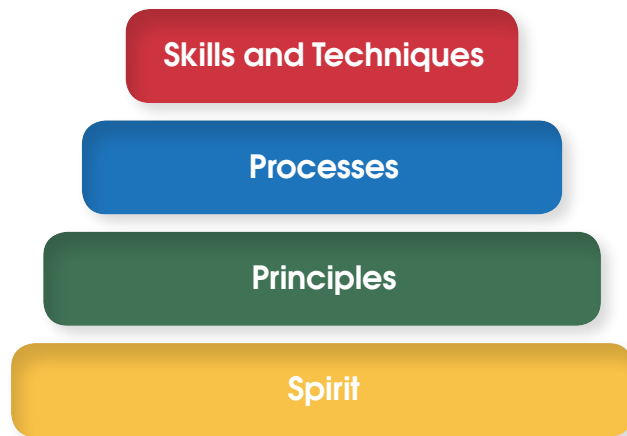
The spirit and principles of MI

To practice MI, one must understand its spirit; Goldstein identified three core elements of that spirit:

Collaboration: Collaboration is key to both communication and client-centered care. The conversation is non-authoritarian and nonjudgmental. "We want to support them even when they are not following through the way we would like them to."

Evocation: The client is the expert, and the case manager must explore what is important to that client. When clients express their reasons for change, they are more likely to take action. One test of how well you are doing this, said Goldstein, is to ask, "Who is doing most of the talking?" If it is not the client, you may not be doing MI, he cautioned. The client's own experience may be the answer to helping enhance motivation. "After all, it is their health."

Learning Motivational Interviewing



COURTESY OF: Michael G. Goldstein, MD, associate chief consultant for preventive medicine, Veteran's Health Administration, National Center for Health Promotion and Disease Prevention.

Autonomy: It is the client who is in charge. The encounter doesn't involve coercion or argument. Clinicians remain nonjudgmental about whether their clients choose to change, and the case manager seeks client permission before moving forward. Any decision is entirely up to the client. This approach acknowledges a basic truth, Goldstein said: "Clients will end up doing what they want to do."

This spirit informs the principles and practice of MI, from listening and understanding to planning and

"change talk." (For more on change talk, see sidebar **Listen to the "change talk."**)

The basic principles of MI reflect its spirit; they are summarized with the acronym RULE:

- **Resist the "righting reflex."** It is easy to assume the role of the expert in exchanges with clients. "We sometimes fall into the trap of trying to fix them rather than help them understand themselves," Goldstein said. But even though you may indeed be the expert and have the client's best interest at heart, "people just do not like to be told what to do," he warned. "If we are to help guide the client to make their own decisions in their best self-interest, we have to avoid correcting the client's behavior." Instead, seek to ...

- **Understand your client's motivations.** Work from where

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the client is now, not where you want the client to be. Understand what the client thinks and feels about the issue at hand. What is important to them? What are their feelings and concerns? Ask, Goldstein said. Don't tell...

- **Listen to your client.** Specifically, engage in *reflective* listening: Listen, then reflect back what you think the client said or meant. This is how you find out why the client might—or might not—want to change a particular behavior. This can help you...
- **Empower your client.** Build confidence. Support the client's ability to change or improve health behavior. Make it clear you have every

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confidence in their ability to change, and review and emphasize past successes. This must be genuine and sincere, not patronizing.

The motivational interview process

Goldstein warned there's no shortcut to the MI process. He acknowledged that case managers often

have limited time with a client, but emphasized that the MI process cannot be rushed. "I wish we could make the change happen faster. One of the hardest things for us is recognizing that change doesn't occur overnight."

Rushing the process can backfire. "If we try to push too hard when the (client) is not ready, we end up going backward," he said. One strategy to try to move the process forward is to ask the client about prior successes, and tap into that response for ideas to engage and motivate. But change happens in its own time, he said. "I wish I could say there is a fast way. It really requires a period of knowing one another and building relationships."

The process has four stages:

- 1. Engaging.** To get the client **engaged** is essential, and a prerequisite to everything else.
- 2. Focusing in on something the client is willing to work on.** This process includes collaborating on an agenda, finding a strategic focus, addressing ambivalence and then sharing information and advice.
- 3. Evoking the client's motivation.** This is where the desire for action begins to be expressed.

Listen to the "change talk"

"Change talk" is an important element of MI and, when expressed by the client, a strong predictor of subsequent change, Goldstein said. He identified five elements of change talk; the acronym for these elements is DARN-C:

- **Desire—the client's expression of wanting to change.**
For example: "I *want* to stop coming to the hospital over and over."
- **Ability—the confidence for change.**
"I *can* take better care of my diabetes. I have done it before."
- **Reasons—why the client wants to change.**
"Drinking gets me in trouble, makes my blood pressure higher and makes my family not want to be with me."
- **Need—taking the desire and reasons to the level of high priority.**
"I *need* to take my meds so I can stay healthy and be there for my family."
"We really like hearing statements that reflect need," Goldstein said.
- **Commitment—verbs associated with action.**
"I will plan the meals I eat." "I will quit smoking on a certain date."
This is the highest level of change talk and most likely to be associated with change, he said.

This involves listening, selective responding and selective summaries.

- 4. Planning.** The last phase. It involves moving to an action plan that addresses barriers. It also involves obtaining commitment.

Although each phase is important to the process, the first is both fundamental and essential: Nothing happens without engagement.

Engagement: building a relationship

The goal of engagement is to build a therapeutic relationship and understand the client's reality—feelings, beliefs, values, concerns about change. Engagement provides the opportunity to identify what's important to the client and his or her level of confidence about taking action, Goldstein said. Recognize and affirm strengths and motivation, and accept *without judgment* what you have learned.

"Distill the motivation that is there, accept ambivalence when it's there," he counseled. "Roll with resistance."

He shared four strategies that are central to engagement—and that

How will you know you're doing MI right?

- ✓ Client is doing most of the talking
- ✓ Clients are making a lot of "change talk" statements
- ✓ Resistance is minimized
- ✓ Clients are doing most of the work toward change

are core skills of MI. The acronym for these four strategies is OARS:

■ **Open-ended questions.**

This is key to understanding the client's perspective and motivation—and eliciting "change talk."

- "What are you currently doing that helps you to manage your diabetes?"
- "Tell me more about your interest in staying healthy."
- "What worries you the most about your heart condition?"

The questions go to motivation and current activity—as well as to what worries them. Such questions identify opportunities for and barriers to change.

- **Affirmation** involves recognizing and reinforcing the client's efforts and strengths by making statements that support her

ability to follow through with what she wants, or recognize her strengths, past and present. But the affirmation must be genuine and real—not patronizing. He offered some examples:

- "I am pleased that you were willing to come in today to check on your blood pressure, despite all that is going on."
- "I appreciate your honesty about not taking the medication. I would like to hear more about your concerns or what got in the way."

- **Reflection**—or **reflective listening**—is the intentional use of listening to seek, clarify and deepen understanding. It allows for hypothesis testing and creates awareness of gaps in understanding for both the client and the case manager. MI is built on this skill, he said. However, "it is one of the harder things to learn. Reflective listening requires not only attention and active listening, but also reflecting back what we hear in an effort to confirm, clarify and deepen our understanding of the meaning of what the person is saying."

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After making a reflection, it is important for the listener to wait for the speaker to respond. This allows the speaker to verify, correct and elaborate as needed. Note the difference: "So, you are trying to please your spouse?" vs. "So,

you are trying to please your spouse." The latter is a reflective statement of understanding. It's a *statement*, and the voice goes *down*.

There are various levels of reflection, he explained:

- Simple: repeating the words back to the client.
- Complex: reflecting feelings, concerns, values and deeper meaning (e.g., "It's really important for you to make sure you are there for your wife and kids:").
- Summaries: reflections that contain a summary of the speaker's statements.

Moving beyond frustration

Sometimes, case managers need to deal with their own attitudes that may create barriers to engagement, Goldstein said. "When we become frustrated or judgmental, we become less effective." Remember that change is challenging.

He offered these strategies for moving beyond frustration:

- Ask the client what it would take to be more actively involved. Ask about what is going on that makes it difficult to change.
- Seek to understand rather than assume.
- Recognize that clients are often doing the best they can.
- Give up the need to fix everybody. "We can't fix everybody," he said. But by using strategies that draw out the client's own motivation, the case manager can keep the focus on the client.

■ **Summary**, a form of reflective listening, entails understanding, eliciting more and reinforcing "change talk." It is a way to begin to move the interaction—increasing focus and/or planning (e.g., "So, where would you like to go from here?"). It also gives the case manager a chance to collect herself and check her assumptions.

Goldstein likens summaries to a bouquet. The case manager gathers flowers—each of which represents a piece of "change talk"—then puts them in a bouquet. He offered the following example:

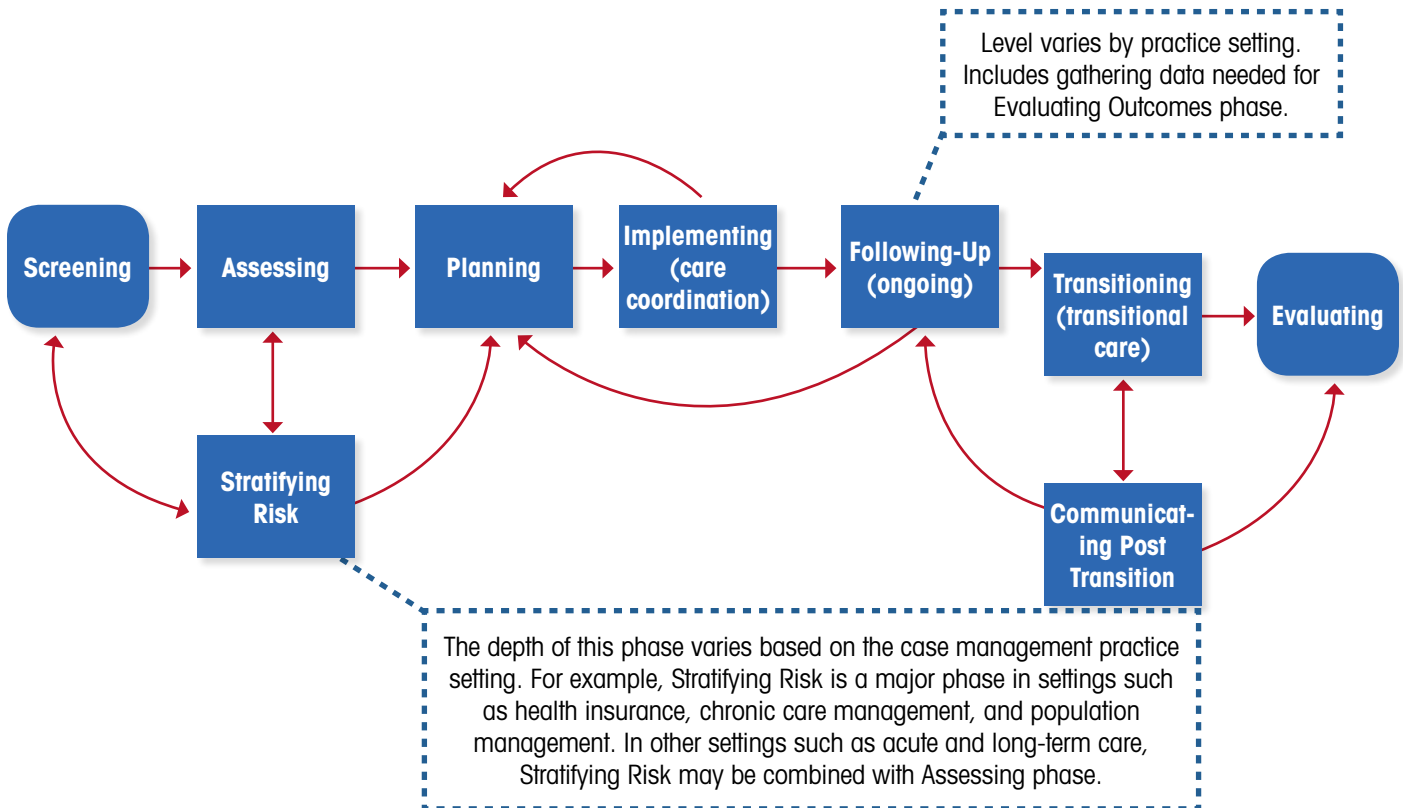
"So, you mentioned several reasons for working on healthy eating and meal planning, including being able to reduce the number of meds you are taking for your diabetes. You also want to gain better control over your diabetes and want to avoid the complications that your mother had. You are frustrated by previous attempts to work on your weight, but you have had some success in the past. I would like to help you develop a plan that will work for you."

An example of a summary "bouquet"

"So, you mentioned several reasons for working on healthy eating and meal planning, including being able to reduce the number of meds you are taking for your diabetes. You also want to gain better control over your diabetes and want to avoid the complications that your mother had. You are frustrated by previous attempts to work on your weight, but you have had some success in the past. I would like to help you develop a plan that will work for you."

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Case Management Process (High Level)



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Dancing, not wrestling

"MI is conducted by working *with*, rather than *at*, the client." The interaction represents a collaborative effort in the interest of the client, and can be viewed as a

partnership—it is, Goldstein explained, like dancing, not wrestling.

"We are in sync, linked, connected, moving together. We take one step forward, hoping the client comes

with us." And sometimes, he added, being in a dance means following the client's lead for a while. "It becomes a collaborative, even artistic, way of working together."

As with dance, achieving this level of coordination and partnership takes time and practice. Done well, you will have a client who is engaged, activated, motivated, empowered and confident, he said. "If we dance with the patient by working with him or her rather than directing—guiding rather than wrestling—we are much more likely to promote meaningful change and be satisfied with the result." ■

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About the Experts



**Catherine M. Mullahy,
RN, BS, CRRN, CCM,
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With more than four decades of experience managing health care, Catherine M. Mullahy, RN, BS, CRRN, CCM is a consultant to case management firms, managed care organizations, hospitals, health care providers, government agencies including Veteran's Health Administration and Indian Health Services.

Mullahy's direct case management experience spans home, hospital, hospice and critical care settings. Her firm, Options Unlimited, provided utilization management, case management, disease management, employee risk review and other programs to corporations. The firm was acquired by Matria Healthcare, Inc. in 2003 and began serving as its Case Management Division.

She is a past chair of the Commission and served as its representative to the Foundation for Rehabilitation Education and Research and on ongoing expert panels in connection with the development of the CCM[®] credential. She served on the Case Management Advisory Committee for URAC and was a board member of the Foundation for Rehabilitation Education and Research from 2001 to 2005.

Mullahy was named the Distinguished Case Manager of the Year by CMSA and received CMSA's Lifetime Achievement Award. She served as president of CMSA's board from 2001-2002. She is author of *The Case Manager's Handbook*, now in its fourth edition. Editor of *The Case Manager*, she serves as contributing editor for *Case Management Advisor* and other publications.



**Michael G. Goldstein, MD, associate chief
consultant for preventive medicine,
Veteran's Health Administration (VHA),
National Center for Health Promotion
and Disease Prevention**

Goldstein supports elements of a new VHA initiative to enhance the integration of preventive care within Patient Aligned Care Teams the VHA's version of a patient-centered medical home. He is also an adjunct professor of psychiatry and human behavior at Alpert Medical School, Brown University.

He is trained in both primary care internal medicine and psychiatry and also completed a fellowship in medicine and psychiatry, all at the University of Rochester. Throughout his career, he has worked at the interface between medicine and psychiatry, serving as a consultation-liaison psychiatrist, a medical director of a behavioral medicine clinic, a teacher of patient-centered communication and counseling skills, and as a researcher in the areas of tobacco cessation, physical activity adoption, clinician-patient communication and delivery of preventive services.

He was a member of the Public Health Service's Tobacco Dependence Treatment Guideline Panel and the FDA's Risk Communication Advisory Committee. Goldstein is a past president of the Society of Behavioral Medicine and a fellow of the American Psychiatric Association, the Society of Behavioral Medicine and the American Academy on Communication in Healthcare.

Disclaimer: Dr. Goldstein's comments and opinions are his own and do not represent the official views or positions of the Veterans Health Administration.

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