The Art of Motivating Behavior Change: The Use of Motivational Interviewing to Promote Health

Harold E. Shinitzky, Psy.D., and Joan Kub, Ph.D., R.N., C.S.

INTRODUCTION

Health promotion and disease prevention have always been essential to public health nursing. With the changing health care system and an increased emphasis on cost-containment, the role of the nurse is expanding even more into this arena. A challenge for public health nurses, then, is to motivate and facilitate health behavior change in working with individuals, families, and communities and designing programs based on theory. Leading causes of death continue to relate to health behaviors that require change. The purpose of this article is to integrate theory with practice by describing the Transtheoretical Model of Change as well as the principles of motivational interviewing that can be used in motivating behavioral change. A case scenario is presented to illustrate the use of the models with effective interviewing skills that can be used to enhance health. Implications for practice with an emphasis on providing an individually tailored matched intervention is stressed.

Key words: Transtheoretical Model, motivational interviewing, health promotion, health behavior.

Abstract Health promotion and disease prevention have always been essential to public health nursing. With the changing health care system and an increased emphasis on cost-containment, the role of the nurse is expanding even more into this arena. A challenge for public health nurses, then, is to motivate and facilitate health behavior change in working with individuals, families, and communities and designing programs based on theory. Leading causes of death continue to relate to health behaviors that require change. The purpose of this article is to integrate theory with practice by describing the Transtheoretical Model of Change as well as the principles of motivational interviewing that can be used in motivating behavioral change. A case scenario is presented to illustrate the use of the models with effective interviewing skills that can be used to enhance health. Implications for practice with an emphasis on providing an individually tailored matched intervention is stressed.

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With the changing health care system and an increased emphasis on cost-containment, the role of the nurse is expanding more and more into the arena of health promotion. In 1986, the First International Conference on Health Promotion was held in Ottawa, Canada. This conference has served as a source of inspiration for health promotion since that time. Five levels of action were outlined: (1) building health public policy, (2) creating supportive environments, (3) strengthening community action, (4) developing personal skills, and (5) reorienting the health system (World Health Organization [WHO], Health and Welfare Canada, and the Canadian Public Health Association, 1986). It is increasingly recognized that action on all of these levels is necessary for a comprehensive approach to health. Influences on health occur at several levels including individual, interpersonal, community, environmental, and health care system (Donatelle & Davis, 1998).

Health promotion strategies, which influence an individual or population, may be either active or passive. Passive strategies involve the client as an inactive participant and include approaches such as maintaining clean water. Active strategies on the other hand, depend on the individual becoming personally involved in adopting a proposed program of health promotion that might include exercise regimens or decreasing daily calories (Edelman & Mandle, 1998). Personal health behavior began to attract attention in the 1960s, with the release of the First Surgeon General’s Report on Smoking and Health. Since that time other areas of human behavior, such as dietary patterns and physical activity, have been subjects of major Surgeon General’s Reports (Lee & Estes, 1997).
As outlined in the Ottawa Charter, we seek to explore the role that nurses can play in promoting and developing personal skills leading to healthier clinical outcomes. This is not to negate the importance of the other skills, but it is increasingly recognized that behavioral determinants of health are contributing factors of premature death. These leading causes of death in order of priority are tobacco, diet and activity, alcohol, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles, and the illicit use of drugs (McGinnis & Foege, 1993).

A challenge for public health nurses then, is to motivate and facilitate health behavior change. Effective interpersonal skills are essential techniques that can be used to accomplish this task. Enhancing the interpersonal communication skills of health providers results in increased levels of satisfaction among clients and providers, greater adherence to treatment regimens, fewer lawsuits, continuity of the same provider, and better follow-up on appointment keeping (Hall, Roter, & Tand, 1988; Levinson, Roter, Mullooly, Dull, & Frankel, 1997; Wissow et al., 1998; Haynes, 1976).

Noneffective encounters often result in barriers to optimal care. Although most patients are able to identify approximately three to four issues that they would like to address with their health care provider, one study revealed that the average health care provider interrupts his or her patients’ disclosures after 18 seconds (Beckman & Frankel, 1984). Post visit research has also revealed that 30 to 60% of medical information discussed in an encounter is forgotten, and 50% of medical treatment regimens are not followed to their fullest extent (Haynes, Taylor, & Sackett, 1981).

Our role as effective health care providers must include then, an understanding of the interpersonal skills that can be used to motivate individuals to move towards optimal health. The purpose of this article is to integrate theory with practice by describing one model, the Transtheoretical Model of Change, that can guide nurses in facilitating change and to further discuss principles of motivational interviewing that can be used in facilitating this change.

**Transtheoretical Model of Change**

The Transtheoretical Model of Change, which consists of five stages, has emerged from the research efforts of Carlo DiClemente and James Prochaska over the past 18 years. Most of the research has focused on smoking cessation, but the model has also been applied to other addictive behaviors including drug abuse, obesity, eating disorders, gambling, exercise, and condom use (DiClemente & Prochaska, 1998). In the model, intentional behavior change is emphasized as opposed to societal, developmental, or imposed change (Prochaska, DiClemente, & Norcress, 1992). The three organizing constructs of the model are stages of change, processes of change, and levels of change (DiClemente & Prochaska, 1998).

**Stages of Change**

The stages of change consist of five categories along a continuum that reflect an individual’s interest and motivation to alter a current behavior. It is through movement along these stages that one is able to achieve successful behavioral change (DiClemente & Prochaska, 1998). These stages include precontemplation, contemplation, preparation, action, and maintenance. Each health care provider must determine the readiness to change or the stage in which each patient is in prior to developing a treatment plan.

1. **Precontemplation** is the stage in which there is an unwillingness to change a problem behavior or there is a lack of recognition of the problem. If a patient is not thinking about any behavior change in the next 6 months, she or he is classified as a precontemplator.

2. **Contemplation** involves the stage in which there is a consideration of change ... the patients’ disclosures after 18 seconds (Beckman & Frankel, 1984). Post visit research has also revealed that 30 to 60% of medical information discussed in an encounter is forgotten, and 50% of medical treatment regimens are not followed to their fullest extent (Haynes, Taylor, & Sackett, 1981).

3. **Preparation** represents the period when there is a commitment to change in the near future, usually 1-month. Patients express a high degree of motivation towards the desired behaviors and outcomes. Patients in the preparation stage have determined that the adverse costs of maintaining their current behavior exceed the benefits. Therefore, initiating a new behavior is more likely. These patients have moved from thinking about the issue to doing something about it.

4. **The fourth stage, Action, is when change or modification of behavior actually takes place.**

5. **After 3 to 6 months of success, the last stage of Maintenance is begun.** During this stage, there is a focus on lifestyle modification in order to avoid relapse and to stabilize the behavior change (Cassidy, 1997; DiClemente & Prochaska, 1998).

**Processes of Change**

The processes of change facilitate movement through the stages of change. There are 10 processes that have been identified that are responsible for movement (DiClemente & Prochaska, 1998). Five of these processes, which include consciousness raising, dramatic relief, environ-
mental reevaluation, social liberation, and self reevaluation, are experiential or cognitive processes. These are internally mediated factors that are associated with an individual’s emotions, values, and cognitions (Cassidy, 1997). Consciousness raising is described as encouraging individuals to increase their level of awareness, seek new information, or to gain an understanding about a problem. Dramatic relief is experiencing and expressing feelings about one’s problems. Environmental reevaluation is assessing how one’s problem affects the physical environment. Social liberation is increasing alternatives for nonproblem behaviors in society. Self reevaluation is assessing how one feels and thinks about oneself in relationship to the problem (Prochaska et al., 1992).

The five other processes (counter conditioning, helping relationships, reinforcement management, stimulus control, and self-liberation) are behavioral processes (Prochaska et al., 1992; Cassidy, 1997). Counter conditioning is substituting alternatives for problem behaviors. An example might be the use of meditation to cope with unpleasant emotions (Cassidy, 1997). Helping relationships are defined as those that provide trust, acceptance, and support. The provider that listens when there is a need to discuss the problem is an example of this process. Reinforcement management is the use of positive reinforcements and appropriate goal setting with the patient. Stimulus control is helping the patient to restructure the environment so that the stimuli or triggers for the undesired behavior are controlled. Self-liberation is when an individual believes in himself or herself and his or her ability to change.

An integration of these processes with the stages can be seen in Figure 1. In other words, there is a match between the stage that the patient is in and the intervention that is used. Individuals in the contemplation stage would be most open to consciousness raising, the use of dramatic relief, and an environmental reevaluation. In the action phase, effective use of the behavioral processes is particularly helpful (Prochaska et al., 1992); (Prochaska & DiClemente, 1983).

Levels of Change
Clinicians recognize that individuals have multiple problems that often overlap. Addiction, for example, may be associated with marital problems, financial problems, personality disorders, depression, and violence. With this recognition, the Transtheoretical Model of Change incorporates five levels of change for consideration. These include changes that relate to the symptoms or situations, maladaptive cognitions, interpersonal problems, family/systems problems, and intrapersonal conflicts. Treatment outcomes are often better when a patient’s multiple problems are addressed (DiClemente & Scott, 1997). Understanding the life context of our patients increases the probability that treatment plans will fit their overall needs and be individually tailored. If we enter into this relationship with the belief that we are to assess, diagnose, and treat only the most obvious issue, we are likely to overlook other important issues. If we remain open to the multiple factors impacting our patients’ lives, however, we are apt to be inclusive rather than exclusive of potential issues.

Research Findings
Support for the Transtheoretical Model of Change has been accumulating over the past 15 years (DiClemente & Prochaska, 1998). Assessment of the stage of change that a person is in is one of the most relevant findings for practice. Previous research on estimating stage distribution has found that typically 40% of a population with an unhealthy behavior would be categorized in the precontemplation stage, 40% would fall in the contemplation stage, and 20% would self-assess in the preparation stage (Dijkstra, DeVries, & Bakker, 1996; Fava, Velicer, & Prochaska, 1995). Several studies have focused on creating assessment tools to determine the level of motivation for change which include the 12-item Readiness to Change measure (Rollnick, Heather, Gold, & Hall, 1992), the 20-item Alcohol Abstinence Self-Efficacy Scale (DiClemente, Carbonari, Montgomery, & Hughes, 1993), the University of Rhode Island Change Assessment (URICA) (McConnaughy, DiClemente, Prochaska, & Velicer, 1989), the Stages of Change Readiness and Treatment Eagerness Scale (SOC-RATES) (Miller & Tonigan, 1996), and the Readiness Ruler (D’Nofrio, Bernstein, & Rollnick, 1996).

Action oriented interventions often target the 20% of the individuals in the preparation stage while the remaining needs of the entire population are not being met. It would therefore be incumbent to develop programs and interventions that either match the needs of individuals who have not yet made the conscious effort to change or for health.

<table>
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<tr>
<th>Processes</th>
<th>Stages of Change</th>
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<td>Consciousness raising</td>
<td>Precontemplation</td>
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<td>Dramatic relief</td>
<td>Contemplation</td>
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<td>Environmental reevaluation</td>
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<td>Self-revaluation</td>
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<td>Self-liberation</td>
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<td>Contingency management</td>
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<td>Helping relationships</td>
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<td>Counterconditioning</td>
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Figure 1. Stages of change in which processes are most emphasized. Reprinted with permission from Prochaska, Redding, & Evers, 1997.
MOTIVATIONAL INTERVIEWING

Once a patient’s stage of change is identified, the health care practitioner needs to implement clinical skills that will help facilitate the patient’s progression and movement along the continuum. Motivational interviewing is a framework developed by Miller and Rollnick (1991) that can help to facilitate this movement. It builds on the foundation of understanding that our role as the health care provider is to assist our patients to move toward a state of action that leads to improved health status outcomes. A mutually agreed upon treatment plan that is acceptable to the patient and fits within the medical parameters is more likely to be attained. Motivational interviewing is comprised of two equally important phases, which include: Phase I—building a therapeutic rapport and commitment, and Phase II—facilitating the movement through decisional analysis and behavior change. Table 1 outlines the principles of motivational interviewing.

Motivational interviewing is a process that is based on input by both parties. A starting point is to establish a safe environment in which our patients and their families feel as though they can reveal personal information.

The art of motivational interviewing is therefore a dance between two individuals suspending judgment and avoiding a confrontational style thereby minimizing defensive reactions by the patient. Providers need to challenge patients without eliciting defensiveness. When a patient reacts defensively, many providers tend to negatively label the patient and accuse him or her of being noncompliant and resistant. We view this as a logical behavioral reaction on the part of the patient who may not perceive the issues in the same manner. Providers need to be cautioned then, about challenging a patient too early and creating a dynamic relationship that requires a defensive posture. As all behaviors are purposeful, we must understand what it is that our patient values that leads to improved health status outcomes. A mutually agreed upon treatment plan that is acceptable to the patient by maintaining his or her current unhealthy lifestyle behavior (for example, smoking).

Acceptance of the person does not mean agreement with his or her behavior, but rather an appreciation of his or her perceived issues. We need to be more open to and understanding of our patients’ life contexts. It is best to start out with the patient’s agenda. No patient comes to us without some emotional concern. The emotional concern is frequently the motivating factor that prompted him or

<table>
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<th>TABLE 1. The Five General Principles of Motivational Interviewing (Miller, 1983)</th>
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| 1. Express empathy  
| a. Acceptance and understanding facilitates change  
| b. Skillful reflective listening is fundamental  
| c. Ambivalence is normal |
| 2. Develop discrepancies  
| a. Awareness of consequences is important  
| b. Engage in a discussion between present behavior and valued goals  
| c. Client driven rational for change |
| 3. Avoid argumentation  
| a. Arguments are counterproductive  
| b. Judging (why?) breeds defensiveness  
| c. Resistance is a signal to change therapeutic strategies  
| d. Labeling is unnecessary |
| 4. Roll with resistance  
| a. New perceptions are invited but not imposed  
| b. Client is a valuable resource re: solutions  
| c. Collaboration is valued  
| d. Mutually negotiated solutions |
| 5. Support self-efficacy  
| a. Hope is motivating  
| b. Patient is responsible for choosing and initiating  
| c. There is hope in the range of alternatives  
| d. Knowledge that certain behaviors lead to desired outcomes  
| e. Possession of those behavior |
Another important role of the provider is to help our patients see that they are in control of their lives. The sense of an internal locus of control, self-efficacy, and personal empowerment leads to taking a more active role in one’s life (Egan, 1998). The patient is ultimately the one responsible for making behavioral changes in his or her life.

When mutually discussing treatment options and alternatives, it is important to brainstorm. During the brainstorming phase, “cast the net” as wide as possible. Subsequent to identifying the vast array of possibilities, we then narrow our options to the most viable alternatives. A key concept during the brainstorming phase is to suspend judging the best therapeutic fit. Criticizing forestalls creativity and identification of all possibilities. Patients moving along the continuum of change, need their providers to amplify the discrepancy between the pros and cons which make up their decision-making equation. During the encounter it is important to refrain from lecturing, for pontificating the “right way” only alienates our patients.

As providers we need to weigh our words wisely. Every question asked needs to have some underlying purpose. We need to be reflective of our style and of the line of questioning. Whenever possible, providers need to avoid habitually asking the question, why? (Benjamin, 1987). This connotes disapproval and forces the patient to respond with excuses or alibis. Asking open-ended questions is a technique that encourages the patient to elaborate while habitually using closed-ended questions leads to brief responses (that is, Yes or No). By utilizing these techniques and skills, the encounter can be more rewarding. Recall that each session must address the needs, concerns, and opinions of the patient. Lastly, emotional factors are dealt with and problem solving is mutually managed. Common problems that providers can encounter are seen in Table 2.

### CASE SCENARIO

The following case scenario depicts a patient in the different phases of the Transtheoretical Model of Change. Different motivational interviewing approaches, some less effective and colleagues more effective, are presented to illustrate the value of applying appropriately matched techniques to help patients progress towards change. It is your task to determine the stage of change that this patient currently fits and assess the encounter. The case scenario that we present is based on a synthesis of actual patient encounters.

Mr. Smith is a 46-year-old, African American male. He presents with an upper respiratory infection (that is, wheezing, cough, and expectorant for 4 weeks). He has smoked for 25 years. He is 5’8”, 185 pounds, and has an unremarkable medical history. He has a positive family history for lung cancer in father and paternal grandfather. He requested some prescribed antibiotics to resolve his infection.

**Nurse M:** Mr. Smith, from what you have told me about your symptoms, what do think might have contributed to your infection?

**Rationale:** Respecting and valuing the patient as the expert in his own life is an important skill. This question is posed as an open-ended question, which allows the patient to elaborate from his perspective. This question also assesses the level of knowledge and insight the patient has regarding his current condition as well as initiates an evaluation of his location regarding potential behavioral changes.

**Mr. S:** I really don’t know. I just need an order for some meds.

**Rationale:** Patient appears to be unaware or potentially resistant and therefore, Precontemplative.

**Nurse M:** Based on the length of time of your symptoms, I believe that your smoking cigarettes adds to your condition. You should stop smoking.

**Rationale:** The provider has made a summarizing comment, however, this comment is latent with judgment and confrontation. In essence, the provider is attempting to force the patient from precontemplation into the action stage. This provider was talking at, rather than with the patient. The statement of “obviously” is filled with judgment. The provider asserts the “Gold Standards,” yet

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**TABLE 2. Common Problems That Providers Display**

1. Asking closed-ended questions. These do not foster an open dialogue between the patient and the provider. They usually limit the discussion to a yes or a no response.
2. Double options. Providers frequently assert an either-or scenario. This implies that there are only two options and that the provider is the one who knows which options are best. This style does not empower the patient to take an active role in problem solving.
3. Not responding to the emotional needs of a patient. Many providers feel comfortable focusing on the bio-medical needs. If a therapeutic rapport is not established, however, the patient is likely to remain focused on their underlying emotional issues that interfere with the effective flow of information and negotiation.
4. Using clichés to respond to patient disclosures. If used too often, they are perceived as trite and minimizing to the patients.
Mr. S: No, I don’t think so. I have been smoking cigarettes for several decades and I have never had this before.

**Rationale:** The patient responds with resistance to the confrontation. Denial is not a symptom of the addiction, rather it is a defensive response to the provider’s accusation. From the responses of this patient (that is, lack of insight or awareness of behavior problem and resistance) we can determine that he falls within the category, precontemplation.

**Encounter Analysis:** If this provider dictates the medical treatment requirements without understanding and appreciating his or her patient’s life context, the patient will likely fail and be labeled as noncompliant. Now that the provider knows that once you have determined the correct stage of change, however, the goal is to facilitate movement to the next stage (Precontemplative to Contemplative). This is best accomplished by matching motivational interviewing techniques. Let us continue with Mr. Smith.

Nurse M: Mr. Smith, from the symptoms that you have expressed and your history, I wonder if your smoking adds to this condition? You might want to think about the potential impact of smoking cigarettes has on your overall health.

**Rationale:** Again, using the history that the patient has provided, active listening, and summarizing key points back to the patient, the nurse displays genuine interest in what has been said. This response also displays an active listening style and the use of an indirect question. This free-floating style continues the assessment of motivation and insight into the patient’s condition. By offering numerous suggestions without any declarative accusations, the provider is using the process of consciousness raising.

Mr. S: I never gave much thought to that. I know my family and home has been affected by cigarette smoking and perhaps I have too.

**Rationale:** Patient is willing to consider this as a point of reflection due to the nonjudgmental style of the provider. The patient also reveals a potential consequence associated with the at-risk behaviors. Therefore, this patient has shifted to the contemplation stage. The nurse has helped the patient to use the processes of environmental reevaluation and self-liberation.

Nurse M: Would you care if I provided you with some information for you to look over?

**Rationale:** Here the provider is establishing a partnership with this patient. Based on what he has said before, we know that he had not considered this as contributing to the problem. Engaging in option development without imposing a judgment is vital.

Mr. S: Well, you know, I guess there wouldn’t be any harm in that.

**Rationale:** By not directly challenging, the patient is more accepting along the continuum. The patient is willing to be reflective and accept educational information. We see the movement from precontemplation to contemplation.

To further illustrate the movement along the continuum, we shall continue with this patient encounter. Once a patient is in the contemplative stage, our goal is to assist his or her positive, healthy progression towards behavioral change.

Nurse M: Mr. S, from what you have told me about your symptoms, what do you think might have contributed to your infection?

**Rationale:** Asking an open-ended question facilitates the encounter. This question elicits the patient’s opinions. Again, we present this in a respectful manner that values the patient’s observations and is therefore inclusive for solutions.

Mr. S: Well, we have talked about how my smoking may be making my infection worse and maybe even affecting my general health.

**Rationale:** The patient used the word “we,” indicating a mutual discussion rather than lecture from the provider. Additionally, the patient states the possible connection between this behavior and adverse consequences. This individual appears to be in the contemplation stage.

Nurse M: You’ve smoked for a couple of decades, what do you find that you get from smoking?

**Rationale:** Since all behavior is purposeful, we need to understand the reinforcing factors associated with this behavior in order to adequately address this patient’s needs. This is helping the patient to do a self-reevaluation.

Mr. S: I smoke when I am with my friends and it helps me to relax.

**Rationale:** The patient openly discusses the rewards for his current unhealthy behavior. These are needed when seeking leverage and when increasing the discrepancy between the pros and cons.

Nurse M: I see. And what are the drawbacks?

**Rationale:** Determining the patient’s level of insight and now assessing the negatives that will facilitate the decision-making process.

Mr. S: Well, we both know that it’s not doing me any good healthwise and it costs a lot.

**Rationale:** Mr. S is able to discuss both sides of the equation. He openly discusses the negative consequences associated with the at-risk behaviors. Again, these shall be
used to accentuate the discrepancy between reinforcing agents and contraindicators from the patient’s point of view.

_Nurse M:_ It sounds like there are a few reasons that keep you smoking and a few on the downside. There is a lot of evidence that indicates cigarette smoking contributes to upper respiratory problems and knowing your family history places you at further risk for problems. If you were to see yourself in 6 months, what would you be doing differently and how would you go about getting there?

**Rationale:** This provider paraphrases the relevant history using the patient’s words. An indicator of the contemplation stage is the motivation to change behavior over the next 6 months.

_Mr. S:_ Well, I have tried to quit in the past. I guess I could try to cut back. I would hopefully feel better than I do now.

**Rationale:** This patient affirms his willingness to problem solve by altering his at-risk behavior. This patient is expressing the emotional struggle associated with changing behaviors. Knowing that 50% of all medical treatment plans are not followed through to their fullest extent, this provider expresses an appreciation for the patient’s identified issue and attempts to partner with the patient to develop a mutually agreed option.

_Nurse M:_ That certainly sounds reasonable. Why don’t you give that a try. What do you think you could change over the next month?

**Rationale:** Empathy and support. Rather than focusing on the negatives, this provider has chosen to begin by establishing a therapeutic rapport through reinforcing a positive. The provider is determining if this patient is in the preparation stage by inquiring if the behavior change will occur within 1 month.

_Mr. S:_ I can think about what we have talked about and start making a game plan for changing my behavior. I guess I could have fewer cigarettes.

**Rationale:** This patient has progressed to the preparation stage by displaying motivation and a plan to alter his behavior within the coming month.

_Nurse M:_ Is there anything I can do to help you reach this goal?

**Rationale:** Always survey for more information or concerns. This displays your level of commitment and involvement and prevents those dreaded, “Oh, by the way” comments as you and your patient are leaving the office.

_Mr. S:_ Well besides standing next to me every moment, can you tell me about some of those new treatment programs that I have heard about?

**Rationale:** This response displays an active listening style to the patient. As this patient has already declared a potential contributing behavior, we then pose an indirect question. We have moved this patient further along the continuum through empathetic listening, enhancing the discrepancies, nonjudgmental problem solving, and empowering the patient. This free-floating style continues the assessment of motivation and insight into his condition. The provider refrained from labeling or presenting this in an accusatory manner. The provider is now using the behavioral processes in the Transtheoretical Model of Change. In particular, reinforcement management is being used with the helping relationship.

**SUMMARY**

This scenario provides us with examples of a patient in different stages of the change process. This scenario also provides us with examples of motivational interviewing techniques that can be used to help our patient’s progress through each stage. Therapeutic movement is one stage at a time. Assessing the patient’s readiness to change is the first task for the provider. Once we have determined where our patients are along the continuum, our task is to facilitate movement from their current position to the next stage. An individually tailored, matched service is recommended.

The health care encounter consists of two parties, in which both play a significant role in the dynamic process. A provider who chooses not to utilize communication skills that have been shown to improve the visit and the clinical outcomes is doing a disservice to his or her patient. We have the capabilities to positively affect the medical visit and to influence health. Using specific communication skills that enlist the patient’s active involvement in the encounter, developing the discrepancies between the pros and the cons of change, and mutually negotiating viable options can shift a patient further toward adaptive healthy behavior. Health promotion has been defined as the “science and art of helping people change their lifestyle to move toward a state of optimal health” (O’Donnell, 1987, p. 4). The integration of Prochaska and DiClemente’s Transtheoretical Model of Change and Miller and Rollnick’s Motivational Interviewing techniques seamlessly merge together to create an optimal patient encounter.

This article has discussed the importance of using a model of change and motivational interviewing to improve health. Health promotion into the 21st century demands an approach that improves the ability of individuals to take action. Taking action involves at least two of the levels of action outlined in the Ottawa Charter (WHO, Health and Welfare Canada, and the Canadian Public Health Association, 1986). It includes creating supportive environments where clinicians take into consideration the life context of their patients. In addition, it involves the development of personal skills to promote health. The Jakarta Fourth Inter-
national Conference on Health Promotion has stressed that one priority is that of empowering individuals (WHO, 1997). This entails reliable access to the decision-making process and skills and knowledge essential to effect change. Through the art of motivating, health care providers can influence and empower individuals to positively influence their level of health.

REFERENCES


