Motivational Interviewing for LGBT Patients

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Over the past century, there has been a remarkable shift in the leading causes of death in the United States. In 1900, infectious diseases including influenza and pneumonia, tuberculosis, and gastrointestinal infections were among the most common causes of death [1]. With advances in healthcare in the twentieth century, the burden of mortality caused by infectious diseases waned. The leading causes of death today have shifted to cancers, heart disease, diabetes, HIV/AIDS, and obesity – all of which are strongly linked to lifestyles and health behaviors. Contemporary theories of disease distribution link biomedical and lifestyle perspectives to understand patterns of disease occurrence as being influenced by a patient's genetic background, their environment, and their behaviors [2]. While many illnesses and afflictions that drive individuals to seek the advice of a healthcare professional are biomedical in origin, many may be preventable or their progression mitigated through behavior change.

For many patients, a visit to a healthcare professional is seen as an encounter in which they are asked questions about their health and the reason for their visit, undergo a targeted physical examination, and are then recommended an appropriate treatment that is often pharmaceutical in nature. While some visits with practitioners may look like this, others may be more conversational in nature, with a healthcare provider giving advice and counsel related to a patient's health and behavior. The process of visiting a provider can be incredibly stressful for LGBT-identified patients, who have life experiences and unique health challenges with which many health providers are unfamiliar and poorly equipped to handle. Many LGBT individuals have felt a societal pressure to conform to specific behaviors throughout their life, perhaps to be less "gay," to act "normal," or to "blend in" with a desired community [3–5]. Behavior change is tricky to accomplish and must be facilitated in a manner that is intrinsically tied to the individual's participation and consent, particularly with individuals whose autonomy has been diminished personally, socially, and institutionally.

The classic example in behavior change theory is related to patients with high alcohol consumption and liver disease [6]. While treatment options may be available to address progression to liver disease and subsequent complications, talking with such patients about changing their chosen drinking patterns to improve their health is also an integral aspect of care. As another example, consider an HIV-positive patient with suboptimal adherence to their antiretroviral therapy (ART). A prescriber might opt to shift the patient to an easier treatment regimen with fewer pills, but there is also an opportunity for the provider to help the patient address behavioral barriers that are contributing to their adherence difficulties. Behavior change thus plays an important part in modern healthcare; however, some methods of facilitating this change are more effective than others.

Conversations with patients about behaviors that impact their health are common occurrences for all types of medical professionals who provide direct patient care. The importance of these conversations is clear; however, the manner in which these dialogues are structured so as to both respect the patient's autonomy and be most effective at changing unhealthy behaviors is less apparent. In this chapter, we discuss the utility of motivational interviewing (MI), a type of counseling that emphasizes a patient's own intrinsic motivations to change a behavior with a focus on a specific goal [7]. At its core, behavior change does not happen by a provider *telling* a patient how to behave [8], e.g., telling a patient to curtail their number of sexual partners to reduce their risk for HIV and sexually transmitted infections (STIs)

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K.L. Eckstrand, J. Potter (eds.), *Trauma, Resilience, and Health Promotion in LGBT Patients*,
DOI 10.1007/978-3-319-54509-7_17

will most likely not result in effective behavior change. Rather, MI relies on building an internal motivation within the patient to change behaviors that the patient realizes are having a negative impact on an aspect of their life and health that they want to improve (Fig. 17.1).

The patient-centric, nonjudgmental, and nonconfrontational nature of MI is a flexible and empathetic approach to working with patients who identify as LGBT. The supportive tone of MI is particularly well suited to the LGBT community in that it promotes behavior change and resilience without condescension or overt direction, which may turn LGBT patients away from affecting a positive change in their health behaviors. For an LGBT person with a history of trauma, be it physical, sexual, emotional, cultural, or institutional, MI works well to return the locus of control to the individual, who may otherwise feel that their ability to control events and situations in their life has been lost [9, 10]. Beyond this, MI allows providers to better understand their patient's perspectives and become more effective resources for their patients. This chapter presents the basic principles of MI, provides tips and techniques to effectively integrate these principles into everyday interactions with patients, and discusses how MI techniques can be inclusive of LGBT populations.

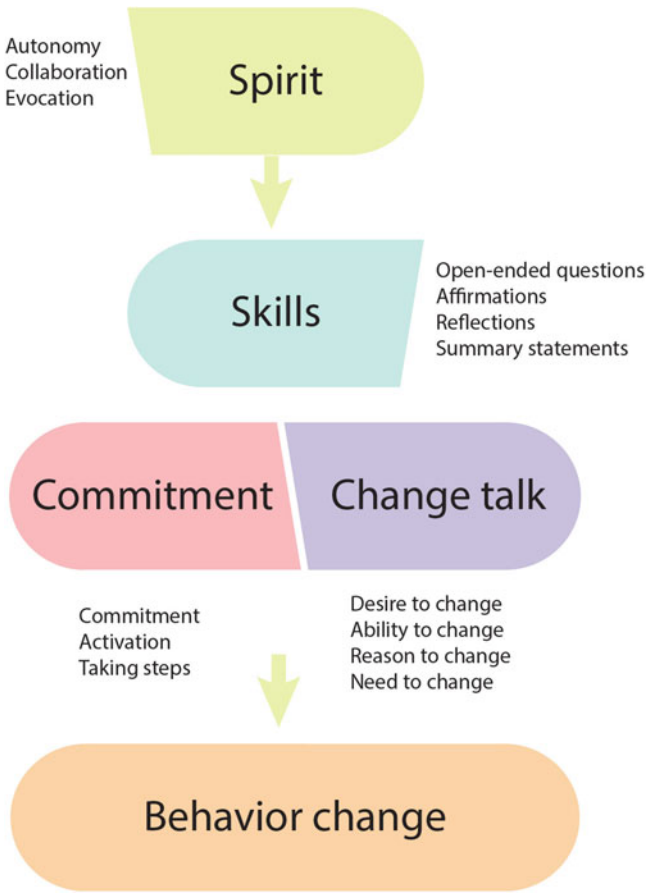

Fig. 17.1 Components of motivational interviewing

Origins of Motivation Interviewing in Theories of Behavior Change

William Miller, a psychologist at the University of New Mexico, developed motivational interviewing techniques during the late 1970s and early 1980s in an effort to change behaviors of individuals with alcohol addiction [6]. Stephen Rollnick then described the application of MI to clinical practice in 1995 [11]. Miller and Rollnick argue that behavior change can be communicated in three distinct styles: following, directing, and guiding.

Following

In the communication style of following, the key skill is listening and understanding. A patient-provider interaction in which the provider relies on the following to effect a change in behavior puts the emphasis on the patient's vocalizations about their behaviors and trusting that the patient will set the pace and goals that are appropriate to effect a change in their own behavior. This allows the patient to take the lead in their decisions to make a change in their own behavior and embodies the locus of control within the patient.

Directing

A directing style of communicating behavior change resembles the more traditional type of behavior change practiced in healthcare, in which providers attempt to influence an individual's behaviors directly [12]. In essence, providers who utilize a directing style of communicating behavior change tell their patient what to do, without much explanation or reason. While many patients have come to expect this of their providers, the top-down nature of directing often creates a barrier between patient and provider, ultimately failing to facilitate behavior changes [13]. For example, consider the following encounter between a family medicine physician and Anthony, a 52-year-old gay man being seen for a chronic cough. Anthony has been smoking tobacco for 35 years (Fig. 17.2).

PROVIDER: How has your cough been since the last time I saw you?

ANTHONY: Well, it hasn't improved much and it's keeping me awake at night. I can't seem to figure out why it won't go away.

PROVIDER: Have you quit smoking like I asked you to the last time you visited?

Fig. 17.2 Anthony is a 52-year-old gay man being seen for a chronic cough

ANTHONY: No. . ..well smoking helps me stay awake at work, and since I haven't been sleeping that well because of the cough, I've been having some trouble quitting. Also, I smoke most when I'm out at the bar with friends, and that's the only time I have with my gay friends given my work schedule.

PROVIDER: Well, my recommendation is that you need to quit smoking. I can put you in touch with a smoking cessation counselor, but you really need to focus on quitting.

Here, the provider solely utilizes a directing style and comes off as gruff and uninterested in the details surrounding the patient's struggle to quit smoking. The top-down directing style, albeit useful to emphasize importance when used sparingly, is not effective when used as the sole communication style.

Guiding

Of the three styles of communicating behavior change, MI is most embodied in guiding. In essence, a practitioner can use a guiding style to serve as a resource and help an individual realize, set, and achieve their goals. Using principles of guiding, a practitioner provides their expertise to set up options and alternatives to help a patient, rather than communicating about one set path that a patient must follow, as seen in the directing style above.

While providers can, and should, skillfully integrate following, directing, and guiding communication styles into all conversations with patients, MI is rooted in a guiding style of communication in which a provider focuses on helping the individual move past feelings of ambivalence to build their internal motivation to effect behavior change. As we will discuss in the remainder of the chapter, MI is nonjudgmental, nonconfrontational, and nonadversarial, making it a well-suited framework to guide conversations between providers and their LGBT-identified patients. In the context of resilience and health promotion, shifting to a guiding communication style is a simple way to support patients in everyday conversations by engaging the patient in their own healthcare. Further, while providers may not have training in discussing topics of sexual orientation, gender identity, or sexual behavior, the process of MI can support the provider's own growth by virtue of listening to the patient's experience, their chosen language to talk about themselves and their lives, and the diversity of motivations for which people initiate – and change – behaviors.

Fundamentals of Motivational Interviewing

A core goal of MI is to build the patient's internal motivations to change a specific behavior. Stated simply, this involves guiding the patient to think about their life experiences and concerns, and to examine the consequences that specific behaviors and decisions have on their aspirations and goals. As discussed with the three core communication styles of behavior change earlier in this chapter, a provider *guides* their patient to thinking about behavior change by leading patients to explore the effect a behavior change would make in their life, i.e., building the patient's internal motivation for behavior change. In this vein, Miller and Rollnick describe the fundamental spirit of MI to be collaborative, evocative, and honoring of patient autonomy [7].

In MI the provider and patient are equal in power and make decisions *collaboratively* to help the patient enact change. To do this, a provider must often *evoke* a patient's own internal motivations to affect a health behavior change, usually by guiding the patient to make the connection between their goals or concerns and the behavior change. To facilitate this, MI is always conducted with the utmost respect for patient autonomy. While a provider can advise, instruct, or encourage a behavior change within a patient, MI recognizes that it is the patient who must ultimately decide what to do and whether or not they will actually make an agreed-upon behavior change. Further, MI can be strategically used to enhance an individual's self-efficacy in engaging in a particular behavior. If a behavior change or an action plan suggested by a provider seems overwhelming for a patient, a provider can use MI to break that plan or behavior change into smaller steps. By empowering a patient

to accomplish each of these smaller steps, a provider can enhance the confidence an individual has in their ability to get through their struggle to achieving healthy behavior change.

While seemingly simple, complexities arise in motivation interviewing. *Ambivalence* in an individual is the first core complexity. Consider the following interaction, noting the use of contrasting conjunctions (but, however, although, though, etc.) to express ambivalence. Here a provider is meeting with Sarah, a transwoman who was diagnosed with HIV 20 years ago, before she began transitioning (Fig. 17.3). Sarah's viral load has been consistently undetectable but has recently started to rise.

PROVIDER: By taking your HIV medications every day as scheduled, you can keep your viral load down. That would help keep you healthy, and it will also protect your partner from acquiring HIV. Improved adherence to HIV medications helps keep everyone in a relationship healthy.

SARAH: Yes, I do know all of this and I want to keep my partners healthy. *But* when I don't take my HIV meds, I'm less bloated and I feel more alert and awake. And my viral load has always been low, even when I've missed some doses, and I make my partners wear condoms.

Here, the patient is ambivalent about the idea of changing her behavior regarding how she takes her HIV medications. On the one hand, she feels okay – perhaps even better – when she skips doses; on the other, she doesn't want her partners to contract HIV from her and feels she currently tries to minimize this risk by having her partners wear condoms. While many providers may perceive patient ambivalence as impossible to navigate, ambivalence is best understood as a natural response to being encouraged to change. For example, no matter how many times a dentist explains the benefits of flossing, a patient might be resistant to make flossing part of their daily routine because of time constraints during the morning rush or their gums feeling sore after flossing. Thus, patients may understand that a health behavior is appropriate for them, but because of certain constraints or limitations, they are ambivalent about making a change in their behaviors or lifestyle [14]. By coming forward and suggesting a change in behavior, a provider may provoke an opposing or ambivalent response. To avoid this outcome, the provider should use MI techniques to get the patient to articulate the arguments in support of behavior change rather than vocalize a counterargument to behavior change. To navigate these conversations, MI relies on four guiding principles, easily remembered using the acronym RULE, first described by Miller and Rollnick in 1992 [11, 15].

Fig. 17.3 Sarah is a transwoman who was diagnosed with HIV 20 years ago before she began transitioning

R: Resist the Righting Reflex

In the previous example demonstrating a patient's ambivalence to improve their HIV medication adherence, a provider's suggestion for a behavior change was met with ambivalence and would likely result in a failed attempt at health behavior change if the provider continues in a directing communication style. It makes sense that clinicians often instinctually attempt to correct what they perceive is an unhealthy behavior, in an effort to protect a patient's health. However, the reflex to "right" a patient is frequently determined based on what the provider perceives to be of the utmost importance – optimizing health. This reflex can come through in a directing style, establishing an uneven power dynamic in the patient-provider interaction. To effectively utilize MI, providers must check their reflex to right and instead allow a patient to vocalize their motivations and understanding of what behaviors they may need to change. This technique will help providers navigate through a patient's ambivalence, and helps to avoid the patient vocalizing any ambivalence they may have, as an individual tends to attach to or believe what they hear themselves say [7].

U: Understand the Motivations of Your Patient

MI can be adapted for individuals from all backgrounds, and techniques can be adjusted to account for different levels of client readiness to change their behaviors. A key aspect to helping guide a patient to a health behavior change is to understand their perspectives, motivations, and thoughts about their behaviors, as well as their goals and concerns related to changing those behaviors. When ample time is available, providers can explore a patient's current situation in depth to understand the patient's motivations. However, patient-provider interactions are often constrained to 20-min visits, and providers may therefore be limited in their ability

to fully examine all of a patient's motivations. In situations with limited time, it is helpful to focus on understanding a patient's motivations for change and discussing how they might make a change in an incremental fashion in an effort to establish a foundation for additional discussions in the future.

L: Listen to Your Patient

Perhaps the most important aspect of MI is listening to the patient. Effective listening is a difficult skill to master, particularly as many providers are seen as having the answers to concerns that patients may come with to a visit. As MI relies on understanding perspectives within the patient, the "answers" more often than not originate within the patient rather than the provider. Listening techniques, including reflective listening, are discussed in the next part of this chapter.

E: Empower, Engage, and Encourage Your Patient

There is a clear body of evidence suggesting that patients who are engaged in their own healthcare experience better outcomes than patients who are disinterested or disengaged in their treatment plans and overall healthcare [16–19]. The fourth guiding principle of MI centers on empowering a patient to make a behavior change in their lives.

Let's revisit the conversation with Sarah, this time approaching her challenges with taking her HIV medications using RULE, the four guiding principles of MI.

PROVIDER: Can you tell me about how taking your HIV medication has been since the last time I saw you? [R, U]

SARAH: It's been more a challenge in the last few months – I've been taking my meds for so many years and I'm tired of them.

PROVIDER: When you say that you're tired of your meds, what do you mean? [R, U, L]

SARAH: Well, the routine of taking my meds every day has never bothered me. More recently, I have been thinking that over the past 20 years I haven't felt sick and my counts have always been low, even when I've missed a few doses here and there. Maybe it's not the drugs that are keeping me healthy – maybe it's something else. The drugs just make me feel bloated and I don't feel attractive some days.

PROVIDER: So you don't feel like the drugs are what are keeping you healthy? Why might you want to keep taking your medications on schedule? [U]

SARAH: Yeah. . .and being bloated makes me want to skip my medications. The rational part of me knows that I should be better at taking my meds to keep my counts low and I want to be healthy for both me and my partner.

PROVIDER: I'm glad to hear that keeping your counts low is a priority for you, but that feeling bloated may distract on that goal. Let's focus on keeping you healthy, and also try tweaking when you take your meds to try and minimize the times that you feel bloated. How important is it to you to focus on keeping your counts low? [E]

SARAH: It's really important to me – especially if we could do something to help with the bloating and my feelings about my body image when I take my meds.

Here, the provider skillfully avoids prompting Sarah to vocalize her ambivalence by using the RULE principles. Rather than talking to Sarah with a directing style that prompts Sarah to express her ambivalence, the provider guides Sarah and hones in on her goals to stay healthy, while also considering her concerns. Simply focusing on going through each of the RULE principles is key technique to skillfully navigate through a patient's ambivalence. In the next portion of this chapter we will discuss more techniques that can be used to incorporate MI into healthcare practice, particularly for LGBT patients.

Incorporating Motivational Interviewing into Patient-Provider Interactions

Motivational interviewing builds on key skills that providers may use in everyday practice, focusing on the *guiding* communication style and the core principles of RULE. Here we detail the three skills of MI: asking, informing, and listening.

Asking

There are a number of considerations that must be taken into account when asking questions in the context of MI. Asking is particularly useful in getting to understand your patient, so as to direct conversation and guide patients toward thinking about behavior change with respect to their unique perspectives and goals.

Open vs. Closed Questions

In time-limited settings such as healthcare clinics, closed-ended questions can be helpful in ascertaining the most relevant information in a patient encounter. However, this leaves little room for the patient to respond and elaborate. Consider the following closed questions:

"On a typical night, how many drinks do you have?"
"When you have sex, what percentage of the time are you using a condom?"
"How many times a week do you exercise?"
"Are you depressed or anxious?"
"Have you missed any doses of your HIV medications in the last month?"

While these questions may seem informative, they each have an expected, limited response. For example, if a patient responds to the second question above saying they use a condom 75% of the time, this does not provide any insight into the gender of their sexual partners, the type of sexual activities in which they are engaging (oral, anal, vaginal, etc.), their positioning during sexual activities (top, bottom, versatile, etc.), or any other information that may be crucial to understanding a patient's sexual risk. These types of questions may appear to be efficient in their direct nature, but they often require a number of follow-up questions. By transitioning to questions that are more open in format, providers can ascertain more information and cultivate a conversational rapport with their patient, allowing the patient to provide more information that they feel is relevant in each of their answers. Consider the following open versions of the five questions posed above:

"What role does alcohol play in your life?"
"How do condoms fit into your sex life?"
"In what ways do you incorporate exercise into your life?"
"What does depression feel like to you?"
"How has taking your HIV medications this past month been?"

Shifting to asking open questions allows the patient to share a story, rather than a simple answer, and provides an opportunity for patients to elaborate on their perspectives. This plays into RULE, specifically into understanding your patient's perspectives [U], and is one technique that can be used to successfully incorporate MI into a 20-min consultation. The manner in which a provider asks follow-up questions is also important. Open-ended follow-up questions are particularly useful and emphasize a pattern of asking-listening-asking. Here, the provider guides the conversation to focus on the patient's internal motivations and to progressively gain more and more insight into the patient's perspectives.

Agenda Setting

Another reason to begin an interaction with open questions is to allow the patient to bring specificity to the conversation on their own accord. In contrast, if the provider focuses on a topic that they think is important – for example, discussing body image with a patient who identifies as lesbian who has high blood pressure and an above-average BMI – this may prematurely focus the conversation, boxing the patient-provider interaction into a conversation about the patient's body, when the patient may also have other things they would like to discuss. Rather, the provider should allow the patient to discuss things broadly, and then set an agenda with follow-up questions in an effort to allow a conversation to touch multiple aspects of behavior change. This may include the patient's concerns with body image, but also can include other aspects of the patient's life that she may feel are relevant to discuss with a provider. By beginning with a patient's concerns, rather than the provider's, the patient will be more likely to be receptive to suggestions. With agenda setting, a provider can outline a few different aspects of a specific behavior that they want to discuss with the patient during a single visit, based on their patient's background discussed at the beginning of the consultation. This agenda can be set to incorporate both the topics that a patient brings up in the first few minutes of open questioning in a patient-provider interaction and also the items that a provider wants to discuss with a patient, without being overly directing. This reduces the pressure on both provider and patient and is likely to make the patient more receptive to suggestions from the provider.

Consider the following interaction with Stephen, a gay man in his mid-20s who is in the emergency room after passing out during a workout. Stephen works out at least eight times a week and presents anxious and irritable, with abnormally high creatinine kinase levels, suggesting that Stephen is overexerting himself with an unhealthy gym use.

PROVIDER: Can you tell me about your gym use, including what motivates you to go to the gym and how you fit going to the gym into your daily life?
STEPHEN: You're the fiftieth person today to ask me these questions – seriously, I'm fine, I am just exhausted from work and friends. I work out a lot to burn stress off and to keep my body tight – really just trying to look and feel good for the summer in P-town, you know, Provincetown, Massachusetts – gay beach destination.
PROVIDER: I completely understand, and I just want to help get a better picture of your gym use, to help me understand how you came to the ER today and how using the gym fits into your everyday life. If you like, we can talk about your gym habits – when you go, how often you go, what you do when you're at the gym, what motivates you to go to the gym so often. I'd then like to talk about some techniques to help you keep you from over-training and some changes you can make to improve your health. Would this be an okay order for our conversation? Or

are there perhaps other things that you would like to bring up in our conversation?

Here, the provider uses agenda setting to outline an interaction with a patient, which is particularly useful considering Stephen's mood. The provider sets a tone for a dialogue about behavior change, set in the context of understanding Stephen's motivations for his gym use. Agenda setting can also be useful when a provider is offering a number of potential options or solutions for a patient to take going forth, and is laden with asking the patient for consent to continue a conversation. The provider can present a list of these options to the patient, allowing the patient to choose a handful of options to discuss together, thus engaging the patient in setting the course of the conversation and creating a positive rapport for change dialog.

Key Techniques to Asking the Right Questions

1. "What next?" questions
   "What next?" questions serve a variety of purposes in gauging where a patient is on their journey to behavior change. Primarily, these types of questions ask an individual what the next step for them will be, and help to establish the *how* when building internal motivations for a change in behavior. For example:
   - "With everything we just talked about in mind, what will you do next?"
   - "So what do you think about your adherence to your HIV medication now?"
   - "What will you do next with regard to your smoking?"

   These questions serve a "check-in" function in assessing the patient's commitment to change and can be followed up with further planning questions or may indicate the need to backtrack and reassess the patient's perspectives and goals before proceeding further.
2. "What if?" questions
   "What if?" questions pose hypothetical situations that can be used to foster motivation in patients who may be less inclined to make a change in their behavior and present a friendly way to envision change, particularly in situations where the patient is more ambivalent. Potential hypotheticals include:
   - "Suppose you were able to use condoms more frequently with your outside partners: what might some of the benefits be for you and your primary partner?"
   - "If your relationship with your parents were stronger, how would your life be different?"
   - "What do you think your life will be like in 10 years if you don't make any change in your substance use?"
3. Scales to assess motivations [1–10]
   For a patient who you feel is less motivated to change a behavior, scales can be a useful tool to help gauge their motivations and to brainstorm what might help them become more confident in their ability to change. Scales, partnered with hypotheticals and targeted follow-up questions, can be useful for both the provider and the patient to gain insight into a patient's perspective. The Miller and Rollnick set of scales have two sides: one side holds the advantages associated with doing a particular behavior and the expected disadvantage of making a behavior change, while the other side holds the disadvantages experienced with doing a particular behavior and the expected advantages of making a behavior change [7, 11, 15]. Providers can utilize scales to help determine a patient's readiness for behavior change, and a patient's responses can identify potential hurdles for the provider and patient to work through to facilitate effective behavior change. Consider the following interaction between a family medicine physician and Max, a genderqueer teenager, born female, who has been struggling with an eating disorder and their body dysmorphia (Fig. 17.4).

PROVIDER: On a scale of 1–10, how ready would you say you are to use a food diary to help you keep track of what you are eating for each meal, with 1 being "not ready at all" and 10 being "extremely ready."

MAX: I don't know, maybe a 6 or so?

PROVIDER: Okay, why did you say 6 and not a lower number, say a 1?

MAX: Well, I want to be able to make sure I'm eating regularly – I don't want my grades to slip anymore than they already have and thinking about my weight has been really stressful. So I guess I'm ready to try something to help me keep track of how I'm doing with eating.

PROVIDER: If you could have anything in the world to help you, what would it take to get you feeling like a ten, or extremely ready to use the food journal?

MAX: Hmm. . .maybe if some of my friends knew about my struggles with my weight they could help me out – but I feel like I've already been labeled as the odd one out, you know, since the girls in my class think I'm too

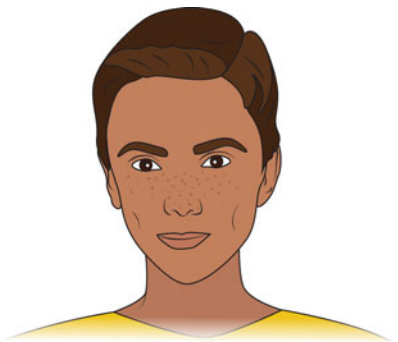

Fig. 17.4 Max is a genderqueer teenager, born female, who has been struggling with an eating disorder and their body dysmorphia

boyish and the boys in my class aren't really comfortable with my masculinity. I don't know if I know how to approach my friends to talk about my diet.

PROVIDER: Do you have one or two friends that are close to you and would support you and help you be more attentive to your diet? I think it's a great idea to help expand your support – and, if you'd like, I have some tools that we can discuss that may help you with talking to your friends about helping you keep track of your eating and may help you boost your social support.

Scales are particularly useful in checking back with the patient after you have made a preliminary plan, typically toward the end of a patient-provider interaction. Here, Max expresses some doubt about how they feel about using a specific strategy to help them with their eating behaviors. By posing hypotheticals and asking Max how they may be able to increase their confidence and readiness to use a specific tool, the provider can better understand what might be holding Max back and adjust their recommendations accordingly.

4. Listen!

Above all, when asking questions, be sure to listen to your patient. It's an easy trap to do all the talking as a provider, but in MI the primary source of information should always be the patient. We'll delve into listening in the next section.

Listening

Listening provides the opportunity to develop an understanding of a patient's perspectives and the foundation for developing a strong rapport between the provider and the patient. Listening serves many purposes in the context of MI, but above all, good listening alone indicates that a provider is taking the time to invest in a patient, and patients can be extremely perceptive of this subtlety. Listening is a key aspect of the *following* style of communicating behavior change, and holds particular importance at the beginning of a visit, when a provider can gather detailed information about the reasons for the patient's visit and motivations for and against a potential behavior change. Additionally, listening is of utmost importance after asking questions and when patients express concern, confusion, or have some other emotional response during the course of a patient-provider interaction. It is important to note that the act of asking a question does not constitute listening; do not fall into the trap of asking a question without listening to the answer.

In particular, providers should listen for "change talk," honing in on a patient's language that is directly related to behavior change [7, 20]. Change talk can be broadly broken into seven categories, easily remembered using the acronym D-A-R-N C-A-T:

1. *Desire* statements express an individual's preferences for change or lack thereof.
2. *Ability* statements express an individual's perception of their ability to accomplish something, which, in part, signifies their motivation to accomplish something. Regardless of an individual's ability, if they are not motivated they may perceive their ability to change their behavior to be lacking or nonexistent.
3. *Reason* statements express why an individual wants to make a change or why they want things to remain the same.
4. *Need* statements express the feeling of necessity to make a change.
5. *Commitment* statements can vary in degree from considering making a change to promising or expressing will to making a change.
6. *Activation* statements express an individual's readiness for change.
7. *Taking steps* statements express actual actions an individual has taken toward making a change in their lives, and tend to be expressed more commonly at repeat visits with a patient, when they occur.

Each of the DARN CAT categories of change talk may express a patient's favor for change, or may favor the sustaining existing behaviors (see examples of change talk in Table 17.1). If you hear change talk that favors "sustain talk," work on exploring an individual's goals and concerns, guiding them to change talk that favors behavior change. Consider the following interaction between a therapist and Cindy, a 45-year-old lesbian who has recurring suicidal thoughts (Fig. 17.5). Notice how the therapist asks questions in search of change talk, and Cindy's expression of different types of change talk, categorized by DARN CAT.

PROVIDER: Why would you *want* to work on reducing how often you think about suicide? [*assessing: desire*]

CINDY: It's been taking such a toll on my everyday life. Sometimes I can't even get out of bed because I feel so hopeless, and I don't *want* to lose my job or my friends. These irrational thoughts are getting in the way of my life and I *need* to find a way to get them out of my head. [*stating: desire*, *reasons*, *need*]

PROVIDER: It's clear to me that you want to address your thoughts in an effort to focus more on your life and to get back to a feeling of normalcy. If you decided to work

Table 17.1 Examples of statements with each of the seven kinds of change talk (DARN CAT)

***D**esire*	Statements expressing an individual's preference for change Key verbs: *wish*, *want*, *like to*, *desire*… "I want to be better at quitting smoking" "I would like to focus on taking my HIV medications more regularly" "I wish I was able to make my partner happier"
***A**bility*	Statements expressing an individual's perception of their ability to change Key verbs: *can*, *may be able to*, *could*… "I can try to change how I communicate with my friends" "I could try and go to the gym more" "I may be able to cut back on my partying"
***R**easons*	Statements expressing reasons to make a change Key verbs: no specific verbs, but reason statements may be tied into other change talk "My depression is affecting my relationships with my family and friends" "I want to be able to keep my viral load down" "My issues with eating and thinking about food are too consuming"
***N**eed*	Statements expressing necessity for a change Key verbs: *need*, *must*, *have to*… "I need to make sure my partner can't hurt me anymore" "I have to get better about not drinking too much when I go out" "I should make a change in my life"
***C**ommitment*	Statements committing to making a change Key verbs: *am going to*, *promise*, *am ready to*… "I am going to quit smoking" "I promise to focus on using condoms to help me stay healthy" "I am ready to improve my adherence"
***A**ctivation*	Statements expressing will to make a change Key verbs: *will*, *would*, *want*… "I will consider cutting out herbal hormones I buy off the internet" "I think that speaking up for myself with my partner will help me be happier" "I would think about setting up calendar alerts to pick up my prescription"
***T**aking steps*	Statements about steps that an individual will take to make a change Key verbs: no specific verbs, but these statements outline plans or attempts "I picked up my prescription for PrEP" "I talked to my partner about negotiating our relationship agreement" "I think if I focus on establishing a daily routine, that will help"

Adapted from Miller and Rollnick [7]

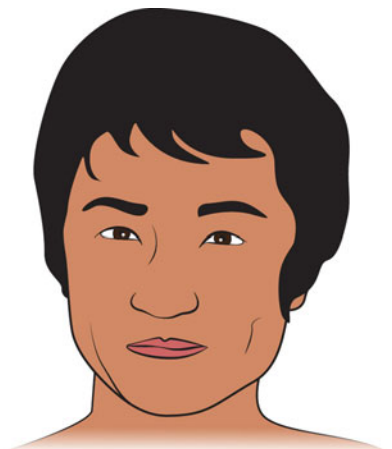

Fig. 17.5 Cindy is a 45-year-old lesbian who has chronic suicidal thoughts

more on these, how do you think you *would* do it? [*assessing: ability*]

CINDY: If I knew, I wouldn't be here talking to you! But, I suppose I *could* try and dig more into the root of my thoughts in my sessions with you. Or maybe I *could* try and build my social support more and get involved with something like community yoga. I don't know… [*stating: ability*]

Here, the provider works to elicit change talk with Cindy, prompting her with specific questions. Together, the first four categories of change talk (desire, ability, reason, and need) convey aspects of motivation for making a change, while the final three categories (commitment, activation, and taking steps) relate to the steps actually necessary for behavior change to occur. In these interactions, listen for change talk, and prompt your patients with questions that are asked with enough specificity to assess their arguments for change or lack thereof. It is important to guide a patient to express the first four categories, but hearing these is not enough to affect a change in behavior, as these expressions merely represent precommitment forms of change talk – that is, expressing a possibility for change. By listening for change talk while going through the RULE principles, a provider

can gain a deeper understanding of their patient's background and readiness for change talk and guide the patient toward effective behavior change.

Silence

If you find yourself asking a patient questions and are met with no response or silence, do not fear! Silence is a useful tool in MI. Sitting in silence can allow a patient more time to adjust to the style of the conversation and formulate a response, whereas interrupting the silence may cut off the conversation and shift it to a top-down directing style of communication between the provider and patient. Additionally, if the provider breaks the silence before the patient, this trend is likely to continue throughout the encounter. This creates a one-sided conversation in which the provider must draw answers out of the patient and is less likely to develop the rapport needed to identify change talk and facilitate behavior change.

Reflective Listening and Summarizing

Throughout a patient-provider interaction, it is helpful to reflect on illustrative statements made by the patient, particularly when these statements are related to change talk. To listen reflectively, the provider touches back on previous statements the patient made, demonstrating that they were listening and guiding the conversation to highlight and revisit key topics. This is a type of active listening, which helps the conversation flow, demonstrates a provider's genuine interest in the patient's situation, and serves as a check of the provider's understanding of the patient's perspective. Reflective listening can be used to steer a conversation away from digressive topics and focus instead on statements that are relevant to facilitating behavior change. At the end of an interaction with a patient, and at intermittent points throughout the conversation, the provider should summarize what has been discussed thus far, piecing together the most salient points and allowing the conversation to transition to the next step in the journey toward facilitated behavior change. Reflective summary statements are essential to agenda setting, and can keep a time-limited conversation with a patient on track. Consider the following dialogue between a provider and Andy, a young transman who recently came out (Fig. 17.6). Andy lives in a small rural community and has been struggling with feelings of isolation and depression. Notice how Andy's provider utilizes reflection and summary statements in this excerpt of their interaction.

Fig. 17.6 Andy is a young transman who recently came out

ANDY: I've just been feeling so lonely recently – coming out was a huge thing for me, and I'm so glad that I am coming into my own identity. But by actually coming out, I've put a huge barrier between me and my classmates who just don't get that I'm a guy. It's so lonely.

PROVIDER: So what I hear is that you're feeling good about being open with your identity, but lonely because you sense that some of your peers have put some distance between themselves and you. [*reflection*]

ANDY: Yeah, for sure.

PROVIDER: How has that made you feel? [*open question*]

ANDY: Pretty crappy. I thought that by coming out I would gain at least some support with my friends, but by actually stating it, there's a wedge between us. I don't really want to socialize with anyone or go to school now – everything is just uncomfortable.

PROVIDER: So you're finding yourself retreating and spending more time alone? [*reflection*]

ANDY: Yeah – and I need more support. More friends – a community. I don't want to spend all this time alone, waiting to go to college in a more welcoming environment. I want to get out of my shell.

PROVIDER: Let me recap to make sure that I'm understanding everything you've just told me. Coming out has made you feel more confident about your identity, but you're finding yourself spending more time alone to avoid interacting with classmates and people at school who you feel are a bit more distant than they were before you came out. You're feeling a bit more lonely and want to find more of a community to be yourself in. [*summarizing*]

Here, the provider skillfully reflects on key points that Andy makes. By recalling certain points that Andy makes, the provider indicates that he is actively listening. Beyond this, the provider can use reflection and summary statements to guide a conversation and hone in on change talk that he hears Andy use.

Informing

As a guide, the provider serves as a resource for their patient, providing unbiased information about various options to

facilitate behavior change. Informing is a tool that can be used by providers in a variety of clinical circumstances, including sharing information, explaining results or procedures, and providing general advice. Information is critical within the context of MI, and it is important to deliver information in a manner that respects patient autonomy and to avoid transitioning the conversation in a direction that is dominated by the provider.

A key aspect to informing within MI settings is asking the patient for permission to share information with them, whether it is educational material, information about treatment options, information that other patients in similar situations have found useful, or other information that the provider feels necessary to convey. By asking for the patient's permission, the patient maintains a sense of control over the patient-provider interaction, shifting the locus of control to the patient. This ensures that the power dynamic between the provider and the patient remains equal and balanced, and is particularly useful if information is heavy or complicated, as asking for permission helps material feel more digestible. Consider the following interaction between a primary care provider and Meg, a 27-year-old transwoman who occasionally attends pumping parties, where she injects nonsurgical silicone in a medically unsupervised environment (Fig. 17.7). Notice how her provider uses informing selectively, and with permission.

MEG: So at these parties, I go into a backroom and there's a man back there that tells me to lie down on a table. He'd use a needle to inject a couple of cups of silicone into my butt and my hips – really help me get that hourglass figure, you know? My insurance won't cover it, and it's the only choice I have to feel more like me. It's worth the pain – he never uses any numbing – and it's way cheaper than I would pay if I went to a plastic surgeon – no way that I could afford that.

Fig. 17.7 Meg is a 27-year-old transwoman who occasionally attends pumping parties, where she injects nonsurgical silicone in a medically unsupervised environment

PROVIDER: There are a couple of concerns that I have about these pumping parties, would it be alright if I told you about them and then we can talk about some things that other patients of mind have done in the past?

MEG: Okay. . .

PROVIDER: I understand the appeal of these parties for sure – your body can feel more feminine and look more like what you want it to look like at a lower cost. But over time, these implants will most likely start to shift, and can cause infections and visible deformities on your skin since they're not being placed by a trained medical professional. While they may feel good now in the short-term, in the long-term, you'll save more money by getting them done in a professional setting. If you would like, I can show you some information and pictures of correctly placed silicone and what it should look like over time.

MEG: Hmm. . .I didn't realize that there was such a risk – I figured that they would keep looking good. But I know I can't afford these treatments, and they do help me feel better about myself now.

PROVIDER: Some of the other transwomen that I work with have had this conflict as well – they want the procedure to feel more at home in their bodies, but they can't afford the procedure or their insurance won't cover it. If you'd like, I can set you up with a health navigator who can talk to you about your insurance options and what doctors we work with who may be able to work with you to get you the care that you need in a safe and affordable way. Would you like me to set up that appointment with the health navigator?

Asking permission is laden throughout this excerpt, in which the provider carefully provides information in a manner that is not overwhelming to the patient. While providers are often seen as the voice of guidance by many patients, it is important that providers using informing in the context of MI maintain a sense of conversation by continually engaging the patient. Additionally, it is imperative that the task of informing does not come off in the *directing* style of communication, and maintains a sense of the provider as a guide. To accomplish this, the provider should endeavor to offer the patient choices that are informed and tailored to that patient's situation, rather than presenting them with only one option. A single option tells the patient what to do, *directing* rather than *guiding* the patient. When presenting options, it is best to present a group of options together, and then discuss the details of choices that interest the patient, rather than singularly presenting an option, explaining it, then explaining a subsequent option, and explaining it. The second method leads to a common trap where the patient will ask you to stop presenting options, choosing the first one presented and opting not to listen to all the options available.

Presenting options is particularly useful in the setting of informing the patient of some options that have worked for other patients, then allowing the patient to explore and grapple with the option that may work best for them.

Balancing Asking, Listening, and Informing

In summary, MI asks the provider to serve as a guide during an interaction with a patient, integrating and balancing the techniques of asking, listening, and informing. The MI process enhances the patient's understanding of their uncertainty surrounding behavior change, guides the patient to resolve their ambivalence by weighing pros and cons, and motivates the patient to accomplish feasible and sustained goals. As we have seen, MI relies on several key skills: the ability to ask open-ended questions, the ability to provide affirmations to the patient, the ability to listen reflectively and verbalize this reflection, and the ability to provide summary statements throughout a patient interaction. MI has a diverse application and can be adapted for individuals at different levels of motivation and readiness for behavior change. While some individuals are completely ready for change and simply need to rely on a provider as a guide to facilitate that change, others may have tried and failed to change their behaviors, and still others may be completely unaware that their behaviors are impacting their lives in unhealthy ways. Regardless, an interaction utilizing MI always begins with assessing where a patient is in the moment and can be seamlessly integrated into routine patient-provider interactions. Although the techniques we have described may feel clunky and unfamiliar at first, with time and practice, they can quickly become second nature.

Applications of Motivational Interviewing in LGBT Health

Motivational interviewing is an effective method for behavior change, and has particular utility for promoting resilience in clinical practice. With respect to LGBT health, MI can be used as a tool to think critically about a population that has unique health needs and a need for informed healthcare providers. Broadly, MI is particularly well suited to patient-provider interactions with LGBT individuals as it can support the individual, promoting resilience within members of populations that have historically been told how they should act or carry out their lives. By utilizing MI to approach interactions with LGBT-identified patients, providers can educate themselves regarding their patients' perspectives, and support patients to make behavior changes in a manner that is affirming and built on intrinsic motivations, rather than external encouragement and/or overt pressure. By focusing on creating a dialogue between the patient and the provider within MI, the locus of control of behavior change shifts from being provider centric, in a directing style of communication, to being within the individual. This shift is useful and works to build resilience and promote the health of individuals, and is well suited to LGBT-identified individuals with a history of trauma.

As discussed throughout this book, LGBT patients have unique life histories and experiences that influence their behaviors later in life. MI approaches behavior change with a focus on shifting the locus of control to the patient. The affirming nature of MI can build a patient's resilience, and is a key tool in health promotion for LGBT individuals, particularly those with a history of trauma. Further, MI can be used to break seemingly overwhelming behavior changes into smaller steps. In this fashion, a provider can promote the confidence an individual has in their ability to accomplish healthy behavior change, and can develop strategies for behavior change that are more likely to have a meaningful impact.

In this chapter we utilized a number of examples related to health behaviors of LGBT-identified individuals, but the application is broad when you consider traumatic experiences related to childhood trauma, sexual assault, bullying, societal rejection, feelings of isolation or shame, disclosure and coming out, intimate partner violence, self-harm, mental health challenges, and other experiences that are frequently experienced by LGBT individuals. The potential application for MI with LGBT patients is near limitless, and includes the following:

- Sexual risk behaviors (condomless sex, HIV prevention, STI prevention, risky sexual behaviors, sexual assault, engaging in sex work, etc.)
- HIV treatment and prophylaxis (PrEP use/adherence, ART use/adherence, retention in the HIV care continuum, engagement with HIV care providers, etc.)
- Diet and exercise (anabolic steroid use, disordered eating, elevated body mass index among some lesbian populations, etc.)
- Gender-affirming care without medical supervision in the transgender community (herbal preparations or hormones purchased off the Internet, pumping parties, etc.)
- Substance use disorders (smoking, alcohol use, party drugs, etc.)
- Mental health treatments and care (depression, anxiety, feelings of shame or isolation, self-harm, suicidal thoughts, etc.)

In summary, motivational interviewing is a useful tool for a wide range of patients and can be applied to patient-

provider interactions in varying degrees. While this chapter focused on LGBT-specific examples, the tools and techniques discussed here – particularly those related to skillful question asking and reflective listening – are useful to promote insightful conversations in any consultation setting. By using the key skills of MI (asking open questions, providing affirmations, listening reflectively, and providing summary statements) and thinking critically about RULE, you can gain an understanding of your patients' motivations and perspectives and guide them toward their goals by facilitating behavior change. Fundamentally, MI promotes resilience in all individuals, regardless of background, empowering them to make changes in their lives that may previously have been unattainable. While each interaction does not need to follow a formal motivational interviewing process, by picking and choosing appropriate counseling techniques, you can promote health for patients who identify as LGBT and those who do not and expand your knowledge of patients with backgrounds different from your own or your typical patient base while working to become a better resource for all of your patients.

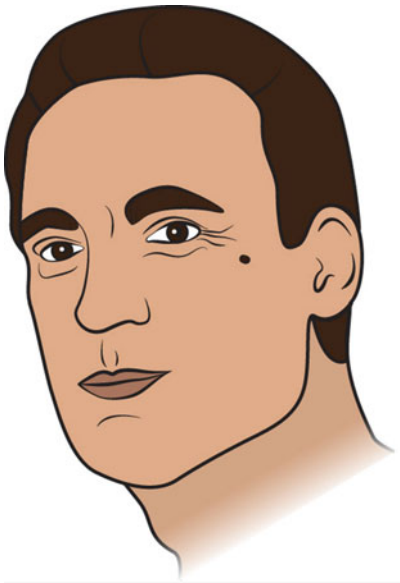

Fig. 17.8 47-year-old White male presenting with a slightly elevated viral load after being on HIV medications for over 20 years

Case Study #1

In the following example, pair up with a colleague to role-play an interaction between a provider and a patient. Halt the dialogue after 10–15 min, and evaluate the interaction using the questions listed below as a guide. Do not read the patient vignette before you decide who will be the patient and who will be the provider. If there are more than two of you working together, those not directly conducting the role play can observe the interaction, practice active listening, and provide feedback after the scenario is complete.

Instructions for Provider (Actor 1)

Introduce yourself to your patient and begin your interaction, obtaining information about what brings them to the visit today and guiding them using key skills in motivational interviewing. You have the following information on your patient: 47-year-old White male, presenting with a slightly elevated viral load after being on HIV medications for over 20 years (Fig. 17.8).

Instructions for Patient (Actor 2)

You are a man who has been living with HIV for over 20 years. You have been on a number of different treatment regimens over the years, many of which have failed. Your current regimen has a lot of side effects, including diarrhea, and you don't like to take the medications on days where you can't afford to have gastrointestinal distress. You've slowly stopped taking your medications, sometimes for weeks at a time. You understand the risks of poor adherence, but you feel okay and don't feel the need to take your meds. You have a partner who is HIV negative, and you are unhappy in your relationship and not motivated to protect your own or your partner's health. At today's meeting, while discussing the fact that your viral load is now slightly elevated, you begin to explain that you've been skipping some of your doses. Challenge your provider, expressing ambivalence about medication adherence: on the one hand, you want to be healthy and should protect your partner, and on the other hand, your medication makes you feel ill and you've already failed other medications so why would this one be different? Attempt to redirect the conversation away from discussion of medication adherence on several occasions to challenge the provider to continue focus on fostering behavior change.

Provider Follow-Up Questions

1. What were your overall impressions of the interaction?
2. How did the types of questions you asked work in the *guiding* style of communicating behavior change?
3. Were you able to listen for different types of change talk and provide reflective summaries on these statements?

4. If your patient had presented with strong ambivalence, or even resistance to change, how would you have approached this interaction?
5. How might you change your approach to this interaction as a provider?

Patient Follow-Up Questions

1. What were your overall impressions of the interaction?
2. What questions were most helpful in eliciting motivation for change?
3. How might the provider improve their interaction to better support behavior change?

Continue practicing with other patients of your own creation, and challenge each other to work through ambivalence, get to understand your patients' perspectives, and foster internal motivations while listening for change talk.

Fig. 17.9 19-year-old Hispanic female complaining of fatigue, feelings of isolation, and a lack of motivation

Case Study #2

In the following example, pair up with a colleague to role-play an interaction between a provider and a patient. Halt the dialogue after 10–15 min, and evaluate the interaction using the questions listed below as a guide. Do not read the patient vignette before you decide who will be the patient and who will be the provider. If there are more than two of you working together, those not directly conducting the role play can observe the interaction, practice active listening, and provide feedback after the scenario is complete.

Instructions for Provider (Actor 1)

Introduce yourself to your patient and begin your interaction, obtaining information about what brings them to the visit today and guiding them using key skills in motivational interviewing. You have the following information on your patient: 19-year-old Hispanic female complaining of fatigue, feelings of isolation, and a lack of motivation to engage in activities she once enjoyed (Fig. 17.9).

Instructions for Patient (Actor 2)

You are teenager who has recently come out as a lesbian. You have been feeling lonely, lacking the motivation to engage in activities you once enjoyed, and are sleepy all the time. You feel anxious about your relationships with your family and friends at school, some of whom haven't been accepting of your coming out. Present to the provider without much motivation to start therapy or treatment for your depression, and slowly introduce some change talk as the provider guides you toward wanting to address your depression. Challenge your provider with ambivalence: on the one hand, you want to feel like your "normal" self again and be open with people about how their lack of support has impacted you and on the other hand, you worry about being rejected by your family and friends and feel that being seeking treatment for depression would just give people something else to make fun of. Attempt to redirect the conversation away from discussion of depression treatment on several occasions to challenge the provider to continue focus on fostering behavior change.

Challenge your provider with ambivalence, but inject change talk slowly. Feel free to resist change, and include diversions to challenge your provider to guide the conversation in the direction of fostering behavior change.

Provider Follow-Up Questions

1. What were your overall impressions of the interaction?
2. How did the types of questions you asked work in the *guiding* style of communicating behavior change?
3. Were you able to listen for different types of change talks and provide reflective summaries on these statements?

4. If your patient had presented with strong ambivalence, or even resistance to change, how would you have approached this interaction?
5. How might you change your approach to this interaction as a provider?

Patient Follow-Up Questions

1. What were your overall impressions of the interaction?
2. What questions were most helpful in eliciting motivation for change?
3. How might the provider improve their interaction to better support behavior change?

Continue practicing with other patients of your own creation, and challenge each other to work through ambivalence, get to understand your patients' perspectives, and foster internal motivations while listening for change talk.

Additional Resources

Many youtube.com videos demonstrate patient-provider interactions using motivational interviewing techniques. Try a Google Search for some examples. Here are a few that we identified as particularly useful:

1. Good and bad examples of MI, Alan Lyme.
   (a) Good example: https://youtu.be/67I6g1I7Zao?list=PL0Iq5_Y7Dui-KRC5Z4ordPG1j7syCsLhq
   (b) Bad example: https://www.youtube.com/watch?v=_VlvanBFkvI
2. Dr. Jonathan Fader demonstrates MI skills: https://www.youtube.com/watch?v=ZxKZaKFzgF8
3. MI: Evoking Commitment to Change: https://www.youtube.com/watch?v=dm-rJJPCuTE&list=PL0Iq5_Y7Dui-KRC5Z4ordPG1j7syCsLhq&index=5
4. Advanced MI: Depression: https://www.youtube.com/watch?v=3rSt4KIaN8I
5. The effective physician: MI Demonstration: https://www.youtube.com/watch?v=URiKA7CKtfc&list=PL0Iq5_Y7Dui-KRC5Z4ordPG1j7syCsLhq&index=10

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