MENTAL HEALTH AND ADDICTION

MOTIVATIONAL INTERVIEWING

Jassin M. Jouria, MD

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ABSTRACT

The traditional methods of evoking health change in individuals involves providing education and professional guidance that is crucial to health. During such encounters, the focus is on improving the health of individuals through motivational interviewing strategies aimed at progress toward a specific treatment goal. Motivational interviewing may not agree with all individuals. Some may feel criticized or judged for their decisions and may have low motivation to change. Motivational interviewing is a collaborative process aimed at improving health clinician and patient communication, understanding the patient's desire and level of motivation, and ultimately

working with the patient to seek change.

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Continuing Education Credit Designation

This educational activity is credited for 2 hours. Nurses may only claim credit commensurate with the credit awarded for completion of this course activity.

Statement of Learning Need

Motivational interviewing focuses on patients and their desire to change behavior to improve health. Health clinicians are integral in supporting patients to recognize the need for change and to facilitate improvements in their health outcomes.

Course Purpose

To provide health clinicians with knowledge of motivational interviewing to support health behavior change in patients with the goal to improve health outcomes.

Target Audience

Advanced Practice Registered Nurses and Registered Nurses

(Interdisciplinary Health Team Members, including Vocational Nurses and Medical Assistants may obtain a *Certificate of Completion*)

Course Author & Planning Team Conflict of Interest Disclosures

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Acknowledgement of Commercial Support

There is no commercial support for this course.

Please take time to complete a self-assessment of knowledge, on page 4, sample questions *before* reading the article. Opportunity to complete a self-assessment of knowledge learned will be provided at the end of the course.

1. **Motivational interviewing (MI) may be used as part of a treatment plan to manage and treat a patient diagnosed with**

    a. depression.
    b. suicidal ideation.
    c. substance abuse.
    d. All of the above

2. **A severe and persistent mental illness is**

    a. a long-term condition.
    b. an immutable condition.
    c. a mental illness that does not abate.
    d. a mental illness that rarely returns after it subsides.

3. **_____ occurs when a person has symptoms of depression as well as another type of mental illness, such as delusional disorder.**

    a. Suicidal ideation
    b. Concurrent depression
    c. Psychotic depression
    d. Persistent depressive disorder

4. **A person whose moods shift back and forth between depression and mania is characteristic of**

    a. seasonal affective disorder.
    b. bipolar disorder.
    c. concurrent depression.
    d. Psychotic depression.

5. **Treatment of depression through motivational interviewing (MI) can be challenging because it can be difficult to actively engage patients who are suffering from depressive symptoms**

    a. in a manner that leads to change.
    b. without using pharmaceuticals, which cannot be used with MI.
    c. because of the potential for suicidal ideation.
    d. because MI is not an adjunctive therapy.

Introduction

Severe and persistent mental illness is a chronic condition. People diagnosed with it often have symptoms that fluctuate. This condition may lead to depression, suicidal ideation and suicide. Motivational interviewing may be used to manage and treat severe and persistent mental illness, as well as a treatment resistant depression and co-occurring disorders such as substance use and addiction. Motivational interviewing can also be helpful for patients who feel hopeless and are suicidal.

Severe and Persistent Mental Illness

Severe and persistent mental illness, formerly referred to as chronic mental illness, consists of a group of conditions that cause complex symptoms and behaviors. Some examples of common severe and persistent mental illness include severe depression, bipolar disorder, schizophrenia and delusional disorder,[41-44] and often involve long-term, chronic symptoms.

People diagnosed with a mental illness that is severe and persistent often have symptoms that fluctuate; the symptoms worsen and then abate over time. The symptoms do not abate permanently in most cases, and rather patients will usually experience episodes of relapse followed by a period of recovery. A patient with persistent mental illness can have difficulty controlling thoughts and behaviors. This can lead to behavior that is sometimes considered erratic, bizarre, confusing, or concerning.

For many people who struggle with mental illness, the disease takes over a considerable portion of their lives, impacting their abilities to function on a daily basis, and putting them at higher risk of complications that can develop as a coping mechanism for the ongoing illness, such as substance use and

addiction, violence, or suicidal ideation.[49,53]

Because severe and persistent mental illness is chronic it requires ongoing treatment and management. Depending on the severity of the diagnosis, patients with severe and persistent mental illness may require assistance with activities of daily living, obtaining jobs, finding housing, going to school, or making social contacts.[41-44] Health clinicians who treat patients with severe and persistent mental illness must be aware of possible complications that can develop. The goal of treatment is to encourage and maintain appropriate behavior as much as possible so that the patient may live a productive and healthy life.

The patient's condition is typically variable and requires ongoing case management and interventions, which may be necessary in some situations. While the patient's daily thoughts and behaviors may be generally under control, there could develop crisis situations that occur on an occasional basis. Crisis may lead to suicidal ideation and may culminate in suicide.

Depression And MI

Depression is another type of mental illness that can be classified according to different terms, depending on the types of symptoms experienced, the extent of the symptoms, and the length of time they have occurred.[43,44] Depression is one of the most common mental health disorders in the United States. It is characterized by persistent feelings of sadness, emptiness, hopelessness, pessimism, loss of interest in normal activities that used to be pleasurable, suicidal ideation, fatigue, sleep problems, changes in appetite, difficulties with memory and concentration; and some physical discomfort, such as joint pain, or chronic back pain.

Depending on patient circumstances and symptoms, the main categories of depression are *major depression* and *persistent depressive disorder*. Major depression occurs when symptoms considerably disrupt a person's life and a person's ability to function on a daily basis. Persistent depressive disorder may occur as underlying feelings of depression; its symptoms occur continuously over the course of at least two years. A person with persistent depressive disorder may have occasional exacerbation of depression symptoms, causing a disruption of daily activities.[43,44]

Other types of depression can also cause significant problems for some people but are classified slightly differently than major depression or persistent depressive disorder. *Postpartum depression* is diagnosed when depressive symptoms occur after delivering a baby. *Seasonal affective disorder results* in depressive symptoms that more commonly develop during certain times of the year, such as during the winter when there is less sunlight; and, *psychotic depression*, which occurs when a person has symptoms of depression as well as another type of mental illness, such as a delusional disorder.[33,40-42]

Bipolar Disorder

Bipolar disorder is also classified as a form of depression, as the person suffering from this condition has periods of depression followed by periods of mania. When depression is apparent, the patient with bipolar disorder experiences the symptoms associated with depression, including sadness, fatigue, and hopelessness. The person may later shift to an episode of mania in which a very elevated mood, increased energy and tolerance for activities occurs. The back and forth cycles between depression and mania characterize bipolar disorder. This mental illness used to be called manic-depression.[43,44]

People who suffer from depression are at higher risk of complications because the symptoms are often overwhelming. They may be more likely to consider suicide or other types of self-harm. People with depression may also suffer from other health conditions that either contributes to the depression or that have developed as a result of the depressive symptoms. For example, a person who suffers from chronic pain due to arthritis may develop symptoms of depression when unable to function in the same manner as previously.

Combination Treatment of Depression

Treatment of depression through motivational interviewing (MI) can be challenging because it can be difficult to actively engage patients who are suffering from depressive symptoms in a manner that leads to change. Pharmacologic intervention to treat depression may be initiated concurrently with MI. In some situations, MI may play a role in getting a patient to accept taking medications to treat the depression. In other cases, MI can be adjunctive to medication use.[4-6,43]

Motivational interviewing can also be used in conjunction with other traditional forms of treatment for depression that are related to counseling or psychotherapy. One form of psychotherapy that is commonly used as part of treatment for depression is cognitive-behavioral therapy (CBT). Cognitive-behavioral therapy focuses on negative thoughts, views, and opinions that the patient holds and examines how those ideas affect behavior. It may be used as a type of therapy for a number of mental health disorders and has been effectively used as treatment for depression.[4-6,47]

Burke, in *Cognitive and Behavioral Practice,* looked at how well MI could be blended throughout the use of CBT to assess motivation, encourage self-

efficacy, and resolve ambivalence among patients suffering from depression. Because MI is not necessarily a distinct therapy itself, it can be blended with other therapeutic treatment approaches as a means of connecting with patients on a deeper level.

Cognitive behavioral therapy and MI have a number of elements in common. Both types of interventions work together to help patients set goals and both types of therapy involve patient follow up to evaluate how they are progressing toward their goals.[4,5] Cognitive behavioral therapy has been well accepted by mental health professionals as beneficial to treat patients with depression but studies have also shown that the remission rate from depressive symptoms for CBT patients is not as successful as for those given pharmacologic treatment for depression. Pharmacologic treatments are 50% more effective that CBT for depression.

Despite large numbers of patients undergoing CBT for depression, there are still many patients who continue to suffer from depressive symptoms, even after this therapy.[4,5] Alternatively, there have been studies that have shown that patients with depression who went through therapy that focused on motivation and behavior activation responded better to the treatment than those who went through therapy that was focused on cognitive behavior interventions and used pharmacologic treatment. Because MI focuses on behavior activation and motivation, it is a viable intervention to add as part of traditional therapy and may be more promising with depressed patients than when it is not used.

Suicide And MI

According to the American Foundation for Suicide Prevention, 90 percent of people who died by suicide had some form of mental disorder at the time of

death.[47] Suicide, classified as self-directed violence and defined as the willful taking of one's own life, is completed by individuals for a variety of reasons. As many as one-third of people who follow through with suicide do not communicate their suicidal intent prior to death. Even more concerning are the results of one study that showed approximately 45 percent of people who had died by suicide had seen a primary care clinician within the past month before their deaths, and 77 percent had seen a primary care clinician within the year preceding their suicide.[47] These statistics place the role of primary care clinicians and other health professionals in an important position to recognize situations that could contribute to suicidal ideation and to intervene as necessary.

The interventions provided through MI can be helpful for patients who are considering suicide. If a clinician recognizes the possibility of suicidal ideation in a patient, whether due to the presence of a severe mental illness or through exhibiting other concerning symptoms, a non-judgmental and non-threatening approach through MI principles could be a helpful and possibly life-saving patient intervention.

A 2012 preliminary trial published in *The Journal of Clinical Psychology* worked with U.S., veterans who were hospitalized for psychiatric suicidal ideation to determine if MI was effective as part of treatment. The participants completed two sessions of MI after a preliminary assessment, another session following treatment and hospitalization, and a final session 60 days after the intervention. The study showed that the participants were open to MI as part of therapy and responded well to it as an intervention. The participants showed significant reductions in suicidal ideation, both after treatment had ended and at the 60-day follow-up evaluation. This study, because it is preliminary, opened the door for further research into use of MI

as part of treatment for people who are experiencing thoughts of suicide.[46]

Co-occurring Disorders And MI

Patients with mental illness are at higher risk of developing co-occurring disorders, most commonly substance use and addiction. This is often referred to as dual diagnosis or comorbidity and occurs when one or more illnesses are diagnosed in an individual, whether at the same time or one after the other. For instance, people who struggle with drug addiction are almost twice as likely to suffer from anxiety or mood disorders when compared to the general population.[50] Rates of mental illness are increasing among adolescent patients, which often co-occur with substance use issues. A study by The Center for Substance Abuse Treatment found that 62 percent of male patients and 83 percent of female patients entering treatment facilities for substance use also had co-occurring mental health diagnoses.[13]

The comorbidity of mental illness combined with substance use places MI clinicians in the position of addressing more than one problem behavior. When discussing options with the patient and assessing levels of motivation, clinicians and patients may need to determine the highest priority for change or whether to tackle both issues at the same time. The *change talk* that occurs as part of motivational therapy encourages individuals to share more of their thoughts and feelings about their behavior in a method that is open-ended, non-judgmental, and that promotes self-efficacy (eliciting hope in the patient that they can accomplish change). When the patient opens up and expands on certain subjects because of the change talk that happens during MI, he/she may be more likely to see the discrepancies between their current behavior and the lifestyle or behavior that they would like to have, which also may promote change.

Another important aspect of MI that is essential to remember when working with patients who have psychiatric comorbidities is that eliciting change in a person who is not ready for change is counterproductive, a waste of time, and can even be damaging to the therapeutic relationship. Thus, the clinician needs to approach each person at the level of motivation each person shows.[51]

Patients who are cognitively impaired at times because of mental illness may also benefit from the elicit-provide-elicit technique of motivational therapy. This technique asks the patient permission before offering or generating information or advice. At the patient's approval, the clinician provides the information and asks the patient to respond. Using this process in a patient who may be cognitively impaired because of mental illness can work better to keep the patient on track with the conversation and decisions that are being made. The patient often must repeat back the important information to the clinician as part of the process, which further conveys the patient's understanding of the topic and helps keep the patient involved in treatment.[51] According to the book, *Intervention in Mental Health-Substance Abuse*, the elicit-provide-elicit method is similar to the PAPA technique. The PAPA method starts with the following:

- **P**ermission: the clinician seeks *permission* to give advice or information and when allowed.
- **A**sks: the clinician then *asks* the patient what he/she knows about the topic they are discussing.
- **P**rovided: further information is *provided* to the patient to clarify about the topic or to summarize his/her understanding of the topic.
- **A**sked: finally, the patient is *asked* about what he/she thinks of the topic and the idea of change.

The PAPA method may elicit more information from the patient and helps the patient stay focused on the conversation.[51]

Personality Disorders And MI

Personality disorders are a prevalent form of persistent mental illness and are classified into three groups, according to the American Academy of Family Physicians.[46]

- Cluster A: schizoid and paranoid personality disorders
- Cluster B: borderline, histrionic, narcissistic, and antisocial personality disorders
- Cluster C: avoidant, dependent, and obsessive-compulsive personality disorders

Cluster A Personality Disorder

Cluster A personality disorders are classified according to bizarre or odd characteristics among patients, and may involve an inability to maintain close relationships as well as misguided thoughts and feelings related to others. For example, some people who suffer from cluster A personality disorder may have a lot of paranoid feelings from others and feel judged or threatened.

Cluster B Personality Disorder

Cluster B personality disorders are more related to dramatic, self-involved behavior. They may include feelings of grandiosity, attention seeking, or lack of impulse control. People with cluster B types of illnesses can also cause difficulties with relationships when excessively emotional behavior or the near-constant need for validation gets in the way of the normal give and

take of relationships.

Cluster C Personality

Cluster C personality disorder is marked by anxious or fearful behaviors, which often impact relationships with others. Cluster C disorders may cause social phobia, overdependence on others, perfectionism and control, or clingy behaviors, which are often challenging to healthcare clinicians as well as the families and friends of these patients.[46]

An important aspect of working with patients who have personality disorders is to avoid succumbing to or otherwise being drawn into their situations. A clinician who is working with a patient who has a personality disorder must maintain a line of professionalism and a working relationship to avoid becoming too involved in the situation. For example, a clinician working with a patient who has histrionic personality disorder may need to have a number of discussions that involve the patient's emotions and feelings. The patient may consistently talk about a number of situations that have caused pain or that have been difficult to experience, in an effort to get the clinician to feel sorry and act comforting. In order to provide effective care for the patient, the clinician must be aware of the challenges presented with this situation before even starting the therapeutic relationship and to establish clear boundaries. It can be difficult to know how to provide comfort and help to a patient without being drawn too far into the personal lives of some patients with personality disorders.[46]

Counseling

Personality disorders are treated in psychiatric practice through counseling and intervention but many patients with these types of mental illness are also seen for primary care in a number of other community settings,

including by general medical clinicians. As noted by their title, personality disorders cause changes in personality, which may be characterized in a number of methods, from bizarre or confusing words and attitudes to outright anger, aggression, and violence. Often, clinicians who work with people with personality disorders are challenged with providing quality care while simultaneously managing feelings of frustration, helplessness, or even anger when trying to help these patients because of their challenging behaviors.[46]

Personality disorders may be prevalent in almost 15 percent of the population in the United States. It is not uncommon for some people to have more than one type of personality disorder or co-occurring mental illness, including substance use alongside the condition.[46]

Motivational interviewing has been shown to be helpful when working with some patients who have personality disorders. While the MI techniques will not change the disorder, it can help patients suffering from these illnesses to make positive choices that impact themselves and their behavior as well as their relationships with others. Motivational interviewing can be used as part of other therapeutic interventions or even during primary care evaluations to help patients with personality disorders during decision-making and setting goals that will create positive outcomes.

A health clinician may use MI techniques during an appointment with a patient who has histrionic personality disorder to discuss the patient's needs.[4,5] For example, the patient may be seeking help to take care of his/her children. The patient may recognize that he/she has trouble taking care of children and helping a spouse or basically with being involved with family. Through MI techniques, the clinician could work with the patient to

come up with goals to support a desire for change in this one area of the patient's life. The patient might set a goal to start picking up the children from daycare at the same time each day, or spending 30 minutes every evening playing games with them in a focused manner. The goal of MI in this situation is not to cure the personality disorder or even to reduce symptoms of a personality disorder to a large degree, but rather to help the patient with the disorder to manage life better around the condition.

One condition that clinicians may need to manage and that may coincide with personality disorders is crisis intervention. A crisis occurs when a person is overwhelmed by events and is unable to cope with the situation. If the person cannot handle what is happening, he/she may develop maladaptive behaviors in a further attempt to cope, such as through substance use or violence, or the person may succumb to the situation and exhibit behaviors that demonstrate an unwillingness or inability to function, such as having panic attacks or psychotic events.

Crisis Intervention

Crisis intervention aims to work with patients in acute distress to help them manage the current situation. It may then go on to help affected patients with problem solving or assist them with changing their situations so that they are less likely to have another crisis. Therapy for crises involves counseling and working with family members and friends of the affected person to provide support and to educate those involved about appropriate coping mechanisms that are available.[4,5,46] It is important, however, that some techniques be used for a short time instead of a long therapeutic relationship. In many situations of working with people who are in crisis or who have personality disorders, MI may need to be delivered in short but intense sessions in order to prevent the patient from becoming dependent

on the therapist.[46]

Studies have shown that MI can be helpful when working with patients as part of crisis intervention. Motivational interviewing may be used concurrently with other forms of behavioral therapy and crisis intervention methods. It shows the patient that the clinician is a trusted partner in therapy and intervention and is someone who is willing to help bring about change. It also helps the patient to better visualize the discrepancies in his/her behavior and the ultimate goals or outcomes.[4,5] For example, if a patient is seeking help for excessive drinking and has concurrent narcissistic personality disorder, he/she may meet with a therapist for crisis intervention for help with stopping the harmful behaviors.[46] During the course of the intervention, the clinician may utilize MI to discuss the patient's current situation and to assess the patient's goals and objectives.

During the interview, the patient may become more aware that their current situation of drinking to excess and taking advantage of their personal relationships is far from where they want to be. The clinician can then use techniques of MI to promote self-efficacy in the patient. The techniques leave the decision ultimately up to the patient, although the clinician will act as a guide along the way.

Some personality disorders also leave patients more prone to violence and aggressive behavior, which could lead to a need for crisis intervention.[46] Motivational interviewing is also beneficial in these situations because the core of the MI sessions is to have the patient take responsibility for his/her own behavior. If the patient is willing to change or sees the need for it, the clinician may work with the patient to assist with making changes but ultimately it is the patient's responsibility to take charge of angry or

aggressive behavior.

Anger is a normal feeling that may occur in response to feeling judged, slighted, insulted, or ignored. It can develop based on real or perceived situations. It is important that patients understand that anger is a normal emotion that almost everyone feels at one time or another, however, aggression and violence as a result of anger are not normal. Peter Prisgrove of the Western Australian Department of Corrective Services stated that clinicians can work with patients on anger control issues through such interventions as cognitive-behavioral skills training, in which the focus is on recognizing the impact of thoughts related to behavior and working through negative or angry thoughts to recognize them and to deal with them before they lead to problem behaviors.[49] Behavioral skills training also considers those situations that might lead to aggressive or negative reactions and teaches the patient how to behave and handle urges or loss of control.

When using MI as part of cognitive or behavioral skills training, the patient may have mixed responses for being motivated to change, depending on the patient's background and situation. Some patients feel true remorse and are motivated to change because they have hurt someone they care for or they are facing legal consequences of their actions. Alternatively, other patients may have little motivation to change and may feel justified in their actions or continue to feel angry about the situation. Just as with any other situation that requires MI, the clinician must first assess the patient's level of motivation and amount of ambivalence toward change before progressing into change talk.

Prisgrove also states that there are two main types of aggression often seen among individuals who are in treatment for this kind of behavior:

instrumental aggression and *reactive aggression*.[49] Instrumental aggression often occurs because of a cause that the offender deemed necessary or justified at the time, or to achieve some sort of objective. An example might be when a patient attacks their employer because they have been angry about unfair treatment at work and believes that through force the employer can be made to change. Alternatively, reactive aggression is the result of loss of control over a situation in which the patient acts out. An example might be when a patient comes home and becomes angry and violent toward a spouse because he/she forgot to perform a task.[49]

In the area of treatment, patients will arrive for help and treatment of different needs. The clinician using MI will need to understand the background of the aggression, or whether it was instrumental or reactive aggression, in order to better understand the patient's level of motivation for change. Finally, when working with aggressive patients, whether or not due to underlying personality disorders, the probability for repeat offenses is high.[49] A patient may be seen for therapy or treatment of an aggressive outburst, go through the steps of change, and then return for treatment again at a later date. The change invoked through MI may or may not be permanent because the anger and aggression takes on an almost addictive framework in which the patient is drawn to repeating the same offenses over and over. A patient in this situation may need repeated sessions or ongoing, long-term treatment and therapy in order to handle aggressive feelings and avoid acting out. Studies have shown that the most difficult area of treating patients with anger-control issues is the long-term maintenance of behavior change.[48]

The goal, therefore, of treatment along with motivational therapy is not to cure patients of their anger, but rather to help them change behavior so that

better choices can be made when frustrating situations arise. This involves learning new skills, and the MI process is there to help patients acquire these skills to implement them into daily life. If a lapse in behavior occurs, the patient may have learned the skills needed to cope with the situation before completely losing control. The clinician, however, can use this lapse in behavior in a positive way to reinforce the need for change and to elicit further growth in the patient.

Summary

Severe and persistent mental illness is a long-term condition that often involves symptoms that fluctuate over time. Patients usually experience periods of relapse followed by a period of recovery. Motivational interviewing is used to actively engage patients who are suffering from symptoms, such as depression or suicidal thought, and to elicit change. Pharmacologic intervention may be combined with MI, which can also be used in conjunction with other forms of counseling or psychotherapy.

Motivational interviewing may be used to treat depression, along with co-occurring disorders such as substance use and addiction and personality disorders. While the MI techniques will not change the disorder, it can help patients suffering from mental illness to make positive choices that impact themselves and their relationships with others.

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1. **Motivational interviewing (MI) may be used as part of a treatment plan to manage and treat a patient diagnosed with**

    a. depression.
    b. suicidal ideation.
    c. substance abuse.
    d. All of the above

2. **A severe and persistent mental illness is**

    a. a long-term condition.
    b. an immutable condition.
    c. a mental illness that does not abate.
    d. a mental illness that rarely returns after it subsides.

3. **_____ occurs when a person has symptoms of depression as well as another type of mental illness, such as delusional disorder.**

    a. Suicidal ideation
    b. Concurrent depression
    c. Psychotic depression
    d. Persistent depressive disorder

4. **A person whose moods shift back and forth between depression and mania is characteristic of**

    a. seasonal affective disorder.
    b. bipolar disorder.
    c. concurrent depression.
    d. psychotic depression.

5. **Treatment of depression through motivational interviewing (MI) can be challenging because it can be difficult to actively engage patients who are suffering from depressive symptoms**

    a. in a manner that leads to change.
    b. without using pharmaceuticals, which cannot be used with MI.
    c. because of the potential for suicidal ideation.
    d. because MI is not an adjunctive therapy.

6. **Which of the following therapies specifically focuses on negative thoughts, views, and opinions and their effects on a patient's behavior?**

    a. Motivational interviewing (MI)
    b. Cognitive-behavioral therapy (CBT)
    c. Physiotherapy
    d. Adjunctive therapy

7. **According to the American Foundation for Suicide Prevention, _____ of people who died by suicide had some form of mental disorder at the time of death.**

    a. 90 percent
    b. half
    c. 20%
    d. 75 percent

8. **One study has shown that participants with suicidal ideation who used motivational interviewing (MI) as a therapy**

    a. had initial success but did not follow up.
    b. required hospitalization for MI to work.
    c. responded well to MI as an intervention.
    d. did not do better statistically but further study was needed.

9. **True or False: As many as one-third of people who commit suicide do not communicate their suicidal intent prior to death.**

    a. True
    b. False

10. **Patients with mental illness are at higher risk of developing concurrent disorders, most commonly**

    a. anorexia.
    b. physical abuse.
    c. substance abuse.
    d. anxiety.

11. When working with a patient who has mental health issues and a co-occurring disorder or comorbidity,

a. it is even more urgent to push for change.
b. change is imperative to avoid suicidal ideation.
c. these patients are usually ready for change.
d. eliciting change in a patient who is not ready for change is counterproductive.

12. A patient repeats back important information to the clinician as part of the method known as

a. elicit-provide-elicit.
b. pros and cons.
c. OARS.
d. the 5 A's.

13. The PAPA technique is similar to

a. pros and cons.
b. elicit-provide-elicit.
c. OARS.
d. DARN CAT.

14. When a health clinician is utilizing motivational interviewing to work with a patient who has a personality disorder, the clinician

a. must be drawn into the patient's situation if the clinician is to help.
b. tell the patient the pros and cons of the patient's behavior.
c. must allow the patient to take charge as with the "OARS" method.
d. needs to approach each person based on his or her level of motivation.

15. Motivational interviewing (MI) has been shown to be helpful when working with patients who have personality disorders by

a. curing the disorder.
b. helping them make positive behavioral choices.
c. preventing relapses in particular disorders.
d. reducing or eliminating the symptoms of the disorder.

CORRECT ANSWERS:

1. **Motivational interviewing (MI) may be used as part of a treatment plan to manage and treat a patient diagnosed with**

    a. depression.
    b. suicidal ideation.
    c. substance abuse.
    d. All of the above *[correct answer]*

    "*Motivational interviewing may be used to treat depression, along with co-occurring disorders such as substance use and addiction. Motivational interviewing can also be helpful for patients who are suicidal.*"

2. **A severe and persistent mental illness is**

    a. a long-term condition.

    "*Severe and persistent mental illness is a long-term condition. People diagnosed with a mental illness that is severe and persistent often have symptoms that fluctuate; the symptoms worsen and then abate over time. These symptoms do not abate permanently in most cases; instead, a patient will usually experience periods of relapse followed by a period of recovery.*"

3. **_____ occurs when a person has symptoms of depression as well as another type of mental illness, such as delusional disorder.**

    c. Psychotic depression

    "*Other types of depression can also cause significant problems for some people but are classified slightly differently than major depression or persistent depressive disorder. Postpartum depression is diagnosed when depressive symptoms occur after delivering a baby. Seasonal affective disorder results in depressive symptoms that more commonly develop during certain times of the year, such as during the winter when there is less sunlight; and, psychotic depression, which occurs when a person has symptoms of depression as well as another type of mental illness, such as delusional disorder.*"

4. **A person whose moods shift back and forth between depression and mania is characteristic of**

    b. bipolar disorder.

    "*Bipolar disorder is also classified as a form of depression, as the person suffering from this condition has periods of depression followed by periods of mania. When depression is apparent, the patient with bipolar disorder experiences the symptoms associated with depression, including sadness, fatigue, and hopelessness. The person may later shift to a time of mania in which he/she experiences an elevated mood and has increased energy and tolerance for activities. The back and forth cycles between depression and mania characterize bipolar disorder.*"

5. **Treatment of depression through motivational interviewing (MI) can be challenging because it can be difficult to actively engage patients who are suffering from depressive symptoms**

    a. in a manner that leads to change.

    "*Treatment of depression through motivational interviewing (MI) can be challenging because it can be difficult to actively engage patients who are suffering from depressive symptoms in a manner that leads to change. Treatment of depression through pharmacologic intervention may occur concurrently with MI. In some situations, MI may play a role in getting a patient to take medications to treat depression. In other cases, MI can be adjunctive to medication use.*"

6. **Which of the following therapies specifically focuses on negative thoughts, views, and opinions and their effects on a patient's behavior?**

    b. Cognitive-behavioral therapy (CBT)

    "*Motivational interviewing can also be used in conjunction with other traditional forms of treatment for depression that are related to counseling or psychotherapy. One form of psychotherapy that is commonly used as part of treatment for depression is cognitive-behavioral therapy (CBT). Cognitive-behavioral therapy focuses on negative thoughts, views, and opinions that the patient holds and examines how those ideas affect behavior.*"

7. According to the American Foundation for Suicide Prevention, _____ of people who died by suicide had some form of mental disorder at the time of death.

a. 90 percent

"*According to the American Foundation for Suicide Prevention, 90 percent of people who died by suicide had some form of mental disorder at the time of death.*"

8. One study has shown that participants with suicidal ideation who used motivational interviewing (MI) as a therapy

c. responded well to MI as an intervention.

"*The participants completed two sessions of MI after a preliminary assessment, another session following treatment and hospitalization and a final session 60 days after the intervention. The study showed that the participants were open to MI as part of therapy and responded well to it as an intervention. The participants showed significant reductions in suicidal ideation, both after treatment had ended and at the 60-day follow-up appraisal.*"

9. True or False: As many as one-third of people who commit suicide do not communicate their suicidal intent prior to death.

a. True

"*People who commit suicide do so for a variety of reasons, although as many as one-third of people who commit suicide do not communicate their suicidal intent prior to death.*"

10. Patients with mental illness are at higher risk of developing concurrent disorders, most commonly

c. substance use.

"*Patients with mental illness are at higher risk of developing concurrent disorders, most commonly substance use. This is often referred to as dual diagnosis or comorbidity and occurs when one or more illnesses occur in a person, whether at the same time or one after the other.*"

11. When working with a client who has mental health issues and a co-occurring disorder or comorbidity,

d. eliciting change in a client who is not ready for change is counterproductive.

"*Another important aspect of MI that is essential to remember when working with clients who have comorbidities of mental health issues is that eliciting change in the client who is not ready for change is counterproductive, a waste of time, and can even be damaging to the therapeutic relationship.*"

12. A patient repeats back important information to the clinician as part of the method known as

a. elicit-provide-elicit.

"*Patients who are cognitively impaired at times because of their mental illnesses may also benefit from the elicit-provide-elicit technique of motivational therapy.... The patient often must repeat back the important information to the clinician as part of this method, ...*"

13. The PAPA technique is similar to

b. elicit-provide-elicit.

"*According to the book, Intervention in Mental Health-Substance Abuse, the elicit-provide-elicit method is similar to the PAPA technique.*"

14. When a health clinician is utilizing motivational interviewing to work with a patient who has a personality disorder, the clinician

d. needs to approach each person based on his/her level of motivation.

"*…the clinician needs to approach each person at the level of motivation each person shows.*"

15. Motivational interviewing (MI) has been shown to be helpful when working with patients who have personality disorders by

b. helping them make positive behavioral choices.

"*Motivational interviewing has been shown to be helpful when working with some patients who have personality disorders. While the MI techniques will not change the disorder, it can help patients suffering from these illnesses to make positive choices that impact themselves and their behavior as well as their relationships with others.*"

Reference Section

The References below include published works and in-text citations of published works that are intended as helpful material for your further reading. [References are for a multi-part series on *Motivational Interviewing*].

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