**Motivational Counseling Strategies for the Herbalist**

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*First the word - Then the herb – Lastly the knife. -Asclepius of Thessaly*

There are two assumptions practitioners commonly make about patients who seek help with a health concern 1) the patient values health and 2) the patient is ready to change.

Studies of patient adherence consistently demonstrate that lifestyle changes have lower adherence rates than medication use (Martin, Williams, Haskard, & Dimatteo, 2005). For example in the Medical Outcomes Study analyzing patient adherence to disease-specific recommendations for diabetes; 91% of diabetics took the medication as prescribed, 69% recalled and followed a prescribed diabetics diet and 19% followed exercise recommendations (Kravitz, Hays, Sherbourne, DiMatteo, Rogers, Ordway, & Greenfield, 1993). Adherence is often correlated to the degree of suffering a patient is experiencing, more severe illnesses usually correlate to a greater willingness to make dietary and lifestyle changes (DiMatteo, 2004).

Looking at obesity rates and increasing incidence of preventable chronic disease in the US further illustrates the point. Compiled data from the National Health Interview Surveys, self-administered to 190,000 adults between 2002-2009, showed a steady increase in lifestyle and behavior-related chronic conditions, “30.9 million adults had 2 or more major lifestyle behavior-related chronic conditions in 2009” (Ford, Croft, Posner, Goodman, & Giles, 2013, p. 4).

Health care practitioners value health, and can wrongly assume that their patients value health as well. In two self-administered surveys of 3,000 adults, respondents identified the primary driver for their personal eating decisions. Taste was the number one factor that influenced food choices, followed by cost, convenience and last was health (Glanz, Basil, Maibach, Goldberg, & Snyder, 1998).

In the early 1980s, Proschaska and Diclemente developed the Transtheoretical Model of Change (TTMC), providing a new model for understanding human behavior change. By acknowledging that change is a process and that ambivalence is a normal part of the change process, TTMC helped to radically improve addiction counseling. According to TTMC individuals pass through various stages including precontemplation (not ready), contemplation (ambivalence), preparation (getting ready), action, and maintenance (Prochaska & DiClemente, 1982). By identifying a client’s readiness to change, practitioners avoid assumptions and can match recommendations and suggestions to a client’s stage of readiness.

Around the same time that TTMC was articulated, William Miller developed a psychotherapeutic method called Motivational Interviewing (MI). The method was a client-centered interview style that avoided confrontation and placed focus on strengthening and mirroring client’s verbalized and nonverbalized motivation for change. A good definition of the method is a “guiding style for enhancing intrinsic motivation to change.” The method was developed working clinically with heavy drinkers but was soon applied in a variety of clinical settings (Miller & Rose, 2009).

More than 200 clinical trials in MI have been published, demonstrating positive effects for a variety of conditions and issues, “including cardiovascular rehabilitation, diabetes management, dietary change, hypertension, illicit drug use, infection risk reduction, management of chronic mental disorders, problem drinking, problem gambling, smoking, and concomitant mental and substance use disorders” (Miller and Rollnick, 2009, pp. 3-4). In a meta analysis of 72 randomized controlled trials, MI counseling was more effective than traditional advice giving, improving outcome measures such as BMI, blood alcohol levels, systolic blood pressure and blood cholesterol levels. The authors noted that longer consults were correlated with better success, 81% of 60-minute encounters studies demonstrated efficacy compared to 64% of 20-minute encounters. (Rubak, Sandbaek, Lauritzen, & Christensen, 2005).

The founders of MI frequently note that the “Spirit of MI” is the foundation of the method,” The practice of MI without understanding and manifesting this spirit is like the words without the music of a song. It is missing something essential” (Miller & Rollnick, 2009, p. 131). This “Spirit of MI” must include a therapeutic partnership or alliance between patient and practitioner. Key features of the therapeutic alliance include 1) the quality of the practitioner and patient bond, 2) patient autonomy 3) practitioner and patient agreement on goals of the treatment 4) shared belief that the given treatment will address the patient’s concerns (Madson, Loignon, & Lane, 2009; Meissner, 2006: Bordin, 1994). A quality interpersonal relationship between practitioner and patient as well as patient involvement in decision making are both determinants of patient adherence and key features of MI (Martin, et al., 2005).

Motivational Interviewing can be readily incorporated into Western Herbal Medicine (WHM) practice. In a review of social science literature, Nissen and Evans identify the collaborative patient-practitioner relationship as one of the key features of WHM. The WHM practitioner tends to value a collaborative approach to patient care. Other common features include lengthier consults, listening to the patient’s story, negotiating shared goals and strategies, and building rapport (Nissen and Evans, 2012).

It is often necessary for the WHM practitioner to reorient patient expectations in regards to outcomes of herbal treatment and length of care. In his classic 6th edition of Herbal Medicine, Rudolf Weiss differentiates the gentle and powerful herbal drugs, placing chamomile on the gentle end of the spectrum and belladonna on the other end. Today’s herbalist rarely uses potentially toxic herbs such as belladonna and digitalis; instead the modern herbalist relies on the gentle or midrange herbals such as chamomile and licorice. Weiss is careful to point out that gentle does not mean ineffective but rather that effects are best achieved over a longer period of time in the context of a practitioner-patient relationship. “If there is a dialogue between physician and patient, and at the same time a plant medicament is given, it is the ideal method of healing, and all that is needed in the majority of cases.” (Weiss, 1985, p. 11.)

With a materia medica of gentle and midrange herbals, today’s herbalist will be most successful when herbs are given in the context of exploring behavior and lifestyle choices of the client. For instance, when prescribing a sedative to a client with insomnia, it is essential to explore behaviors such as caffeine and alcohol use, blue light exposure, and stress management. Just as the herbalist uses herbs to nudge the innate healing ability of the human body, the herbalist can use MI skills to nudge the ‘intrinsic motivation’ in their patient so that behavior change is not coerced but rather is evoked with dialogue and an exploration of client ambivalence.

This lecture and workshop will delve into MI tools that build on a collaborative approach to patient care. Tools explored in the workshop include:

* OARS interview style
* Agenda Setting
* Elicit-Provide-Elicit
* Building Self-efficacy
* Recognizing Change Talk
* Recognizing and Reducing Resistance
* Exploring ambivalence

**Bibliography**

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**Clinical Resources**

**Recommended Reading**

Conway, P. (2011). *The Consultation in Phytotherapy* (pp 205-321). Edinburgh: Churchill Livingstone, Elsevier.

Mason, P., C. Butler, et al. (2010). *Health Behavior Change: A Guide for Practitioners*. Edinburgh: Churchill Livingstone/Elsevier. *Select readings*

Rollnick, S., W. R. Miller, et al. (2008). *Motivational Interviewing in Health Care: Helping Patients with Change Behavior*. New York: The Guilford Press.

**Websites**

**ATTC Network on Motivational Interviewing**

[**http://www.motivationalinterview.org/index.html**](http://www.motivationalinterview.org/index.html)

Key Resources: Articles and videos with Bill Miller, one of the co-originators of MI, and an introductory webinar to evidence-based program and implementation process listed under “MI Basics”; Several useful handouts and skills sheets listed under “Skills and Tools” for “Clinicians”

**Boston University School of Public Health, The BNI ART Institute**

[**http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/**](http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/)

Key resources: Videos of Brief Negotiated Interviews by conventional health practitioners under “SBIRT Materials” and “Videos”; Substance abuse screening and educational tools under “Screening Tools”

**Case Western Reserve University, Center for Evidence Based Practices** [**http://www.centerforebp.case.edu/resources/tools/the-spirit-of-mi**](http://www.centerforebp.case.edu/resources/tools/the-spirit-of-mi)

Key resources: Short audio clips on the Spirit of MI, including topics such as ambivalence, tone of voice, rolling with resistance.

**Health Behavior Change**

[**http://www.elsevierhealthbehaviorchange.com/assets.php**](http://www.elsevierhealthbehaviorchange.com/assets.php)

Corresponds to Mason and Butler, 2010 book above

Key resources: Several worksheets to assist your clinical practice, including 1) Agenda Setting Chart, 2) Decision Balance Sheet, 3) Readiness Ruler, 4) Importance and Confidence Continuum; A 20-minute video that models MI in a patient and practitioner interaction. The practitioner uses numerous MI skills such as agenda setting, building rapport, asking open questions, building client efficacy, eliciting change talk, and importance and confidence scales.