

Motivational interviewing: The RULES, PACE, and OARS

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CASE

Mr. C, a veteran in his 60s who has posttraumatic stress disorder (PTSD), presents to your clinic for a 45-minute follow-up visit. He has a remote history of depression and a 20-year history of substance use disorder (SUD); he uses heroin, at least 3 bags a day by insufflation. You review his response to his currently prescribed PTSD treatment regimen, ask if he is experiencing any adverse effects, and perform a mental status exam and a review of systems. You offer Mr. C detoxification and rehabilitation treatment for his heroin use, but he refuses. With 15 minutes left in the appointment, you consider conducting motivational interviewing (MI) to help him reconsider getting treatment for his SUD.

Even when delivered as a brief, one-time intervention, MI can be effective in getting patients to change their behavior.¹ First created in part by psychologists William Miller, PhD, and Stephen Rollnick, PhD,² MI is based on the premise that a patient's ambivalence to change is normal and that all patients vary in their readiness to change. MI can be brief, and can be more helpful than providing only prescriptive advice, which sometimes can be counterproductive.³

To effectively implement MI during a brief visit, it is helpful to keep in mind 3 mnemonics: **RULE**, **PACE**, and **OARS**.

RULE

RULE can be used to remember the core principles of MI.⁴ First, **Resist** the righting reflex, which means we should resist giving suggestions to our patients for their problems. While we may mean well, offer-

ing suggestions might actually make the patient less likely to make a positive change. **Understand** the patient's motivation by being a curious listener and attempting to elicit the patient's own underlying motivation for change. **Listen** with a patient-centered, empathic approach. Lastly, **Empower** the patient. He must understand that he is in control of his actions, and any change he desires will require him to take steps toward that change.

PACE

PACE is the "spirit" or mindset that clinicians should have when conducting MI.^{4,5} Always work in **Partnership** with the patient; this allows the patient and clinician to collaborate on the same level. While the physician is a clinical expert, the patient is an expert in prior efforts at trying to change his or her circumstances for the better. Make the therapeutic environment as positive as possible so that your patient will find it comfortable to discuss change. The patient should see the clinician as a guide who offers information about paths the patient may choose, not someone who decides the destination.⁵ While as physicians we must continue to educate our patients about the harms of behaviors such as excessive drinking or substance use, we recognize that ultimately the decision is the patient's. Make every effort to draw from the patients' goals and values, so that the patient, and not the clinician, can argue for why change is needed. This **Acceptance** helps foster an attitude that we are on the patient's side and that his past choices in life do not negatively affect our perception of him. The patient should be accepted for who he is, and not met with

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Disclosures

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Motivational interviewing can be brief, and more helpful than providing only proscriptive advice

disapproval over any personal decisions that he made.⁵ Exercise **Compassion** towards the patient's struggles and experiences,⁵ and never be punitive. Make every attempt to have discussions that can be **Evocative** for the patient. Strong feelings and memories can be particularly salient to discuss, especially if they could help change the patient's attitude towards maladaptive behaviors.

OARS

OARS can be used to help remember core skills of MI.⁵ These include asking **Open-ended** questions to get the patient to think before responding, providing frequent **Affirmations** of the patient's positive traits, using **Reflective** listening techniques while your patient talks about his disorder, and providing succinct **Summaries** of the experiences expressed by your patient throughout the encounter to invite continued exploration of his behaviors.

Getting patients to talk about change

Use **RULE**, **PACE**, and **OARS** to elicit "change talk,"⁴ so that your patient makes his own arguments for change. Here ambivalence is good, in that an ambivalent patient may be open to discuss reasons for making changes. It is important to remember not to use the righting reflex to give suggestions to change.

CASE CONTINUED

You use the last 15 minutes of Mr. C's visit to conduct MI and acknowledge his ambivalence to change. Mr. C reveals that his motivation for change centers on how he perceives himself as a disappointment to his daughter because of his continuous drug use. At the end of the encounter, Mr. C is in tears but has a renewed motivation to stop using heroin. He agrees to enter substance abuse treatment.