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Motivational Interviewing and the 5A Model in Primary Care

Birinci Basamakta Motivasyonel Görüşme ve 5A Modeli

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ABSTRACT
Motivational Interviewing (MI) is a client-centered communication approach that aims to activate internal motivation by making the individual's ambivalence visible and can be adapted to short sessions. It is applied in primary care across a wide range of areas, including smoking and substance use, chronic disease management, lifestyle changes, vaccine hesitancy, maternal and child health, oral health, screening programs, and palliative care. MI's core micro-skills (open-ended questions, validation, reflective listening, summarizing) and advanced techniques (scaling questions, double reflection, focusing, and planning) strengthen the client's change conversations and bridge them to behavior. The 5A model (Assess–Advise–Agree–Assist–Arrange), which offers a short and structured counseling flow, increases applicability in daily clinical practice; it allows for goal setting and information sharing in initial contacts, and for maintaining change through obstacle resolution and follow-up arrangements in subsequent sessions. The section discusses how MI and 5A can be integrated, how they can be incorporated into brief consultation flows, and how they can be made sustainable through team-based follow-up. In conclusion, when the relational and evocative power of MI is combined with the structure and follow-up discipline of 5A, a practical and scalable approach emerges for lasting behavior change in primary care, despite time constraints.
Keywords: Motivational interviewing, 5A model, primary care, behavior change, chronic disease management

ÖZET
Motivasyonel Görüşme (MI), danışan merkezli yapısıyla bireyin ambivalansını görünür kılarak içsel motivasyonu harekete geçirmeyi amaçlayan, kısa görüşmelere de uyarlanabilen bir iletişim yaklaşımıdır. Birinci basamakta sigara ve madde kullanımı, kronik hastalık yönetimi, yaşam tarzı değişiklikleri, aşı tereddüdü, anne-çocuk sağlığı, ağız-diş sağlığı, tarama programları ve palyatif bakım gibi geniş bir yelpazede uygulanmaktadır. MI'nin temel mikro-becerileri (açık uçlu sorular, onaylama, yansıtıcı dinleme, özetleme) ile ileri teknikleri (ölçek soruları, çift taraflı yansıtma, odaklanma ve planlama) danışanın değişim konuşmalarını güçlendirir ve davranışa köprü kurar. Kısa ve yapılandırılmış bir danışmanlık akışı sunan 5A modeli (Assess–Advise–Agree–Assist–Arrange) ise günlük klinik pratikte uygulanabilirliği artırır; ilk temaslarda hedef belirleme ve bilgilendirme, izleyen görüşmelerde engel çözümü ve takip düzeniyle değişimin sürdürülmesine olanak tanır. Bölümde MI ile 5A'nın nasıl bütünleştirilebileceği, kısa görüşme akışlarına nasıl yerleştirileceği ve ekip temelli izlemle nasıl sürdürülebilir kılınacağı ele alınmaktadır. Sonuç olarak, MI'nin ilişki ve evokasyon gücü ile 5A'nın yapı ve takip disiplini bir araya geldiğinde, birinci basamakta zaman kısıtına rağmen kalıcı davranış değişimi için pratik ve ölçeklenebilir bir çerçeve ortaya çıkmaktadır.
Anahtar kelimeler: Motivasyonel görüşme, 5A modeli, birinci basamak, davranış değişikliği, kronik hastalık yönetimi

Introduction

Healthcare professionals, especially primary care physicians, often have trouble in changing patients' health behaviors. The sustainability of behaviors such as smoking cessation, healthy eating, physical activity, medication adherence, or vaccine acceptance cannot be achieved by providing information alone. At this point, motivational interviewing (MI) stands out as an effective method that aims to activate the individual's internal motivation[1].

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Although both Motivational Interviewing (MI) and the 5A model have been extensively studied in the context of behavior change, the literature has largely examined these approaches separately. There is limited narrative synthesis focusing on how MI techniques can be integrated within the structured 5A framework in primary care settings. This review aims to summarize the current evidence on MI, describe the practical components of the 5A model, and discuss how these approaches can be combined to support patient-centered behavior change in routine primary care practice. By focusing on their complementary roles and practical integration, this review seeks to provide a concise and clinically relevant perspective for primary care professionals.

Literature Search Strategy

This narrative review was conducted to summarize the current evidence regarding Motivational Interviewing (MI) and the 5A Model in primary care settings. A literature search was performed using PubMed, Scopus, and Web of Science databases. Articles published in English between January 2000 and October 2025 were considered. The search included combinations of the following keywords: "motivational interviewing," "5A model," "primary care," "behavior change," "smoking cessation," "chronic disease management," "vaccine hesitancy," "health promotion," and "brief counselling." Priority was given to systematic reviews, meta-analyses, randomized controlled trials, and major clinical guidelines. Additional relevant studies were identified through manual screening of reference lists. The retrieved literature was narratively synthesized to provide an overview of current evidence and practical implications for primary care.

Motivational Interviewing: Definition and Historical Development

Motivational Interviewing (MI) is a client-centered and collaborative communication approach that helps individuals explore and resolve their ambivalence about behavior change. Its primary goal is to support the change process by eliciting the individual's own internal motivation[1,2]. MI was first defined in the 1980s by William Miller for the treatment of alcohol dependence, then developed further by Stephen Rollnick and adapted to many areas of health behavior. Initially an approach specific to addiction treatment has become increasingly widespread since the 1990s in tobacco use and other risky behaviors, and since the 2000s in chronic disease management, lifestyle changes, and primary care[2-6].

The literature addresses the development of MI in three phases: 1) Initial phase (1980s): Focused on addiction treatment. 2) Second phase (1990s–2000s): Adaptation to different areas of health behaviors. 3) Third phase (post-2000): Strengthening of theoretical foundations, increase in evidence-based practices, integration into digital health platforms[2–5].

Miller and Rollnick (2022) emphasize that MI is not merely a set of techniques but also carries a certain "spirit." This spirit consists of elements of collaboration, acceptance, compassion, and evocation, and is one of the most important features that distinguishes MI from traditional health education[6].

In conclusion, the historical development of MI reflects its evolution from a narrow technique originating from alcohol dependence to a multifaceted, evidence-based counseling approach used in primary care and public health today.

The Basic Principles of Motivational Interviewing

The success of MI stems not only from the techniques used, but also from the "spirit" it embodies. The four fundamental principles defined by Miller and Rollnick are[1,2,5,6]:

1. Expressing empathy: Understanding the patient's perspective and accepting it without judgment.
2. Developing discrepancy: Helping individuals recognize the inconsistency between their current behaviors and their personal goals, values, or desired health outcomes.
3. Rolling with resistance: Addressing the patient's resistance with an accepting and flexible approach, without directly opposing it.
4. Supporting self-efficacy: Strengthening the patient's belief that they can make changes[1,7].

As Bischof and colleagues (2021) point out, the "spirit" of MI includes the following elements: partnership, acceptance, compassion, and evocation. These elements increase the patient's sense of trust and allow them to express their own reasons for change[7].

Application Areas for Motivational Interviewing

Although MI was initially developed for addiction treatment, it is now successfully applied in numerous areas that influence health behaviors. Meta-analyses show that MI is more effective than standard counseling in reducing risky behaviors, increasing treatment adherence, and promoting lifestyle changes[3,7].

Addictions

Motivational Interviewing (MI) stands out as one of the areas with the strongest evidence base in combating addictive behaviors. First defined in the treatment of alcohol dependence, MI quickly became widespread in tobacco and substance use disorders. MI's success in this field stems from its ability to help individuals explore their ambivalence and find their own reasons for change[6].

Smoking Addiction

Smoking cessation is the most common addiction area where MI is applied. Cochrane reviews show that MI increases smoking cessation rates compared to standard care and traditional information methods; however, the degree of effectiveness varies depending on the duration and intensity of the interview and the competence of the practitioner[8]. The effect of MI has been found to be more pronounced, especially in individuals who are indecisive or have tried to quit before but failed. Meta-analyses reveal that MI provides a small to moderate but significant benefit in smoking cessation[3,7]. These findings demonstrate the applicability and practical value of MI even in brief consultations in primary care. New evidence points to the integration of MI with digital health technologies. In a randomized controlled trial conducted by He et al. (2022) with young adults, an MI-based chatbot was used to increase motivation to quit smoking. The study did not show any additional benefit of the chatbot compared to a neutral chatbot; however, participants in both groups showed increased motivation to quit[9]. This result shows that MI can be applied with digital tools, but its effectiveness depends on session duration, intensity, and the quality of the context.

Alcohol Use

The historical origins of MI lie in the treatment of alcohol dependence. Randomized controlled trials have shown MI to be more effective than traditional approaches in reducing alcohol consumption and increasing treatment initiation rates[4] A systematic review on cannabis use disorder (CUD) evaluated 40 studies (24 adults, 16 adolescents) and found MI to be effective in both adults (OR = 3.84; 95% CI: 2.40–6.16, $p < 0.0001$) and adolescents (OR = 2.02; 95% CI: 1.42–2.89, $p < 0.0001$). Furthermore, in adults, a significant decrease in frequency and amount of use was observed in the MI groups: those in the MI group consumed an average of 0.69 fewer "joints" per day and reported approximately 3.9 fewer days of use per month. In contrast, the decrease in frequency and amount of use was not statistically significant in adolescents.

Other Substance Use Disorders

Motivational Interviewing has also demonstrated effectiveness in other substance use disorders, including cannabis use disorder (CUD). A systematic review evaluating 40 studies found that MI significantly increased abstinence rates and reduced cannabis use in both adult and adolescent populations[10].

MI is also used as a powerful communication tool in substance use disorders. A systematic review by Papus et al. (2022) on medication adherence showed that MI can increase adherence to medication treatment, particularly in psychiatric and addiction contexts. MI's empathy-based approach is effective in overcoming resistance seen in substance use and helps individuals reveal their own motivation for change. In this regard, Schwenker and colleagues' (2023) systematic review, based on 93 studies, reported that MI showed a small to moderate effect in reducing substance use[12].

Chronic Disease Management

Effective management of chronic diseases is possible not only through clinical treatment approaches but also through patient adherence to medication and participation in lifestyle changes. Motivational Interviewing (MI) is an important tool in this process, increasing treatment adherence by activating the individual's internal motivation. Meta-analyses have demonstrated that MI has a positive effect on self-efficacy and behavioral outcomes in chronic diseases such as diabetes, hypertension, chronic obstructive pulmonary disease (COPD), and Obesity[3,7]. However, findings regarding effectiveness in biochemical indicators (e.g., HbA1c) are more heterogeneous, with some studies showing no significant additional benefit[3,14]. A comprehensive systematic review published in recent years examined the effects of MI on medication adherence. Papus et al. (2022) evaluated 54 randomized controlled trials and reported that MI significantly increased medication adherence in 23 of them. The strongest effects were seen in the areas of cardiovascular disease (7/14 RCTs) and psychiatric disorders (5/8 RCTs), while efficacy was more limited in endocrinology (e.g., diabetes). Among the RCTs reviewed, there were also studies conducted in primary care settings, showing that even short-term MI interventions can increase medication adherence, particularly in elderly and multimorbid individuals[11,13,15].

In a randomized controlled trial conducted in Brazil, MI-based counseling provided by nurses resulted in a significant decrease in HbA1c levels (0.4%), clinically significant reductions in systolic and diastolic blood pressure (−13.7/−5.7 mmHg), and improved treatment adherence scores[14]. This finding suggests that MI may be effective in primary care for chronic disease management, affecting both behavioral and clinical parameters[14]. A meta-analysis of 9 randomized controlled trials in heart failure patients reported that MI had significant and strong effects on self-care behaviors. MI was found to be effective in increasing self-care confidence (Hedge's g = 0.768), symptom management (Hedge's g = 0.744), and self-care maintenance, which includes treatment adherence and symptom monitoring (Hedge's g = 0.873). However, no significant improvement was observed in physical function measures (e.g., 6-minute walk test). These findings suggest that MI has a strong effect on behavioral and self-efficacy-based outcomes rather than direct physiological outcomes in complex chronic diseases such as heart failure[15]. These findings show that while MI alone does not guarantee "biochemical targets" in chronic disease management, it is a powerful tool for patient engagement, treatment adherence, and lifestyle changes. The effectiveness of MI delivered via telehealth is increasingly being researched, as much as face-to-face applications in chronic disease management. In a systematic review by McDaniel et al. (2022), 21 randomized controlled trials conducted with individuals with diabetes were examined, and telehealth-based MI was shown to have positive effects on clinical and behavioral outcomes. Approximately 60% of the studies reported a significant decrease in HbA1c levels, 56% reported a decrease in systolic blood pressure, 57% reported an increase in diabetes self-efficacy, and 40% reported an improvement in physical activity levels. However, the effects on diastolic blood pressure, lipid profile, body mass index, and quality of life were more limited. These findings suggest that MI can be used in chronic disease management not only through face-to-face consultations but also through telehealth-based interventions, and that it can facilitate patient follow-up, particularly at the primary care level[16].

Lifestyle Changes

MI is also applied to lifestyle behaviors such as physical activity, healthy eating, weight management, and sleep patterns. Even short-term interventions in primary care settings have been shown to support behavioral change[17]. There is a strong literature on the effectiveness of MI in the areas of physical activity and weight management. For example, Zhu et al.'s (2024) meta-analysis showed that interventions incorporating MI significantly increased total physical activity (SMD = 0.45) and MVPA levels while reducing sedentary time[18]. O'Halloran et al. (2014) reported that MI can increase physical activity in individuals with chronic diseases (SMD = 0.19)[19]. Furthermore, the study by Armstrong et al. (2011) showed that obese individuals lost approximately 1.47 kg more weight compared to the control group thanks to MI implementation[20]. This data reveals that MI may be effective not only in terms of behavioral motivation levels but also in concrete physical activity and weight changes.

Immunization and Vaccine Hesitancy

It has been defined by the World Health Organization as one of the global health threats, has become a common problem in primary health care services[21]. Family physicians and nurses are the first health professionals to communicate directly with individuals who have concerns about vaccination, so there is an increasing need for effective communication methods in this area. MI stands out for its empathy-based and non-judgmental approach, particularly in vaccine hesitancy. Systematic reviews show that MI is more effective than standard information methods in increasing vaccine acceptance[22]. The PromoVac study is one notable evidence-based example. In this study, MI-based counseling provided to parents in the postnatal period significantly increased the short-term vaccination coverage of infants[23]. Similarly, a cluster randomized controlled trial conducted in the US showed that adding MI to clinicians' vaccine communication strategy increased vaccine acceptance among children[24]. During the COVID-19 pandemic, MI has also emerged as an important tool against vaccine hesitancy. Breckenridge and colleagues (2022) emphasized that MI can be applied in primary care settings through OARS skills (open-ended questions, affirmation, reflective listening, summarizing). In this approach, healthcare professionals focus primarily on understanding the individual's knowledge and beliefs, validating their concerns, and presenting scientific information with permission. MI has provided an empathetic and reassuring communication framework, particularly regarding the rapid development of COVID-19 vaccines, side effects, and safety during pregnancy[25].

In conclusion, MI offers a more effective and trust-based alternative to standard counseling in addressing vaccine hesitancy. For primary care professionals, integrating MI techniques with brief counseling models is a promising strategy for increasing vaccine uptake.

Maternal and Child Health

MI has been shown to be effective in reducing risky behaviors during pregnancy (e.g., tobacco/alcohol use) and in breastfeeding counseling[26]. A randomized controlled trial conducted in the postpartum period reported that brief MI intervention (bMI) significantly increased breastfeeding self-efficacy. The effect of the intervention was particularly pronounced among mothers with higher education levels and varied depending on the overall level of self-efficacy[27]. In a multicenter randomized controlled trial conducted in the postpartum period, brief MI significantly extended both exclusive breastfeeding and total breastfeeding duration during the first 6 months. The intervention group showed a 63% reduction in the risk of discontinuing breastfeeding (aHR = 0.37) and a 61% reduction in the risk of discontinuing exclusive breastfeeding (aHR = 0.39). Furthermore, breastfeeding self-efficacy was reported to be an important moderator of this effect, with the effect of bMI being more pronounced in mothers with higher self-efficacy. These findings suggest that implementing bMI as part of postpartum care could be a powerful strategy for increasing breastfeeding rates[28]. In a postpartum RCT, bMI implementation not only extended mothers' breastfeeding duration but also significantly reduced their Edinburgh Postnatal Depression Scale scores. It has been reported that a significant portion of this effect was mediated through the increase in breastfeeding duration. This finding suggests that bMI can have positive effects on both nutritional and mental health dimensions of mother-child health[29]. These interventions provide long-term benefits for both maternal and infant health.

Psychiatric Fields

MI stands out as a method that increases treatment motivation and participation, particularly in psychiatric fields. MI's empathy-based and collaborative structure can facilitate patients' continuation of treatment in conditions such as depression, anxiety, schizophrenia, and bipolar disorder. Indeed, a meta-analysis including 14 randomized controlled trials showed that applying MI as a brief intervention before treatment significantly increased participation in therapy and had stronger effects, especially in individuals who were not seeking treatment[30]. A systematic review by Papus et al. (2022) on chronic diseases and medication adherence revealed that MI has a strong effect on increasing medication adherence, particularly in psychiatric disorders. Five of the eight randomized controlled trials reviewed reported that MI significantly increased treatment adherence in psychiatric patients[11]. In a randomized controlled trial conducted with patients with

bipolar disorder, a nurse-led MI intervention (one face-to-face session and two telephone calls) significantly increased medication adherence, self-efficacy, and motivation to change[31]. Similarly, in a study by Harmancı and colleagues (2023), the combined use of psychoeducation and MI had meaningful positive effects on treatment adherence and functioning in bipolar patients[32]. These findings demonstrate that MI is an important tool that increases treatment participation and contributes to clinical improvement not only in physical health areas but also in mental health.

Oral and Dental Health

MI has also been used in recent years to improve oral and dental health behaviors and prevent early childhood caries (ECC). Traditional oral health education increases knowledge levels but has limited impact on long-term behavior change and clinical outcomes[33]. In contrast, MI, with its focus on stimulating the individual's own motivation, positively affects both home care habits and clinical outcomes. A recent systematic review and meta-analysis showed that MI-based interventions can significantly reduce early childhood caries. The study examined 14 different studies and reported that MI was associated with an average of 3.15 fewer decayed, missing, and filled tooth surfaces (dmfs) among children in communities with high caries experience. Improvements were also noted in secondary indicators such as parents' oral health knowledge, home care behaviors, plaque, and gingival indices[34]. Similarly, a systematic review and meta-analysis in the literature examined a total of 2,776 participants in 6 randomized controlled trials and showed that MI is significantly effective in preventing early childhood caries. One of the important findings of this study is that the effect is not solely dependent on the number of sessions, but rather the quality of the sessions and long-term (at least 3 years) follow-up are critical[35]. These results demonstrate that MI is an effective communication method not only in the field of medical chronic diseases and immunization, but also in preventive dentistry and community oral health practices.

Screening Programs and Palliative Care

MI is also used to increase participation in cancer screenings and to support patient-centered decision-making processes in palliative care. Although evidence in these areas is limited, the existing literature emphasizes that MI's empathetic and collaborative nature provides a significant advantage[7].

Screening Programs

In Miller and colleagues' systematic review, face-to-face and telephone-based MI approaches were found to have a significant effect on participation in health screenings; 6 out of 13 studies reported higher screening uptake in MI groups compared to control groups[5]. Chan and colleagues' meta-analysis also demonstrated that MI is effective in breast and cervical cancer screenings, but its effect is mixed in colorectal cancer screening[36]. Long and colleagues' study also supports the potential of MI to increase colorectal cancer screening participation[37]. This data suggests that MI has the potential to change behavior, particularly in screening programs where low participation rates are a problem.

Palliative Care / Advance Care Planning

In palliative care, MI has been used to encourage patients to express their ambivalence regarding care preferences, advance directives, and advance care planning as death approaches. Pollak et al. (2011) demonstrated that MI techniques can be incorporated into palliative care communication through reflective listening, summarizing, and empathy, noting that these strategies may be effective in reducing patient resistance[38]. In a more recent study, Chan et al. (2025) conducted an RCT in ambulatory palliative care settings and demonstrated that an MI-based advanced care planning program increased patients' capacity to document their decisions and preferences while reducing indecision[39].

Motivational Interviewing Techniques (OARS and Advanced Techniques)

MI incorporates various micro-skills to help individuals discover and strengthen their motivation for change. These skills are defined by the acronym OARS: open-ended questions, affirmations, reflections, and summaries. In addition, eliciting change conversations is one of MI's most powerful techniques[1,4].

OARS Micro-Skills

Open-ended questions: These questions, which do not provide open-ended guidance, allow participants to freely express their own feelings and thoughts. For example: "What challenges you the most about this issue?"

Affirmations: The healthcare professional recognizes the participant's strengths and efforts and verbalizes them to increase the participant's self-efficacy and strengthen the mutual trust relationship. For example: "It is very valuable that you are keeping track of your child's vaccinations despite such a busy schedule."

Reflective Listening: This involves rephrasing what the participant has said to reveal the underlying feelings and meaning. This strengthens empathy and plays a critical role in overcoming resistance. For example, a healthcare professional reflects a participant's ambivalence by saying, "On the one hand, you want to protect your child, but on the other hand, you are concerned about possible side effects," when the participant expresses fear of vaccine side effects.

Summaries: Summarizing what has been said at certain points in the conversation reinforces statements about change. For example: "Today you mentioned three issues that are most important to you: your concern about side effects, your child's health, and your trust in your doctor."[1,40].

Bringing Out Change Conversations

One of MI's most powerful techniques is to get the individual to generate statements about change (change talk) in their own words. These statements are generally examined in four groups: • Desire: "I want..." • Ability: "I can..." • Reasons: "Because..." • Need: "It is necessary..." When these statements are reinforced, the individual's commitment to change increases[1,4].

Dealing with Resistance

In MI, participant resistance should be addressed by the health professional by trying to understand the individual's concerns and values without opposing them. This method, which reframes resistance and accepts it, is defined as "rolling with resistance"[40]. For example: "You say you still have questions about the vaccine; this shows how important this decision is to you."

Supporting Self-Efficacy

At the core of MI is supporting the individual's belief in their own capacity for change to increase self-efficacy. Health professionals increase self-efficacy by highlighting small successes, emphasizing strengths, and setting achievable goals[1].

Advanced Techniques

•Scaling Questions: "On a scale of 1 to 10, how strong is your desire to change this behavior?" These types of questions are used not only to measure the individual's motivation for change but also to encourage them to think about change. Questions from the health professional such as "Why did you say 2 instead of 4?" help the client verbalize their own change attempts, strengthening their awareness[1,7].

• **Double-Sided Reflection**: Reflecting the participant's ambivalence helps them understand and try to resolve it rather than conflict with resistance: "On the one hand, you are concerned about the side effects of the vaccine, but on the other hand, you want to protect your child from illness**.**" Such statements help the client think about change[7,41].

• Focusing and Guiding: The healthcare professional begins the consultation with the client's agenda but guides them toward change aimed at protecting their health. For example: Questions such as "Is your main concern today your worries about the vaccine, or your child's overall health?" create a focal point for continuing the session collaboratively[7,41].

The 5A Model in Brief Counseling and Its Effectiveness

The most used brief counseling framework, the 5A model, is a short and structured counseling framework consisting of the steps " Assess–Advise–Agree–Assist–Arrange." It aims to increase the effectiveness of brief counseling by providing an evidence-based approach framework.

Components of the 5A Model:

1. Assess: This involves understanding the patient's current situation, beliefs, motivation level, and readiness for change. This stage overlaps with the engaging and focusing processes of MI.
2. Advise: Clear, empathetic, and personalized information is provided about health risks and benefits. The goal here is to raise awareness rather than directly persuade.
3. Agree: Realistic and achievable goals are set together with the client; this resembles the basis of the MI planning process.
4. Assist: Potential obstacles the client may encounter are identified, solution strategies are developed, and the client's sense of self-efficacy is reinforced.
5. Arrange: A post-session support and follow-up plan is developed; referrals to other resources are provided when necessary.

MI and 5A come from different origins: MI is a psychotherapeutic approach, while 5A is a clinical guideline. They complement each other: Short counseling with 5A in the initial session, deepening with MI in the hesitant/resistant group, and reminders/triggers in follow-ups are recommended[1,42,43]. In practice, MI can be incorporated into each step of the 5A model. Open-ended questions and reflective listening support the Assess phase, collaborative goal setting strengthens Agree, and MI-based support for self-efficacy enhances the Assist and Arrange phases. Thus, MI functions as the communication style that facilitates implementation of the structured 5A framework (Table 1).

The American Heart Association's (AHA) 2022 scientific statement recommends using the 5A model as the core framework for behavioral counseling in primary care to reduce cardiovascular disease (CVD) risk. According to the statement, the "assist" and "arrange" steps are the most decisive steps in achieving meaningful and sustainable behavior change (AHA, 2022). The 5A model demonstrates consistent results with evidence-based behavioral intervention programs, particularly in the areas of increasing physical activity, establishing a nutrition plan, and strengthening treatment adherence[42].

The available evidence suggests that Motivational Interviewing and the 5A model are complementary approaches for supporting behavior change in primary care. While MI strengthens patient engagement, intrinsic motivation, and self-efficacy, the 5A model provides a structured framework for assessment, goal setting, support, and follow-up. Their combined use may be particularly valuable in areas such as smoking cessation, chronic disease management, lifestyle modification, and vaccine hesitancy. However, this review is narrative in nature and did not employ a systematic review methodology; therefore, relevant studies may not have been comprehensively identified or evaluated.

As a narrative review, this article is limited by the potential for selection bias and the absence of a systematic appraisal of the available evidence.

Table 1. Integration of Motivational Interviewing and the 5A Model in Primary Care

5A Step	Purpose	MI Techniques
Assess	Explore beliefs, concerns, and readiness for change	Open-ended questions, reflective listening
Advise	Provide personalized health information	Asking permission, empathetic communication
Agree	Establish patient-centered goals	Change talk, collaborative goal setting
Assist	Address barriers and strengthen self-efficacy	Affirmations, problem-solving strategies
Arrange	Plan follow-up and ongoing support	Reinforcement of motivation, follow-up discussions

Conclusions and Recommendations

Motivational Interviewing (MI) and the 5A model are complementary approaches that support behavior change in primary care. While MI enhances patient engagement, intrinsic motivation, and self-efficacy, the 5A model provides a structured framework for assessment, goal setting, support, and follow-up. Their integration can facilitate the delivery of patient-centered counselling in time-constrained clinical settings. The combined use of these approaches may be particularly valuable in smoking cessation, chronic disease management, lifestyle modification, and vaccine hesitancy. Further research is needed to evaluate the effectiveness of integrated MI–5A interventions across different primary care populations and settings.

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