GP Drug & Alcohol Supplement No.6

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This is the sixth of the monthly Drug and Alcohol Supplements prepared for Central Coast GPs. This supplement describes a brief form of counselling called motivational interviewing which can be used in medical consultations by the GP. Motivational interviewing was developed in the alcohol and other drug field to assist people with their ambivalence in behaviour change. This method is based upon a menu of strategies the practitioner is able to select from depending on the patient's readiness to change.

Motivational Interviewing

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Introduction

Motivational Interviewing is a relatively new procedure developed by Miller (1983) that draws heavily on basic counselling skills. It adds to these in an attempt to alter the patient's view of the costs and benefits of continued alcohol or drug use in a non-confronting way. It is both a style of counselling and a set of specific procedures. A number of studies have revealed motivational interviewing to be particularly effective for patients who are not yet ready to change or are ambivalent about changing their patterns of alcohol, tobacco or drug use[2].

The goal of Motivational Interviewing is to explore ambivalence and to encourage patients to express their concerns and individual reasons for change[2]. Two key concepts in motivational interviewing are ambivalence and readiness to change. Whilst this intervention is used primarily with patients who have a drug or alcohol problem, the principles and method are transferable to many other behaviours such as diet, exercise, and so on.

Ambivalence and giving advice

Ambivalence is a common experience for patient's with drug and alcohol problems as there is often internal conflict about their use of drugs. Ambivalence is often dealt with in the form of advice giving or overt persuasion. Though the advice may be sound and logical to the practitioner, it is often met with opposition giving rise to counter arguments from the patient[1]. For example:

Dr: "Have you thought about giving up smoking, as you know it is very unhealthy particularly for you with your blood pressure?"
Pt: "Well yes doctor, I have tried, though it is very difficult and to be honest with you I enjoy it."

Dr: "But surely there are other things you enjoy. You just need to give up smoking and take up something else that you enjoy."
Pt: "Yes I am aware of the health effects doctor but it really isn't as easy as it sounds."

Dr: "What about you try....."
Pt: "Yes but don't you see....."

Giving patients advice often feels like a futile activity even though it is well intentioned. If a patient is **not ready** to change at the time of the consultation, or is ambivalent, advice in the form of overt persuasion may push them into a defensive position.

Readiness to change

Decisions to change certain behaviours such as smoking, and drug or alcohol use are difficult to make. Patients don't often state openly they would like to change these behaviours. Often they are in a state of ambivalence, and fluctuating motivation before making their decision. A decision can sometimes be made and then reversed before change takes place.

The concept of **stages of change** was developed by Prochaska & DiClemente (figure 1). The **stages of change model** allows the practitioner to fully understand the process where people move through different stages of preparedness to change[3]. The following is a brief summary of this model.

Pre-contemplation

These are the 'happy users' and they are not concerned about their use of drugs and alcohol. For this group the positives far outweigh the negatives and they will ignore or disbelieve that their behaviour is harmful[3].

Contemplation

These patient's feel ambivalent about their drug and alcohol use, they enjoy it though it is causing problems and comes at a cost. This group would like the problems to diminish but the drug use to remain[3].

Action

This group have decided to make a change to their established behaviour by either cutting down or abstaining. They have made a commitment that their drug use needs to change.

Maintenance

This group have successfully changed their drug using behaviour and have sustained the change for sufficient duration to feel that they are ex-problem users. This takes time and it may be that this stage is only entered after some 12-18 months of action.

Relapse

A large number of people who decide to move into action stage change their minds and slip back to their previous drug use. Having relapsed they will then revert back to one of the former stages.

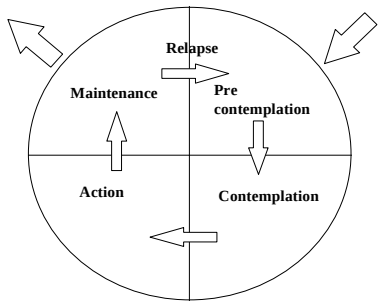

Figure 1 (adapted from Prochaska, DiClemente & Velicer,

It is important to note people can move back and forward through these stages. If the practitioner assists the patient in moving forward even if no decision or behaviour change has occurred, it is still considered an acceptable outcome[3]. The primary task of the practitioner is to establish which stage of change the patient is at and then select an appropriate strategy for the level of motivation. If the practitioner fails to do this resistance will be the most likely outcome[3].

The aim is to increase the patient's own motivation so that change occurs from the patient rather than the practitioner imposing the change[3]. When this technique is done correctly it is the patient who highlights the arguments for change not the practitioner[3]. The patient is likely to feel their personal freedom is respected and therefore the practitioner is confronted with less resistance[3].

Five general principles of motivational interviewing

The five basic clinical principles that underly motivational interviewing are:

1. Express empathy
2. Develop discrepancy
3. Avoid argumentation
4. Roll with resistance
5. Support self-efficacy

1. Express empathy

Empathic warmth and reflective listening are essential characteristics of motivational interviewing. They provide a style which is used throughout the entire interaction with the patient. The practitioner seeks to develop an understanding of the patient's feelings without criticism, blame or judgement. It is important to note the practitioner may not agree with the patient's view. What is crucial, however is respectful listening in order to understand the patient's perspective[3]. The use of reflective listening is to remain with patients wherever they choose to wander, guiding them through the pros and cons of their drug or alcohol use[3].

2. Develop discrepancy

Motivational interviewing is used to create in the patient's mind a **discrepancy** between their current behaviour and their future goals. This discrepancy is triggered by assisting the patient to become aware of the costs of their current behaviour. When alcohol or drug use is seen by the patient as having a negative impact on one's health, relationships, employment and so on, change is more likely to occur[3]. This is an underlying principle to motivational interviewing. People are motivated to change their behaviour when they can clearly see a discrepancy between their present behaviour and broader personal goals[5].

Often patients who ask for assistance to change their use of drugs or alcohol are experiencing a discrepancy between their current behaviour and how they see themselves in the future. Yet they are also feeling ambivalent about reducing or abstaining. A goal of motivational interviewing is to create and amplify the discrepancy in order to change current behaviour. The practitioner utilises the internal conflict that is occurring in the patient so that the discrepancy overrides the present behaviour[5].

3. Avoid argumentation

Another important principle of motivational interviewing is avoiding arguments with the patient. Direct confrontation and argument will often elicit resistance and defensiveness from the patient[5]. What can occur in a consultation is that the practitioner can argue for change on behalf of the patient with the patient taking the opposite viewpoint. This is the least desirable situation and results in head to head confrontation. Motivational interviewing is a technique of gentle persuasion. It increases the patient's awareness of the problems that exist and the need to do something about them.

4. Roll with resistance

Resistance by the patient is evidenced by:

- arguing
- interrupting
- denying
- ignoring

The practitioner should avoid eliciting or strengthening resistance as the more a patient resists the less likely any change will occur. Evidence suggests treatment drop out is common where there is client resistance and that this is strongly determined by the style of the therapist[3]. Practitioners can change their style of intervention and therefore decrease patient resistance. Research has shown this to be associated with long-term change[5].

A good strategy in dealing with resistance is to respond with non resistance and acknowledge the patient's perception. This will assist in further exploration of the problem[5].

5. Support self-efficacy

A general goal of motivational interviewing is to support and promote the patient's perception of their own capacities. This increases the patient's perception of their ability to deal with obstacles and change their behaviour. It is the role of the practitioner to persuade the patient that he or she is able to make a successful change, giving hope and optimism to the patient. The practitioner's belief in the patient's ability to change is a significant factor in determining a positive outcome[5].

Counselling strategies used in motivational interviewing

Menu of strategies

The following is a brief description of the menu of strategies (figure 2) used in motivational interviewing, each taking approximately 5-15 minutes to use.

Practitioners select their approach for a given consultation depending upon the patient's readiness to change. More than one strategy may be employed in a consultation depending upon available time and the progress of the patient. The practitioner moves down the list of strategies as the patient's readiness to change increases[3].

Strategies used in Motivational Interviewing

1. Opening strategy: lifestyle, stresses and substance use
2. Opening strategy: health and substance use
3. A typical day/session
4. The good things and less good things
5. Providing information
6. The future and the present
7. Exploring concerns
8. Helping with decision making

Figure 2 Motivational interviewing strategies[3]

It is essential to establish rapport with the patient and have the patient's agreement to discuss and explore behaviour change. Not all patients are willing to accept lifestyle advice when they enter consultation with their GP[6].

If it feels difficult to introduce the subject, use of the **opening strategies** can be helpful. If the patient shows reluctance to discuss the matter this should be respected[1]. However, if it is easy to raise the topic it is good to begin with a typical day or the good things/less good things[3].

Opening strategy: lifestyle, stresses and substance use

This strategy involves discussion with the patient about their lifestyle and stresses. The practitioner then raises the issue of their substance use with an open question.
Ask "Where does your use of alcohol fit into your life"
Patients often focus on the positive aspects of their drug use. This gives the practitioner an understanding of the context of the patient's drug use[3].

Opening strategy: health and substance use

This strategy is particularly useful in a health care setting when the patient's health is affected by their substance use. This involves an enquiry about their health followed by an open question.
Ask, for example, "How does your use of alcohol affect your health?"

A typical day / session

The main function of this strategy is to build rapport with the patient in a non judgmental framework and to assess the patient's readiness to change[1]. It is also extremely useful for the practitioner in gathering relevant assessment information.
Ask "Tell me about last Friday night. How long after arriving at the pub was your first drink? How did you feel after that? And then what happened?"
The practitioner focuses on feelings and behaviour, following the patient through the day's events. The main input from the practitioner is asking simple open questions. Pacing is also important when using this strategy, pushing ahead if the pace is too slow and returning to important issues if things are moving too quickly. If certain issues are not able to be addressed in the timeframe it is important to acknowledge these and return to them at a later date[3].

The aim here is to raise the patients awareness of the relationship between their drug or alcohol use and what is happening in their lives. This strategy is particularly useful for **precontemplators** (those patients who are happy to continue using)[3].

Pros and cons of drug use

Start by asking about the **good things** and then move on to the **less good things**.
Ask "what are some of the good things about your use of marijuana?"
The answers will emerge quickly, a summary of these is helpful.
Ask "what are some of the less good things about your use of marijuana?"
Find out why the patient feels these are less good things.
Ask "how does this effect you".
Ask "what don't you like about it?"
Summarise the **good things** and **less good things** in clear concise language leaving the patient a little time to react, for example:
Ask "So your use of marijuana helps you relax and you enjoy the feeling it gives you. On the other hand, you say you feel you lack motivation and it is effecting your work performance".

Avoid using language like 'problems' or 'concerns' and don't assume the less good things are a problem for the patient. Keep on task and avoid making your own hypotheses about the patient's behaviour[3].

The crucial factor with this strategy is it allows the practitioner to explore the patient's concerns. It also enables the practitioner to assess the patient's readiness to change. This strategy builds rapport and provides the practitioner with important information about the context of the substance abuse.

However, if the patient is in **precontemplation** there will be resistance with the topic of less good things. The practitioner will need to leave the matter to a later date and offer the patient some appropriate information.

Providing information

Giving patients information about alcohol, tobacco or drugs is routine in general practice consultations. The important issue is the way information is exchanged as it can affect the outcome of the intervention.

It is important to assess the readiness of the patient to receive information and provide the information in a neutral and non personalised way. The patient's reaction to the information should be elicited by the use of an open question.

The future and the present

This strategy is used for patients who are concerned about their behaviour. The practitioner can focus on the present behaviour and how the patient would like to be in the future, thus creating a discrepancy. This can provide the patient with a motivating force to consider changing their behaviour.

Ask, "How would you like things to be different in the future?"

Once the practitioner has focused on future goals it is time to move on to the present.

Ask, "What's stopping you from doing the things you would like to do?"

This will help the practitioner to focus on the negative aspects of the patient's present circumstances.

Ask, "How does your use of alcohol affect you right now?"

This will often lead to a direct exploration of the concerns and problems the substance use is causing the patient and discussion around behaviour change[3].

Exploring concerns

This strategy explores the reasons for concern from the patient and is considered the framework for pursuing the goal of motivational interviewing[3]. It can only be used with patients who are concerned with their behaviour. It involves listening, following the patient's lead and intervening at appropriate moments to keep the discussion moving forward. This strategy involves summarising the patient's first concern.

Ask "What other concerns do you have?"

Continue this line of questioning until all concerns have been covered. The strategy is completed with a summary of all concerns in addition to highlighting the positive aspects of the substance use.

Discussing the **good things** will point out the conflicting elements of the patient's ambivalence. Part of the patient's conflict is wondering what it would be like if they changed their behaviour. The practitioner can then ask open questions exploring the patient's concerns around behaviour change[5].

Helping with decision making

This strategy is only used with patients who have indicated they would like to change their behaviour. It is generally used following the previous strategy. If the practitioner pushes too hard at this point the patient may retreat.

Ask, "Where does this leave you now?"

The question needs to be open and care needs to be taken by the practitioner so as not to fall into the trap of the 'expert problem solver'. At this stage it is possible to offer advice and information without undermining the patient's autonomy[3].

Conclusion

Motivational interviewing strategies can be used effectively when integrated with the **stages of change** model. Knowing which stage of change the patient is in gives you a place to start when deciding which strategy to use. Patients need assistance when negotiating a change in their behaviour and moving through the stages in the process of change. The ultimate goal is to assist the patient to make effective changes in his or her life. The hope is these changes will enhance the patient's life and that they be maintained over time.

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