Motivational interviewing: a positive approach

How do we encourage our patients to give up smoking, drink less alcohol and engage in healthy activities that would enhance and possibly lengthen their lives? Health promotion and explaining risk are part of the GP's everyday job but it is a skill that could be improved. One suggestion for improving health promotion by GPs is that a motivational interviewing (MI) approach could be used. This article aims to describe the MI method and its practical relevance to primary care practitioners in dealing with common patient concerns.

The GP curriculum and motivational interviewing

Curriculum statement 2: The general practice consultation requires GPs to understand the context in which the consultation happens including:

- Demonstrating commitment to health promotion, while recognizing the potential tension between this role and the patient's own agenda
- Negotiating a shared understanding of the problem and its management with the patient, so that he or she is empowered to look after his or her own health
- Responding flexibly to the needs and expectations of different individuals

Curriculum statement 3.3: Clinical ethics and values-based practice requires GPs to have:

- Skills to achieve meaningful consent by a patient to a plan of management by seeing the patient as a unique person in a unique context
- Understanding of the importance of continuity of care and long-term relationships with patients and their families in identifying and understanding the values that influence a patient's approach to health care
- Understanding of the complexity of values that influence patients' attitude to their illness and their health care
- Understanding that respect for patient autonomy is in essence a holistic approach

Curriculum statement 5: Healthy people—promoting health and preventing disease requires GPs to be able to:

- Demonstrate an understanding of the concept of risk and be able to communicate risk effectively to the patient and his or her family
- Describe the effects of smoking, alcohol and drugs on the patient and his or her family
- Promote health on an individual basis as part of the consultation
- Negotiate a shared understanding of problems and their management (including self-management) with the patient, so that the patient is empowered to look after his or her own health and has a commitment to health promotion and self-care. Recognize and contend with the potential tension between the GP's health promotion role and the patient's own agenda.

What is motivational interviewing?

Motivational interviewing (MI) has been defined as 'a client-centred directive style for enhancing intrinsic motivation to change by exploring and resolving ambivalence' (Miller and Rollnick, 2002). MI was developed originally in 1983 as an intervention for problem drinking and other addictions. Since then, MI has been adapted and used effectively in many other health contexts, particularly in the management of chronic diseases and conditions such as obesity, which are closely associated with lifestyle factors.

MI is useful because it encourages both doctor and patient to explore the gains and losses of behaviour change in a non-judgemental manner as opposed to the doctor telling the patient what they should do. For example, this first piece of advice might well take place in a GP's surgery:

> *Mrs Smith, you know you should stop smoking. It's very bad for your chest.*

Contrast this with the MI approach, which is eliciting the patient's views and acknowledging her possible ambivalence to change:

> *Mrs Smith, I wondered if you had ever thought of giving up cigarettes? What do you see as the barriers to stopping smoking, and the potential gains for you?*

Relevance of MI to primary care

The epidemiology of general practice has changed in the last 20 years and many more diseases and chronic conditions are managed at the primary care level rather than in hospitals. A large majority of consultations are concerned with chronic diseases such as diabetes, heart failure, musculoskeletal problems and chronic obstructive airways disease. Often, these conditions are linked to lifestyle factors such as diet, smoking and exercise. GPs have a crucial role to play in health education and helping patients alter their behaviour in order to improve their health and quality of life and reduce or modify their risk of disease.

Discussion of the concept of 'risk' with patients is often challenging and must be individually tailored to the patient's level of comprehension and context. Stressing the positive gains to their health of losing weight or taking more exercise is worth doing but may not always convince patients to alter their behaviour, particularly if they do not appreciate the long-term consequences of not making changes in their lives.

Many techniques and strategies to help patients understand risk have been described, including the use of visual aids, analogies and comparative risk tables (Gigerenzer and Edwards, 2003; Paling, 2003). These tools complement the MI method which stresses a patient-centred approach, a recognition of the difficulties involved in any behaviour modification and that patients may be uncertain about their ability and willingness to achieve change.

How MI can help patients and their doctors

Learning the MI approach can be very useful to doctors performing their health promotion role. Often patients do not follow well-meaning advice from their doctor, which can be frustrating for the health professional involved. We are probably all familiar with the 'yes but . . .' response from patients when we give health promotion messages or suggest lifestyle changes that would make a realistic difference to their current state of health. The GP can fall into the trap of sounding like a disapproving parent or teacher and fail to appreciate the patient's quandary about altering unhealthy behaviour patterns, despite the clear evidence that changing these patterns would be beneficial.

MI promotes a method that recognizes and embraces this ambivalence and moves away from putting the doctor in the position of directing the patient. Rather, the authors of the MI approach talk about 'guiding' the patient and 'activating the patient's own motivation for change and adherence to treatment' (Miller and Rollnick, 2002).

Why change is difficult

We can probably all think of things that we would like to change in our lives and the reasons why these would be desirable. Taking more exercise, drinking alcohol in moderation and not overeating are common goals that many people have in mind.

However, *knowing* the benefits of change and even *how* to change is not enough to make it happen. We need to feel motivated and confident that we can implement change effectively, otherwise we are likely to carry on as before.

Several factors have been identified which are relevant to the difficult business of making change happen. One of these is the perceived threat to personal autonomy if we are 'told' what to do which paradoxically makes it more likely that we will do the opposite. Anyone who has lived with toddlers or teenagers will recognize this theory! Unfortunately, doctors often put themselves in the position of 'telling' their patients what is good for them rather than eliciting the patient's ideas about their health.

Uncertainty about making changes to behaviour is understandable. It requires determination and perseverance to alter any habit, particularly if the habit is pleasurable and/or addictive. A patient may want to stop smoking and know it would improve long-term health, but the pleasure that the patient gets from cigarettes may be substantial and the discomfort experienced on giving up, difficult to tolerate.

Sometimes a health scare or crisis motivates people to implement important changes in their behaviour, but more commonly, people think about changes they *might* make to improve their health for a long time before they act, if they ever do. This has been well described in Prochaska and DiClemente's (1982) stages of change model (Fig. 1). As GPs, we are often moving patients from the precontemplation stage to the contemplation stage. The MI method facilitates the next three stages of preparation, action and maintenance by using some of the principles and tools described in this article.

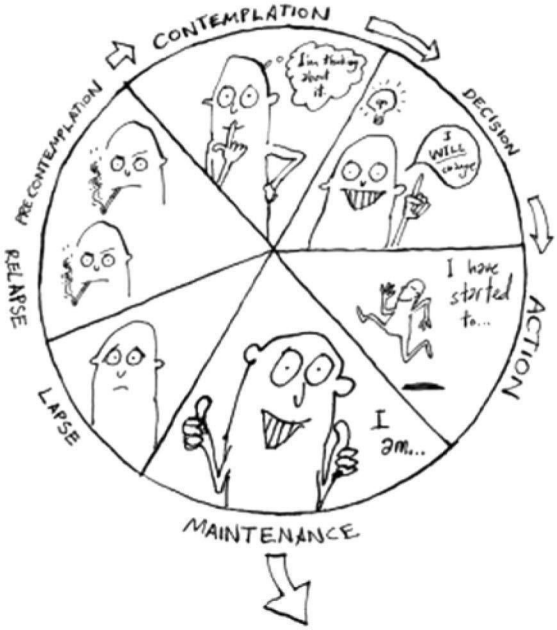

Figure 1. *Stages of change model adapted from Prochaska and DiClemente's 'Stages of Change' model.*
Illustration: Tom Morgan-Jones © Alasdair Cant & Associates Ltd www.cambridgetraining.org.

Guiding principles of MI

The acronym RULE in Box 1 covers the four main tenets of MI. 'Resisting the righting reflex' is an interesting concept. It means not rushing in and telling the patient what they 'should' do to improve their health. Instead, the practitioner attempts to get patients to vocalize the advantages and disadvantages of changing their behaviour and reinforces the former. The ambivalence that patients express about whether they *want* to change and if they *are able* to change is recognized and acknowledged.

Box 1. RULE

R—Resist the righting reflex
U—Understand and explore the patient's own motivations
L—Listen with empathy
E—Empower the patient, encouraging hope and optimism

Source: Rollnick *et al.*, 2008

'Understanding and exploring the patient's own motivations' are part of being patient centred in any consultation. As GPs, we have to recognize that the complex patient in front of us often holds very different values and beliefs to our own. By gentle enquiry, we can elicit patients' perspectives, the pros and cons of any changes that they might make in their behaviour and what expectations they have about their health. We might find out what has worked in the past for them. We can also draw out their ideas about how important they think a change of behaviour might be for them and how confident they are that they can achieve this. If patients are dismissive about giving up smoking or do not see this as a priority for their health, then it is unlikely that they will carry out this change even if the doctor considers it essential.

'Listening with empathy' is closely linked to another step in MI called reflective listening. In order to do this effectively, you have to concentrate very hard and carefully to really hear what the patient is communicating. The next step is to interpret what the patient is saying and reflect it back to check that you have understood the patient's position. This skill can be demonstrated at differing levels of interpretation, depending on the context and engagement of the patient in the MI process.

'Empowering the patient' is about understanding the patients viewpoints, exploring with them any ideas they have about changing their behaviour and reinforcing any steps that they are contemplating that might help. In many cases, empowerment for patients comes from them being able to express their ideas and ambivalence out loud without fear of belittlement or judgement from their doctor.

It is clear from this brief description that several consultations between patient and doctor will be required when MI techniques are employed. The process takes time and effort on the part of both individuals but is enhanced by a good, trusting and respectful relationship in which the patient knows that the GP is exploring potential changes in behaviour with the patient's best interests at heart.

Tools to help in MI

OARS (Box 2) have been described as 'the tools that help build rapport with clients, explore concerns and convey empathy' (Rosengren, 2009). These methods are familiar to anyone who has had communication skills training. Other key concepts in MI are 'change talk' and the 'spirit of MI'. Practitioners of MI aim to elicit change talk from patients as the first step in contemplating a shift in behaviour. Without patient verbalization of the various choices and thoughts about behaviour modification, change is less likely to happen.

Box 2. OARS

O—Open-ended questions
A—Affirmations
R—Reflective listening
S—Summaries

Source: Rosengren (2009)

The 'spirit of MI' (Miller and Rollnick, 2002) is a more abstract idea and covers the guiding philosophy of the approach. Three components form the MI spirit:

- Collaboration
- Evocation
- Autonomy

Collaboration recognizes that patients are experts on themselves, their context and attempts to change in the past. The GP tries to understand the patient's stance and explore with the individual any proposed behaviour alterations. Evocation involves 'drawing out ideas and solutions' from the patient so that they themselves are coming up with potential ways to change rather than the GP being proscriptive. Autonomy refers to respecting the patient's decisions, even when the practitioner may disagree with them or be concerned that harm may result.

MI in practice

The examples below illustrate how the MI approach differs to many consultations in general practice where the GP may exhort the patient to change behaviour. Compare the two conversations and decide which you think would be more effective in encouraging a change of behaviour.

Example 1.

A common scenario in general practice is seeing a patient who is overweight, at risk of developing diabetes and heart disease and who is not taking any regular exercise.

Mr B, a 48-year-old warehouse supervisor, has come to see his GP for some more medication for his painful knees.

Mr B: *I know I'm overweight doctor, but I can't seem to shift it. All my family are big if you know what I mean.*

GP: *Yes, it's difficult isn't it? What exercise are you doing, if any? And your diet? What about alcohol in an average week?*

Mr B: *Well, I walk the dog most days, and my job's pretty physical. I don't eat a lot of sweet things, but I do like my food. I suppose, I have a couple of beers most nights. We don't go out that much . . .*

GP: *Well I think you know the score. You would definitely be better off losing some weight and then your knees might improve. You are also less likely to run into problems later with heart disease or diabetes if you managed to change your diet and take more exercise. Could you do any regular exercise, something a bit more strenuous than walking that puts your pulse rate up? And what about cutting down the size of the portions of food you eat? Beer is quite fattening so if you were able to reduce your drinking to once or twice a week rather than every day, that would be good . . .*

This is all sensible advice and probably goes on everyday in general practice. The GP is trying hard to be positive, but he or she is demonstrating the 'righting reflex' in being proscriptive rather than eliciting ideas from the patient. Now consider how the conversation might have gone if the GP had practised the MI approach with Mr B.

Example 2.

Mr B: *I know I'm overweight doctor, but I can't seem to shift it. All my family are big if you know what I mean.*

GP: *You think your family all have a tendency to be a bit overweight so that might make it more difficult for you. I think losing some weight would be a good thing but I wonder what benefits you think you might gain?*

Mr B: *I suppose it might help with my knees and getting a bit puffed . . .*

GP: *That's right, it might help reduce the strain on your joints and you might feel fitter. Can I ask what exercise you are doing, if any? And your diet? What about alcohol in an average week?*

Mr B: *Well I walk the dog most days and my job's pretty physical. My diet's ok. I don't eat a lot of sweet things, but I do like my food. I suppose I have a couple of beers most nights. We don't go out that much . . .*

GP: *Walking the dog is good and doing your job. I wonder if you had thought about any other exercise that you might enjoy? Ideally it needs to be something that would put your pulse rate up a bit so your heart gets the benefit and you get a bit fitter.*

Mr B: *My knees stop me doing anything too much—I mean I can't run or play football like I used to.*

GP: *That must make life difficult. So exercise which is hard on your knee joints is not possible. Had you thought of any other exercise that might help?*

Mr B. *I could go swimming I suppose . . . not that keen on it though.*

GP: *Swimming would be great if you could go. If you did manage to lose a bit of weight it would help with the pain in your knees and also mean that you wouldn't have to rely on taking tablets so regularly.*

Mr B: *I guess it would be good not to have to take tablets. It's difficult to eat less. I really enjoy my meals and the wife's a good cook. I don't know about cutting out the beer. I don't drink much compared to some of my mates.*

GP: *You are unsure whether you can eat smaller meals because you enjoy your wife's cooking and the amount of beer you drink does not seem excessive by some people's standards.*

Mr B: *That's right and I don't want to upset my wife by refusing her food or my mates by not going for a drink.*

GP: *So you are worried that drinking less might affect your social life. Would it help if I saw you and your wife for a joint appointment to discuss this further? I am concerned that you are taking medication regularly for your knees because all tablets can have side effects. I also know that being over weight can lead to problems later with the heart or developing diabetes. I can see you are thinking about ways you could reduce these health risks and I would like to help you further. What do you think about meeting again?*

Mr B: *Yes, maybe. I'll go home and talk to my wife and see what she says.*

It may seem that not a lot has been achieved in Example 2, but on closer analysis, the GP has probably moved Mr B. along the path of changing his behaviour more effectively than in Example 1. This has been achieved by practising the MI approach and using RULE and OARS to help, particularly in the area of 'reflective listening' and interpreting what the patient is saying.

Mr B. is at the contemplative stage of change. Of course, it is possible that he will never move on to actually altering his diet or taking more exercise. However, the non-judgemental tone of the GP, the acknowledgement of the difficulties of altering his eating patterns and social drinking are likely to help Mr B. consider changing his behaviour. The GP is trying to elicit the patient's ideas about how change might be implemented rather than suggesting or telling him what to do. This approach is reinforced by the GP's statement of concern and pointing out the advantages of Mr B. losing weight and long-term health gains.

Change talk

If Mr B. attends again, with or without his wife, the change talk can be explored further with more concrete plans for what he might do to lose weight. Another useful acronym related to motivating patients to change their behaviour is DARN (Box 3).

Box 3. DARN

D—Desire
A—Ability
R—Reasons
N—Need

Source: Rosengren (2009)

The GP has stated the 'Reasons' and 'Need' for change from her point of view and Mr B. has mentioned his 'Desire' or recognition that it would be good not to have to take tablets regularly. He also voices the idea that he might be less out of breath if he managed to lose some weight. This initial discussion might be revisited with exploration of what Mr B. considers is possible ('Ability') in modifying his lifestyle. Some of the following questions may help clarify specific tasks that the patient has identified:

- What will you do?
- What are you going to do?
- What are you willing to do?
- What are you prepared to do?

Change in behaviour is more likely to occur if patients attach real importance to making the change and believe that they can be successful in achieving it. The gain has to outweigh the loss with patients making a commitment to carrying out the behaviour modification that they have suggested, reinforced by the doctor pointing out the positive health benefits.

Disadvantages of MI

There are some drawbacks to using the MI method in the GP surgery. Practising an MI approach takes time and often involves repeated consultations with the same patient to move the patient into 'change talk' and then actual behavior modification. At a time of further National Health Service (NHS) reform and the introduction of GP commissioning, using MI in the surgery may seem a luxury or too onerous, despite its potential ability to improve patient health and reduce the economic demands of chronic disease on the NHS in the long term.

Training in the MI method is also time consuming and has financial costs for GPs. It is over 25 years since MI was developed and the method has been adapted, expanded and modified in this time. Purists of the MI concept may argue that much of what is called MI today is not preserving the integrity and consistency of the method as it was originally conceived, which also raises the question of the competence and integrity of the practitioners of MI (Moyers *et al.*, 2005). Many new related therapies have grown up which may achieve the same aims as MI, e.g. solution-focused brief therapy.

Finally

MI, despite some of the challenges of implementing it, has many positive benefits to offer general practice. Both doctors and patients may notice a significant change in their consultations as they start to employ the principles of MI. It is clear that the method needs to be practised over time in different contexts with different patient concerns. There are many resources available to GPs to learn about MI, some of which are listed in Box 4, as well as organizations that offer MI training.

Box 4. MI training courses and resources

Alasdair Cant & Associates Ltd, www.cambridgetraining.org

Alasdair Cant & Associates provides training for professionals working with patients and clients who are resistant to change.

www.motivationalinterviewing.org resources for clinicians, researchers and trainers

http://www.skillsdevelopment.co.uk MI and beyond (A module of the Certificate in RBT). A 1-day-course approved by the British Psychological Society (cost £99.00 when accessed January 2011).

Many local NHS organizations offer free courses in MI for health professionals or at a reduced cost compared to the private sector.

Key points

- MI is a patient-centred approach that can help people identify changes in behaviour that would benefit their health
- Motivation to change and ways to achieve this should be elicited from the patient rather than directed by the GP
- The ambivalence associated with changing behaviour should be acknowledged and explored with the patient
- The MI method takes practice, skill and patience to be effective
- MI is helpful in managing many common conditions associated with poor lifestyle habits

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