Assess Readiness to Change

Motivational interviewing: unlocking the patient's own motivation

Session 5

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Overview – aims

- What is motivational interviewing (MI)?
- Evidence to support MI.
- Four guiding principles:
  - resisting the righting reflex
  - understanding and exploring the patient's motivation
  - active listening
  - empowering the patient
- Case studies

What is motivational interviewing (MI)?

•MI is patient-centred counselling; it involves agenda-setting, reflective listening and shared decision-making.

•MI is the opposite of finger-wagging; the aim is to explore the problem from the patient's point of view.

MI can achieve behaviour change

•MI assumes that behaviour change is stimulated by motivation rather than information.

•Ambivalence to change is explored, but so are the benefits of change.

•The answers lie within our patients, not us – our job is to unlock those answers.

Extensive evidence supports MI in a variety of health areas

Low-intensity MI interventions are effective in many health-related areas where patient engagement is key to achieving long-term behaviour change.

- Alcohol, smoking and substance abuse
- Medication adherence – e.g. asthma/COPD
- Cardiovascular health, hypertension, diabetes
- Health promotion, dentistry, obesity, physical activity
- Domestic violence, family relationships, gambling
- Mental health, eating disorders

For further information, see http://www.motivationalinterviewing.org

The Spirit of MI – enabling responsibility to lie with the patient rather than the doctor

MI differs from the traditional “doctor assesses, then informs patient of the problem and solution”. Instead, it aims to:

- collaborate with the patient to understand their perspective;
- evoke – or unlock – solutions that already lie within the patient;
- recognize that a patient’s personal goals, values and aspirations may differ from the health professional’s.

The four guiding principles: RULE

- **Resist** the “righting reflex”.
- **Understand** the patient’s own motivations by exploring feelings behind why a change is wanted and what options the patient wants to try.
- **Listen** – actively and with empathy.
- **Empower** the patient, encouraging hope and optimism.

Develop a “guiding” style rather than a “directing” style:

“How can I help you find your way?” rather than *“Go that way!”*

The consultation – tools

- Ask open questions.
- Listen by reflecting.
- Help to weigh up pros and cons.
- Set SMART goals.
- Use a ruler “scale of 1 to 10”.
- Use hypotheticals – “What might it take for you to make a choice to ...?”

Resisting the “righting reflex”

- The urge to “correct” problems that patients present to us is very strong.
- Yet humans naturally resist persuasion, especially if they feel ambivalent – for instance, drinkers (or teenagers!).
- Even positive changes require effort – staying put is always easier than making a change.
- Urging a patient to do something obviously beneficial can, paradoxically, produce more and more reasons why the change seems impossible.

  Doctor: “I suggest you …”

  *Patient: **“Yes, but …”***

“All you need to do is …”

Active listening

- Key moments for active listening:
  - first “golden minute”
  - cues – points when the patient seems confused, anxious, disengaged or annoyed
  - moments after you ask an open question.
- Listening by reflecting – reflect back a short summary of your understanding:

  “You feel very concerned about your weight, but you are not confident about the approaches you’ve tried.”
- Work through ambivalence.

Active listening

- I should …
- I wish …
- I want to …

Help to change these phrases to:

- **I will**

Roadblocks to listening

Silence is an important part of listening. Interrupting a patient means that they have to deal with this “roadblock” before continuing with their agenda. Limit the following interruptions:

- agreeing/disagreeing
- instructing
- questioning
- warning
- reasoning
- sympathizing
- suggesting
- analysing/interpreting
- persuading

Have you heard this?

- “I can’t see why I need to change.”
- “I can see what you mean but …”
- “Just tell me what to do.”
- “I really can’t cope at all.”

What we can do

Be clear about expectations and minimize the risk of misunderstandings. This will:

- demonstrate respect for patients;
- acknowledge the patient's autonomy;
- increase engagement in treatment.

Listening by reflecting

- Each reflection is a short summary statement (not question) of what is happening at that moment.
- After you reflect back what the patient means (hypothesis), the patient then confirms or refutes the hypothesis.

  "You find it hard to exercise because of your knee pain."

  – "Yes, I'm worried exercise will make it worse."
- Acknowledge the value of what you have heard.

  "You've given me a clear picture …"

  "That has helped me understand …"

Listen out for “change” talk and “resistance” talk

- **Change talk** – where the patient volunteers ideas, suggestions and plans about making a change.

- **Resistance talk** – excuses as to why solutions will not work or comments about feeling ambivalent or defeated.

Choose carefully what to reflect

- Where a patient is using change talk, reflect this back to empower the patient.

  "You plan to choose smaller portions by using a smaller plate."

- Reflect back a patient's ambivalence or resistance talk. This can unlock "the other side of the argument" from the patient.

  "Despite your weight you feel your eating habits are quite healthy."

  – "Well, I suppose they are not that healthy – I have a weakness for cake at teatime."

  "Your diet is mainly OK but you have some weaknesses."

  – "I might try making a fruit smoothie or a piece of toast."

Help the patient (not you) to voice arguments for behaviour change

Task is to elicit change talk from patient rather than resistance talk	
Desire: statement about preference for change	I want to… I wish…
Ability: statement about capacity	I could… I might be able to...
Reasons: specific arguments for change	I would probably feel better if…
Need: statements about feeling obliged to change	I ought to… I really should…
Commitment: statements about likelihood of change	I am going to... I will…
Taking steps: statements about action	This week I started… I actually went out and…

The importance and confidence rulers

- Use the **importance ruler** to determine a patient's level of commitment to making a proposed change.

  "How important would you say it is for you to make this change? On a scale from 0 to 10, where 0 is not at all important and 10 is extremely important, where would you say you are?"

  Use the ruler positively: "Why are you at 8, not 4?"

- Use the **confidence ruler** to determine how confident a patient is that they will follow through on a proposed change.

  "And how confident are you that, if you decided to make the change, you would succeed? On the same scale from 0 to 10, where 0 is not at all confident and 10 is extremely confident, where would you say you are?"

  Use hypotheticals: "What might it take to go from a 7 to a 10?"

Example: using the importance and confidence rulers

“You are planning to start attending the weight management group each week. On a scale of 0 to 10, how important is attending this group to you?”

– “Well, I’d say it’s about an 8.”

“8 tells me it is important to you, but how confident are you that you’ll make it happen? Again, use the 0 to 10 scale.”

– “Hmm, that’s trickier. I sometimes get held up in the evenings. I’d say it’s more like a 6, as I’m not sure I’ll get there every week.”

“As you rated it as important, what might help you make it happen regularly? How could you push that 6 up to an 8 or 9?”

– “I think I just need to be organized. I sometimes get bogged down with housework when I get home from work, but the club meetings aren’t very long, so there’s no reason why I couldn’t do the chores after the meeting.”

“So, because you feel it is important, you’ll do what you can to make it happen.”

–“Yes, I shall start this Wednesday.”

Informing

"Giving the answers" may produce little or no change in behaviour if the patient has become …

- **bewildered –** too much information or delivered too quickly
- **passive** – glazed over, "switched off", bored; information seems irrelevant or too complex
- **highly emotional** – angry, frightened, anxious
- **depressed** or **distracted –** poor concentration due to depression or recent events

Make informing effective (1)

Ask permission	“May I make a suggestion?” This emphasizes collaboration between you and lowers resistance.
Offer choices	“There are several ways you could address this. Would you like me to explain some options?”
Talk about what others do	“In this situation other patients have found the following approach quite helpful.”

Make informing effective (2)

Elicit–provide–elicit	Elicit – “What would you like to know?” Provide – give information requested. Elicit – “What does this mean to you?”
Beware the righting reflex	Avoid making patients feel scared, humiliated, ashamed, guilty, etc. Aim to be supportive, compassionate, empathic and inspiring.
What does this information mean to *you*?	Relate what you are suggesting to the patient’s specific situation to enable their concerns to come forward.

Focusing on the impact of weight on health

Question	GP's hidden agenda	Patient perception
Have you sensed that your weight has affected your joints?	What is level of understanding re inflammatory properties of adipose tissue?	Understanding my condition better may help me to help myself.
Were you aware of the link between weight and periods? ... diabetes? ... sleep apnoea?	Weight loss may be the best treatment option, so I want the patient to feel positive.	I didn't realize the solution may lie with me.
What things have you tried to improve your lifestyle?	What are the lifestyle priorities for this patient?	I might mention I gained weight after I stopped smoking.
We know weight can affect the safety of doing an operation – has anyone talked to you about this?	How can I gently broach the fact that you are unfit for an operation?	Understanding the health risks can help me make the right decision about surgery.

OARS summarizes the overall

O	Open questions	questions that encourage patients to think before answering and allow a choice in how to respond
A	Affirm	acknowledge patient's efforts, strengths and volitional choice
R	Reflective listening	capture patient's meaning
S	Summarize	pull together what's been said

Exercises: unlocking the patient's own motivation

Split into pairs

Exercise C1: Importance and confidence rulers

Role play: try using the importance and confidence rulers to challenge Mrs A's sustain talk in the examples in your workbook.

Exercise C2: Reflecting back sustain talk

Read the example of how reflecting back, or restating, the patient's sustain talk – rather than offering your own solution – can create a space for the patient to present their own solution.

Role play: try the examples given to see if you can unlock change talk from the patient.

Your future practice

Please consider your future practice.

- How will you balance active listening and empathy with the time constraints of a busy practice?
- Do you have personal examples of utilizing the various styles of motivational interviewing (following, guiding, directing)? If so, please discuss.

Might a health professional's own shape affect confidence when they mention weight?

Can slim people have any idea of what fighting obesity is really like?

Could a health professional with obesity have credibility in recommending weight loss to another person?

Does our own shape actually matter?

- Self-help support groups run by fellow sufferers are often the most successful formats of all – there is nothing like personal experience to aid empathy.
- Understanding a patient's perspective can come from active listening – it does not necessarily need to be experienced.

Answer – Not if our aim is to help patients **explore their own goals**.

Group discussion questions

- What is it like living with obesity or a chronic condition? (patient experiences)
- Do weight bias and stigma affect health outcomes and quality of care?