Motivational interviewing for health behaviour change

"I know I should but I don't… I know I shouldn't but I do..."

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Citation: Jones K (2015) Motivational interviewing for health behaviour change. *Diabesity in Practice* **4**: 32–6

Article points

1. Motivational interviewing (MI) is a communication style which relies on the use of four key skills, known in MI as OARS: Open questions, Affirmations, Reflective listening and Summarising.
2. MI has been used successfully for people with diabetes and obesity in Wye Valley NHS Trust, Herefordshire.
3. This article gives practical tips and guidance for clinicians interesting in using MI.

Key words

– Ambivalence
– Motivational interviewing
– Psychology
– Values

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Engaging motivation for health behaviour change in bariatric patients and people with diabetes is a key challenge for clinicians in the NHS today. Ambivalence is at the heart of motivation, and this article describes two psychological models and a set of practical processes that seek to address this challenge. The models described are the information–motivation–behavioural skills model and motivational interviewing, which are being integrated into the diabetes care management in the Wye Valley NHS Trust in Herefordshire.

In 2005, the Department of Health Psychology at Wye Valley NHS Trust, Herefordshire, began a programme of training and supervision for clinicians to provide a service for patients, which addressed the challenge of engaging patients in health behaviour change. Two psychological models, motivational interviewing (MI) and the information–motivation–behavioural skills (IMB) model, were used.

One area in which the training programme has been particularly effective is in supporting staff working with people with diabetes and obesity. The training programme has also shown that individuals with diabetes and obesity very often know what they need to do to manage their health condition, but do not do so because the advantages of not changing their behaviour outweigh the advantages of making some adjustment to their lifestyle. A brief conversation with patients using the style and spirit of MI can help clinicians to get to the heart of ambivalence and to use values to engage motivation, as will be described in this article.

Motivation

Motivation as defined by Miller and Rollnick (2002) is "…a state of readiness or eagerness to change, which may fluctuate from one time or situation to another. This state is one that can be influenced…". It is a drive which is located within the patient – it is not something we can impose on them, or magically induce just by being in the room with them – and it is something that fluctuates. When I hear someone say: "They've just got no motivation", what this actually means is that the person is not motivated to do what we want them to do at this moment in time.

In 2004, the Department of Health published the white paper *Choosing Health: Making healthy choices easier* in which it suggested that a key role for the healthcare professional should be in helping patients to change their health-related behaviours. In particular, the document reported that psychological approaches can be helpful in bringing about that change (Department of Health, 2004).

History of MI

One of the main methodologies aimed at health behaviour change both in the US and UK is MI. It initially evolved from the field of addiction management and was first outlined by Miller (1983). In 1995, Miller and Rollnick elaborated on Miller's initial work and defined MI as:

> "[...] a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence […]. The

examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal." (p. 325)

In addition, the IMB model, first described by Fisher and Fisher (1992), outlines a behavioural change methodology that integrates many of the fundamental concepts of MI. The IMB model was further developed by Klapow and Pruitt (2005) who concluded that, in order to change health behaviours, simple motivation is not enough: a person needs to know the relevant information (the *What*), they need the motivation (the *Want*) and they need the behavioural skills that are required to make the change (the *How*). This model uses the core techniques of MI to create a directive, yet client-centred arena in which patients can make behavioural changes. Its primary difference from MI is that more emphasis is placed on the explicit setting and monitoring of goals.

There is a growing evidence base for using MI in diabetes and obesity management and studies are being undertaken all over the world. The use of MI on dietary intake and weight loss in Iranian obese and overweight women has been shown to be an effective strategy to change lifestyle and reduce BMI in the long term (Saffari et al, 2014). MI has also been found to be an effective intervention with parental involvement for obese adolescents in changing obesity-related and non-obesity-related outcomes, such as anthropometric, biochemical, psychometric and behavioural outcome variables (Pakpour et al, 2015). There are also two recent studies that were published in *Diabetes and Primary Care* which looked at the role of MI and acceptance and commitment therapy (ACT) in diabetes self-management, both showing positive outcomes (Hamilton-West et al, 2013; 2014).

Most studies acknowledge MI as part of a range of interventions, and it is often used in conjunction with other psychological approaches such as cognitive behavioural therapy (CBT) and ACT or as part of a wider psycho-social model.

The spirit and style of MI

MI is a communication style that relies on the use of four key skills, known in MI as OARS: Open questions, Affirmations, Reflective listening and Summarising. To maximise motivational engagement all interventions need to be applied with the MI spirit of compassion not judgement, acceptance of the patient's autonomy, and collaboration and eliciting from the patient, rather than telling or problem-solving (Miller and Rollnick, 2013).

The Herefordshire MI/IMB training programme

The Herefordshire MI/IMB training programme is a mixture of theoretical and experiential learning and has been applied across a diverse range of patient groups. As well as bariatric patients and people with diabetes, the approach has been used in neurology, cardiac, sexual health, rheumatology and podiatry.

Feedback from the training programme has been consistently good, particularly in helping clinicians to understand a patient's motivation. In 2008, an evaluation of the training programme was undertaken and the overall response from healthcare practitioners was that the advantages of the model outweigh the disadvantages, and that they found it useful both in their clinical practice and for their continuing professional development.

The training for clinicians working with all patient groups is divided into four main areas of skill: Information giving and receiving, communication and listening skills, working with ambivalence and goal setting.

MI training for clinicians

Previous research has shown that using the IMB model increases the likelihood of patients changing their health-related behaviour (Fisher and Fisher, 2009). However, in order to help patients change their behaviour, health professionals also need to change their own behaviour to incorporate the IMB model into their practice. Two key components of behaviour change for all are:

1. whether the proposed change is important enough to that person, and
2. whether they feel confident enough to consider making the change.

It is often thought that the purpose of training

Motivational interviewing

Motivational interviewing (MI) is a communication style which relies on the use of four key skills, known in MI as OARS:

- Open questions
- Affirmations
- Reflective listening
- Summarising

Elicit–Provide–Elicit

- **Elicit** from the patient what they already know about managing their diabetes or the risks of not doing so (i.e. what else do they want or need to know?)
- **Provide** any additional information you have neutrally.
- Then **Elicit** from them how they might apply these facts to themselves in their current situation.

is to enhance skills (confidence), but there is also an equally relevant task in helping the professionals to value the approach (importance) (Rollnick et al, 1999).

Both MI and the IMB model are easily taught in a limited time, many of the core techniques are reasonably familiar to health professionals and are easily applied (e.g. open-ended questions and summarising) and most health professionals can relate to health behaviour change issues. However, the model requires health professionals to change the way they work with patients – a way of working which is somewhat at odds with the medical model of diagnosis and treatment.

Therefore, the healthcare professional has to face similar issues of ambivalence in their own training as their patients in managing their health condition. Motivation or intent are key factors in this, but so too are:

> "the beliefs underlying behaviour; the value of it; the perceived costs and benefits of changing; the barriers to changing; belief about our ability to perform the behaviour change; and not least the support and reinforcement of others."
> (Bundy, 2004 [p. 43])

Processes for change

In the current MI technique, there are four processes for change:

1. Building the relationship with the patient with neutral exploration of the problems faced by them in order to establish a common understanding of the starting point or need for change
2. Finding the focus (i.e. the specific change the patient is willing to consider) and the patient's values
3. Evoking and resolving ambivalence, focused on change talk*
4. Decision-making and strengthening of commitment – making a plan or goal setting.

Throughout each of these processes, awareness that motivation is intrinsically linked to values is needed – a core concept in both MI and the third-wave CBT approach: ACT (Hayes et al, 1999).

*_Change talk_ refers to the patient's mention and discussion of his or her Desire, Ability, Reason, and Need to change behaviour and Commitment to changing (DARN-C; Glovsky, 2009).

1. Information sharing

In both MI and the IMB model, the way in which information is exchanged is vital. If we simply hand out information via leaflets or didactic education sessions, the patient remains a passive recipient and the information can often be perceived as not applying to them. If, however, we engage the patient in a dialogue about what they already know, what else might be useful for them to know and how they might apply this new information to themselves, we are much more likely to begin to engage their motivation to change their behaviour.

Simply checking what patients know can save time and misunderstanding: it also begins the collaborative process. In MI there is a simple acronym of EPE (Elicit–Provide–Elicit): *Elicit* from the patient what they already know about managing their diabetes or the risks of not doing so (i.e. what else do they want or need to know?), *Provide* any additional information you have neutrally, and then, *Elicit* from them how they might apply these facts to themselves in their current situation.

Example of a typical conversation following the EPE format

- The **clinician** asks "Can you tell me a bit about your understanding about high blood glucose levels and its effects on your diabetes management?"
- The **patient** responds and shows that he or she has a pretty good grasp of why it is important to get their levels under control, for example "I don't want to have a stroke".
- The **clinician** replies with "You seem to have a very good understanding of why getting your levels under control is important" or "Would it be OK if I share some additional information ..?". The clinician can then provide the relevant information followed by "What do you think about that?" or "What do you think you will do now?". This will evoke and elicit the patient's own ideas for how they can apply this new information to their current situation.
- At the end of the session the clinician might say: "Would you mind telling me what you have understood from our discussion today?" or "If your partner asked you what we discussed today, what would you tell them?".

Box 1. Five key questions for your 10-minute consultation.

1. **Information exchange**: What do you know about diabetes and how to manage it well? What do you need to know?
2. **Values and motivation**: What's important to you? What's driving your need to change what you are currently doing?
3. **Ambivalence**: What do you think has held you back from making this change so far?
4. **Goal setting**: What specific change are you going make in how you manage your diabetes? And what will you get from doing this?
5. **Commitment – a behavioural prescription**: What will you do differently this week?

2. Eliciting values

A value is a way of behaving that matters to the patient; something they choose, that matters to them (e.g. being in loving relationships, experiencing new things or being reliable). "Looking after my health" may be a value for some people, but not everybody. If we are aware of a patient's values, we are more able to help them see how managing their diabesity achieves the goals that genuinely matter to them – even if working towards them is sometimes difficult. For example, how looking after their diabetes will make them better able to look after their grandchildren.

Eliciting values can be done with some very simple questions such as: "What matters most to you in your life? How do you think your diabetes being poorly managed might affect your life, and the things that matter to you? If you were able to manage your diabetes better, how might that benefit you and those that matter to you?" Exploring a patient's values with them will also help to focus on specific changes the patient may be willing to consider.

3. The heart of MI: Exploring ambivalence

At the heart of MI is ambivalence – the conflict between two courses of action, each of which has costs and benefits. In order to explore ambivalence with a patient, we need to establish what the ambivalence is about. Are they ambivalent about changing their diet, checking their bloods, stopping smoking, taking medication or something else entirely? Therefore, finding the focus for change is crucial before we begin to look at the pros and cons of that change.

Often when discussing behavioural change with patients, we will only explore the disadvantages of the current behaviour and the advantages of the changed behaviour. If it were this simple, the patient would probably have done it already – assuming that they knew what was needed. In fact, if all changes were that simple, then everybody would be healthy and there would be no need of models of behaviour change!

What keeps people stuck are the perceived advantages of their current behaviour (even if it is simply habit) and the fear of a change and perceived loss that goes with giving something up. So this is when we need to allow our patients to explore their ambivalence thoroughly. It can feel somewhat counter-intuitive to ask about the benefits of a particular behaviour that we know needs to change, but, if you do, you are much more likely to create a collaborative, compassionate relationship and create a sense of the patient's autonomy. To help explore ambivalence you can use questions such as: "What might be some of the pros and cons of *x*? What do you think would happen if you didn't make this change? What would be difficult for you about...? Why is that important to you? What would you say to someone else in your situation?" It is vital, above all, to elicit the reasons for change from the patient because when they leave our consulting room, they are the ones who must make this change, so the motivation to do so must come from them.

4. Goal setting

The key aim of MI is to help the patient see the value in changing their behaviour in terms of what matters to them (e.g. "I am watching my diet so I can carry on playing with my grandchildren, rather than because the dietitian told me to"). Above all, make sure the set goals are SMART

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1. What keeps people stuck in a particular behaviour are the perceived advantages of their current behaviour (even if it is simply habit) and the fear of a change and perceived loss that goes with giving something up.
2. Goals set should be SMART (Specific, Measurable, Achievable, Relevant and Time-framed).

Example questions for eliciting values:

- What matters most to you in your life?
- How do you think your diabetes being poorly managed might affect your life and the things that matter to you?
- If you were able to manage your diabetes better, how might that benefit you and those that matter to you?

Example questions for exploring ambivalence with patients:

- What might be some of the pros and cons of *x*?
- What do you think would happen if you didn't make this change?
- What would be difficult for you about...?
- Why is that important to you?
- What would you say to someone else in your situation?

"Motivational interviewing is often effective in evoking behaviour change when education and exhortation have failed, and, although it may not suit every practitioner, it might be worth trying a more collaborative, empathic, guiding style."

(Specific, Measurable, Achievable, Relevant and Time-framed).

Final thoughts

One phrase I hear regularly in the workshops I run for clinicians is: "but I've only got 10 minutes", meaning "I don't have time to do all this". Whilst a full MI process with a patient is likely to take more than 10 minutes, obesity and diabetes are often long-term, if not life-long conditions, so one particular consultation is likely to be one of many. *Box 1* suggests five key questions which can be used in one focused consultation or over several consultations, depending on the patient's level of readiness to change. There could be more value for the patient in exploring questions 1 and 2, going away and thinking, then discussing question 3 at the next meeting, going away and reflecting, and then questions 4 and 5 at later appointments.

If we can engage the patient from the start and work with them more collaboratively, they are more likely to change their behaviour in the long-term. MI is often effective in evoking behaviour change when education and exhortation have failed, and, although it may not suit every practitioner, it might be worth trying a more collaborative, empathic, guiding style. At the very least, we may need to think more creatively about how health-care systems can be modified to be more patient empowering. ■

For further information and resources on MI, visit www.motivationalinterviewing.org.

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