UNIT NO. 3

MOTIVATIONAL INTERVIEWING (MI) IN BEHAVIOURAL CHANGE

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ABSTRACT

Patients are often advised to adopt healthier behaviours or change unhealthy ones on the basis that what they are doing or not doing is detrimental to their health. Some of these changes may include going on a diet, exercising, stopping cigarette smoking and even relaxing and sleeping more. MI was initially developed by Rollnick and Miller as a strategy for addictive behaviour change, but it has found many applications in helping patients change other health related behaviours. MI was initially defined as a client-oriented, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. The guiding stance, whilst respecting the patient's autonomy and the patient as the agency of change, maintain controls of the direction and structure of the consultation to evoke the patient's own arguments and strategies for change. The guiding process thus avoids the struggle or "fights" with the patient over changing behaviour and has been likened more to "dancing" with the patient. The four counselling principles in MI are: Develop discrepancy; Express empathy; Roll with resistance; and Support self-efficacy. Facilitating the patient to process and speak more about why and how to change then becomes one of the strategies to motivate change. In MI, this is known as change talk. Once change talk is elicited, the ways the practitioner can respond are: Elicit more (with open questions); Affirm; Reflect; and Summarise. Once the patient decides to change, goal setting becomes the next important process. Needless to say, the goal setting process must be done in collaboration with the patient, with the patient having the final say.

Keywords:
Ambivalence; change talk; Develop discrepancy; Express empathy; Roll with resistance; Support self-efficacy.

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Patients are often advised to adopt healthier behaviours or change unhealthy ones on the basis that what they are doing or not doing is detrimental to their health. Some of these changes may include going on a diet, exercising, stopping cigarette smoking and even relaxing and sleeping more.

The way in which such advice is given varies – it may be a matter-of-factly professional telling but may also involve persuading, pleading, lecturing, admonishing, preaching, etc. Usually, how the advice is dispensed depends on more on "what the situation calls for", rather than a systematic, evidence-based approach. The process of advising behavioural change may also be considered adjunctive to the more "medical" aspects of diagnosis and treatment, and therefore commanded only cursory attention. At other times, advice giving could take on a defensive element of "I have told you to change, and so I am not responsible for that anymore".

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More dramatic occasions could also occur when the practitioner decides to invest in desperate attempts to correct what seemed like incorrigible behaviour. But what often belies many examples of advice giving, especially its exasperation and anguish, is the common belief that as good patients, they should listen to medical advice and comply with what's good for them. Those patients who do not respond accordingly are frequently labelled as "non-compliant", "recalcitrant", or "difficult" - as if these are deficiencies are personal traits and little further could be done about them.

However, what we now know about the processes of change can help resolve many practitioners' conundrum about advising behaviour change. In particular, this paper will present an evidence based approach in counselling behaviour change which can be readily applied in the busy practice. But to begin, let's relook at some of the common assumptions and issues in advising behaviour change in the light of the evidence.

REVIEWING OUR ASSUMPTIONS

Firstly, the task of helping patients change behaviour can no longer be consigned to a secondary role in the modern day clinical practice. Unhealthy behaviours, such as obesity, inactivity, excessive drinking and smoking, matter significantly in disease and death, and may account for as much as 40% of premature deaths [1]. But change may also be desired to enhance health related activities such as the use of aids, devices and medicines [2]. Therefore, addressing behaviour change in patients is not an option, because not doing so can be associated with significant negative impact on the patient's wellbeing.

Secondly, there is little evidence that just simply telling patients that they are at risk of developing a disease is sufficient to change behaviour [2,3]. And it is also not that patients are unreasonable or characterologically deficient of motivation when they don't seem to act in their own health interest either. We need to acknowledge that behaviours are really the products of complex interactions between an individual's biological, social, developmental and psychological processes, and the environment [4]. The biomedical context at the clinic is thus only a part of the wider web of equations that the patient has to navigate consciously or unconsciously when contemplating or attempting behaviour change. Patients, particularly those living in the community, are often required to fulfil roles other than being just a patient, in which he is expected to do all things prescribed in exchange for cure or wellness. Moreover, the incentive for patients with chronic medical conditions to change may be also eroded by the fact that they may not recover or feel better even if they make significant

changes.

Box 1. Common responses to doctor's advice for behaviour change:

"My grandfather smokes like a chimney and he lived to 93 years old"

"My friend was diagnosed with cancer the year he decided to stop smoking"

"I know it is important for me to watch my diet, but…"

"We only live once, so what's the point of living if you can't enjoy eating"

"Yes, I'll try" (As a somewhat polite way of NOT agreeing but helps avoid an otherwise protracted consultation)

Nevertheless, many practitioners would still be able to cite some successes in convincing patients to change their unhealthy behaviour, in spite of difficulties with others. This may be related to heterogeneity of the patients in their receptivity and readiness for change. Some patients just need affirmation about their intentions or efforts in order to change; while others may require more in-depth clarification and processing of their dilemmas.

Yet others may be totally resistant to change. It is a common experience for many practitioners that patient who are not ready for change seem to come prepared with "scripts" or "set pieces" to respond to whatever the doctor has to say to them about changing (see Box 1). This really shouldn't surprise any practitioner - they have after all, worked through within themselves (and often with other doctors!) the rationale or justifications for the behaviour to persist. In general, practitioners tend to have more tools for those who come motivated to change (think of all the pamphlets, gadgets and medications that can be used by those who are asking for change) but are more ill-prepared for those who are unsure or are not ready to change.

But what is veritable about health behaviour change is that it does require motivation on the part of the patient. Enhancing this intrinsic motivation becomes an important element in effecting lasting change. We will now discuss how the concepts and principles of Motivational Interviewing can help the busy practitioner respond to this aspect of care.

WHAT IS MOTIVATIONAL INTERVIEWING (MI)?

MI was initially developed by Rollnick and Miller as a strategy for addictive behaviour change, but it has found many applications in helping patients change other health related behaviours [5-7]. MI was initially defined as a client-oriented, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence [5]. This definition highlights the client centeredness as a central tenet in the process of activating intrinsic motivation. It also features the core concept of ambivalence that so often occurs in the change process. Ambivalence often manifest because of discrepancies that patients have between what they want and how their behaviour impacts these goals. In MI, ambivalence is a natural state that patients can be expected to pass through (but not stay) as they change. Ambivalence is therefore not generally interpreted as an undesirable state, and patients (and practitioners) can therefore feel comfortable about discussing about their conflicting issues and dilemmas. Indeed, it is within ambivalence that patients have their own reasons for wanting to change. The work of the practitioner is thus to create a neutral platform that permits the patient to work through their ambivalence, and derive his/her own motivation to change.

The stance that the practitioner adopts is one of collaboration and guiding. This contrasts with the more commonly subscribed role of the practitioner as the "expert" directing the change process. However, this does not imply that the practitioner is wholly submitting to the patient's wishes. The guiding stance, whilst respecting the patient's autonomy and the patient as the agency of change, maintain controls of the direction and structure of the consultation to evoke the patient's own arguments and strategies for change. The guiding process thus avoids the struggle or "fights" with the patient over changing behaviour and has been likened more to "dancing" with the patient [8].

The four counselling principles in MI are:

- Develop discrepancy
- Express empathy
- Roll with resistance
- Support self-efficacy

DEVELOP DISCREPANCY

By the time patients have established patterns of unhealthy behaviours, they may also have well developed notions about why they should maintain these patterns. These may include arguments for status quo and those against changing. There may also be situations where the pros and cons are so evenly stacked that they just feel "stuck" or immobilised by indecision. The task of the practitioner is to help the patient chalk up more arguments for changing, such that the equilibrium that maintains the state of inertia is tipped towards change. Note that interjecting the patient with the practitioner's own ideas about change will often be met by resistance and is unlikely to succeed in leading to change. This may be because patients may maintain that "you are not me", but the practitioner's iteration for change may prompt the patient to play out the ambivalence by speaking against it (see "Talking about change" later).

Skill	Description	Example
"Asking"	Open questions that invite the patient to consider why and how they might change	"How would you introduce exercise into your evening routine?" "What needs to be done differently in order to …?" "How do you make sense of the urgency of changing?"
"Listening"	Not only to understand their experience, but also to respond actively with statements of understanding or acknowledgement e.g. with acknowledgement or summaries of what was said, or with reflective listening statements. All of which conveys empathy and encourages the patient to further elaborate, and could also reduce resistance from the patient	"Hmm, please tell me more" "There are many things you wished you could do, and these are _____" "I hear your concerns about how changing the routine may result in disapproval from your friends, and this is something you are trying to avoid…" "You are tired of people expecting you to change_____, you have tried so hard"
"Informing"	Giving information and then asking about the impact of the information on the patient	"There is another way of achieving what you wanted; I am wondering if you would like to hear about it?" (Tell) (And then) "How does knowing _____ affect the way you look at/feel about changing?" "The outcome need not be like that…" "You can bring your own water bottle to work instead of getting soft drinks"

(2) EXPRESS EMPATHY

The process in facilitating change is highly dependent on the quality of the communication. Empathetic statements are useful in validating the experience of the patient about change. They may also help convey the practitioner's understanding and acceptance of the patient. These in turn deepen the rapport between the practitioner and the patient, which promotes the platform for the collaboration, exploration and risk taking necessary to facilitate change.

(3) ROLL WITH RESISTANCE

Resistance may be understood as the patient's way of regulating information – where they resist may be what they are not comfortable or unsure to talk about at the pace in the consultation. However, resistance may also occur when they do not seem to understand fully. Moreover, resistance is often a manifestation of the interpersonal process between the practitioner and the patient – they cannot resist themselves; resistance occurs when there is a difference in the stances. Therefore, the practitioner should consider these aspects upon encountering resistance. Confrontational stance is not recommended in MI. Instead, a more accepting attitude that also helps both parties explore the difficulties behind the resistance is the preferred approach in MI.

(4) SUPPORT SELF-EFFICACY

Consistent with the key ideas of MI is the concept that the patient is the one who is doing the work on change, not the practitioner. The practitioner expresses and maintains the belief that the patient has the ability to derive and implement their own plans for change. Part of the process therefore involves ensuring that the patient is well-supported and empowered to change. Imparting information and skills to the patient may be required to promote the readiness for change. However, practitioners should be cautious not to inadvertently reduce the patient's sense of efficacy by adopting the role of the "expert". In MI, the agent and "expert" about change remains the patient; the practitioner only facilitates the patient's own plan and pace of change but may occasionally provide professional input when this is invited by the patient.

Abiding by these principles, the practitioner then applies the following core skills in a consultation for change, which includes asking, listening and informing:

Box 2 Talking about change

Practitioner	Patient
Do you smoke?	*Yes*
How much are you smoking now?	*About 20 cigarettes a day*
Do you intend to stop smoking now?	*Not really*
Not really?	*Yeah*
Why not?	*I just don't feel like stopping cigarettes at this time. I tried stopping last time and I can't concentrate at work after that.*
I must inform you that the cough and breathlessness that you are having is caused by smoking…	*It isn't so bad. It is just a temporary cough; it gets better with the cough mixture. I can still carry on doing my work in spite of the cough.*
As your doctor, I must tell you that smoking is harmful to you and your family. Don't you care for them? *I think you should start on medication to stop smoking*	*My family is not really complaining since I cut down from 2 packs to one and a half a day.* *No need lah! I think I can stop smoking when I really want to.*

Using the core skills, MI explores the patients' inner motivations and helps them to recognise and be responsible for it. When the need for change and the plans for change are owned by the patient, and together with the proper skills either inherently derived or imparted by the practitioner, the process of change and the motivation to keep and maintain change becomes the natural outcome.

The core skills look deceptively simple but the challenge is in maintain fidelity with the four key principles as we apply these "simple" skills. This often requires some awareness of our conversation and discipline. When properly applied, what would transpire is "change talk".

Talking about change

What is also known to reflect the patient's motivation to change is the patient's use of commitment language in a dialogue about change[9]. Generally, those who talk about change, in particular the desire, ability, reasons, need, and commitment for change tend to change. Conversely, those who talk against change are less likely to do so.

Change talk

Facilitating the patient to process and speak more about why and how to change then becomes one of the strategies to motivate change. In MI, this is known as change talk. Change talk may not be so peculiar when we reflect that people often self-talk before doing something they are not so confident or capable of doing, such as speaking on stage or an athletic performance. The content of such self-talk often includes expressions of the importance (e.g. "there are many reasons for me to do this") and confidence to change (e.g. "I feel I can do it now"), which are the determinants of readiness to change in the MI model. By utilising the patient's ability to literally talk themselves into or out of behaviour change, evoking commitment language from patients is a key part of MI work.

Righting reflex

Yet, it is also not uncommon that conversations between practitioners and patients often suppress change talk instead. One of the common impediments is the practitioner's behaviour of trying to fix the "unhealthy" lifestyle or behaviour of the patient for "his/her sake". Examples of such behaviour include attempts to convince patients that they have a problem; arguing for the benefits of change; telling clients how to change; and warning them of the consequences of not changing. This behaviour has been termed the righting reflex in MI. And while it may have originated from positive intentions, it failed to recognise the phenomenon of ambivalence - an ambivalent patient would in such circumstances be encouraged to respond by arguing against changing. An example of such a conversation is shown in Box 2.

In MI understanding, the practitioner has played the wrong role by encouraging the patient to speak against change. The person who should argue for change is the patient and not the practitioner. Evoking the patient's own arguments for change is therefore the appropriate role of the practitioner.

GETTING PATIENTS TO TALK ABOUT CHANGING

Maintain a sensitive curiosity about the stage of change or state of readiness that the patient presents with, e.g. Why is it important for them to change now? What's difficult about staying unchanged? How do they think they can change? Understand the motivation of the patient and reflect it back to them. Elicit "change talk", the content of which includes acknowledging the problems of remaining the same, recognising the benefits of change, intent and commitment to change, and optimism for change. Once change talk is elicited, the ways the practitioner can respond are:

• Elicit more (with open questions)

Box 3. Decision Grid (about losing weight)

	No change	Change
Cost/dislikes	e.g. I tire easily; my knees hurt when I walk; I can't get into my dresses; I am embarrassed to wear a swimsuit; I get teased by my colleagues and strangers	e.g. I need to set aside time for exercise; I will miss my favourite snacks; I will have to get a new wardrobe of clothes
Benefits/likes	e.g. I can get up from bed later; I can avoid embarrassing myself in the gym; I can enjoy the food that I like	e.g. I will feel lighter; I can be feel better about my body; I will be able swim again, which I like; I feel healthier and fitter there are more clothes available to me

After listing down in the boxes, ask: "What are your thoughts as you look at the advantages and disadvantages of changing and not changing?" You may also reflect to the patient the considerations involved in changing.

• Affirm
• Reflect
• Summarise

Some other helpful strategies include:

• Providing information

While simply telling or giving advice to patients has not been found to be useful, patients nevertheless need appropriate information in order to self-manage. One technique is the "elicit, provide, elicit" technique where after the patient's understanding about a matter is elicited, the practitioner provides some other supporting information and then checks back with the patient, the personal implications of the information that has been provided [2]. For example, "Can I check what's your understanding about the control of your diabetes so far?"; then "You are quite right about…, and in addition, other similarly important aspects might be…"; and finally, "So, now knowing these aspects about care, how might that affect the way you deal with your diabetes condition?".

• Exploring importance

We can explore and assess the importance for change with the following questions:

o "How important is keeping up with the medication daily for you right now?" (Explores the patient's sentiments, fears and possible competing issues)
o "On a scale of 0 to 10, where 0 is not important and 10 is extremely important, what would you say the level of importance for changing is?"
o "Can you tell me why you have given yourself a score of x instead of 1?" (Elicit patient's positive reasons for change); "How can you go higher?" (Explores perceived options); "What stops you from moving up from x to [higher number]?" (Explores the perceived obstacles)

• Decisional balance

Another way is to examine the costs and benefits of changing or staying the same. This process helps the patient self-reflect on the internal-external discrepancies, and the ambivalence about change.

Doing so can generate tensions within the patient's internal "world views" which can motivate the patient to change [5]. This process may be achieved with the visual aid of a 'decision grid' as shown in Box 3.

• Enhancing confidence

The following sequence may help assess and enhance confidence:

- "How confident are you right now in changing?"

- "On a scale of 0-10, how confident would you say you are now?"

- "Why had you scored x instead of 1?"; "How can it go higher?"; "What would help you to become more confident?"; "What stops you moving up from x to [higher number]?"

Another method is to brainstorm with the patient the possible courses of action and then allow the patient to choose what is suitable. The purpose is to help the patient realise that there is choice among the many possible courses of action, while conveying optimism. Sometimes, it may be appropriate to talk about the patient's past efforts and his or her successes and failures – to affirm previous attempts at change and past successes. It is not about emphasising the success or dismissing the failures. Rather, helping the patient appreciate a balanced appraisal of the past performances (not the person) is the practitioner's task.

It is however vital not to overinflate the importance of change or the patient's confidence about change. Premature and ill-prepared attempts may lead to disappointments and a sense of failure. The goals for the patient should be realistic and specific, even if they are "small gains" in the eyes of the practitioner. What is important is that they represent the patient's choice and context.

• Other related interventions

Sometimes, it is necessary to provide certain specific interventions before the patient can proceed to make specific changes. For example, relaxation techniques may be useful for patients who are under 'stress' or anxiety. Social interventions should also be considered if mundane needs such as housing rental, child care, marital counselling, job placement etc are wanting. Depending on culture and social status, many such basic needs may rank above health concerns. Adopting this stance may be easier said than done, as many practitioners can feel compelled to revert back to the directing style because of time constraints or if they perceive an urgent need to impose change because of dire medical state of the patient.

Some useful questions in talking about change are shown in Box 4.

Box 4. Top 10 useful questions[2]

What changes would you most like to talk about?
What have you noticed about …?
How important is it for you to change…?
How confident do you feel about changing…?
How do you see the benefits of …?
How do you see the drawback of …?
What will make the most sense to you?
How might things be different if you…?
In what way…?
Where does this leave you now?

PIECING THINGS TOGETHER

One may notice that the MI is a rather principle-driven style of approaching patients rather than a set of techniques. Merely applying MI as a rigid set of techniques would not have been effective in facilitating behaviour change. The rapport with the patient remains critically important for successful change facilitation. As defined, MI is a client-centred approach that respects patient autonomy and efficacy. It requires the practitioner to have genuine curiosity about the patient's circumstances and positive regard for the patient to plan and carry out the change. Creating that safe, non-judgmental and non-confrontational experience during the consultation to enable the patient to explore and process their ambivalence, conflicts and resistance so that they can proceed to change is the desired goal of such sessions. A cookbook or checklist approach is therefore incompatible with this style.

GOAL SETTING

Once the patient decides to change, goal setting becomes the next important process. Goals that are unachievable frustrates and demoralises the patient and discourage them from seeking change. On the other hand, a strategic series of achievable goals can increase the patient's sense of self-efficacy and put the patient on track for a successful change of behaviour. The following recommendations come from our understanding of how goal-setting affects performance:

• Goals that are specific ("I will walk for 30 minutes on Mondays, Wednesdays and Fridays in the park"), preferably including aspects of what, when, how much and how often, are more likely to succeed than vague ones ("I will try to control my food intake", "I will lose some weight")

• Proximal (short term and specific) goals are associated with better performance than distal (long-term and general goals). Short-term goals, also known as action plans, are more likely to result in early success (which enhances self-efficacy), which in turn leads to setting of higher level goals subsequently. Hence, a proximal goal may be "I will bring my own drinking water to work and not consume any soft drinks during lunch", which while not really achieving a holistic dietary modification, may be more useful in the long run than the goal of "I will lose 10kg of my body weight".

Needless to say, the goal setting process must be done in collaboration with the patient, with the patient having the final say.

PATIENTS WHO CHANGE THEIR MINDS

Some practitioners may find it disheartening to have patients who seemed all motivated to change after a rousing session in the clinic but only to return the next session without having achieved much. While this may be an issue with goal setting, it may also reflect the ambivalence around change or it can be a matter of changing circumstances. It is also realistic to accept that change does not occur just because the doctor wants it to happen, even if we use MI, and at the pace we want. Understanding the complex nature of unhealthy behaviour allows us to appreciate that much psychosocial adjustments may be required before change actually takes place. Change is also not a fixed state in which the patient remains indefinitely. Sometimes, after preliminary attempts to change and even after achieving the initial changed behaviour, a new set of challenges appear in the maintenance of the changed behaviour. In these scenarios and those where the patient seemed to have slipped backwards, the practitioner will do well to stick with the supportive, though directive, stance of MI. The fact that the patient returned allows further opportunity to engage and explore in a non-judgmental, empathetic and respectful way the patient's endeavours in change, no matter how small they may turn out to be. The continued positive experience with the practitioner will go a long way in securing lasting success in change eventually.

CONCLUDING COMMENTS – IT ALL SEEMS RATHER DIFFICULT FOR THE PRACTITIONER

No one says that changing behaviour is easy, but leaving unhealthy behaviours in patients with chronic medical conditions is no longer justifiable. Yet, behaviours are often the complex product of historical, bio-psycho-social and environmental situations such that any change is unlikely to take place just because the practitioner directs the patient to

do so. What we need to do is to understand how change takes place, and to learn new skills of facilitating change in patients.

(1) It's such an unnatural way of communicating

Some practitioners may find applying these ideas and methods awkward. This is to be expected in the initial stages as it requires a different way of thinking about and talking to patients. Such an experience is not so different from learning a new language, learning to swim or cycle (where every movement seems strange to the body). For those who feel these methods are rather "unnatural", "artificial" or "unreal", it is probably so because we have long been accustomed to the "usual" doctor-centric relationship which is incidentally more suited to the sporadic and exceptional situations of acute medical care provision and less applicable to caring for patients living in the community. In other words, maintaining the status quo, where patients have to abide by the practitioner's model, may actually be more contrived. Think about it – we will probably not use the usual "doctor speak" with our friends and family! MI on the other hand, may be "friendlier" and socially compatible because of its humanistic origins.

(2) Is there a best way to behaviour change?

No one style fits all patients. Indeed, some patients may respond best with a directing style or relationship. Ultimately, the practitioner needs to have a respectful attitude to the patients and be open to changing styles and methods to be in tandem with the patient's responses. Imposing the practitioner's ideas about change, even if this in accordance with some well used guideline may not necessarily lead to successful change. Duncan and his colleagues have gathered evidence to show that rather than the type of therapeutic intervention provided or the techniques used, the factors that determine outcomes may have more to do with the patient's perceptions of the therapeutic relationship, how consistent the method used is with the patient's own theory about change, whether they feel comfortable and respected, and the level of active participation. Needless to say, the practitioner's ability to find a complementary 'fit' with his patient affects these factors [10-12].

(3) Will I be able or have the time to do this?

By now, it should be obvious that it takes time for the patient to change his/her behaviour. It also requires that the practitioner also spend some time in guiding the patient. But this investment in time may be more efficient and sound, when compared with numerous times the practitioner has to spend giving futile advice for patients to change, or the situation where the patient has repeated consultations for complications arising from the failure to change.

Fortunately, the practitioner may find some solace that sometimes, even brief interaction, if done skilfully may have a significant impact on the patient's behaviour change [7,13]. Understanding and applying what we know about the processes of behavioural change, and making the shift towards a guiding style, which encapsulates principles such as collaboration, negotiation, respecting patients' autonomy, and supporting self-efficacy, might be good beginning steps. The guiding style, on which MI is based, is within the reach of the busy practitioner [2].

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LEARNING POINTS

- **Patients are often advised to adopt healthier behaviours or change unhealthy ones on the basis that what they are doing or not doing is detrimental to their health.**
- **MI was initially developed by Rollnick and Miller as a strategy for addictive behaviour change, but it has found many applications in helping patients change other health related behaviours.**
- **MI was initially defined as a client-oriented, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.**
- **The guiding stance, whilst respecting the patient's autonomy and the patient as the agency of change, maintain controls of the direction and structure of the consultation to evoke the patient's own arguments and strategies for change.**
- **The four counselling principles in MI are: Develop discrepancy; Express empathy; Roll with resistance; and Support self-efficacy.**
- **Facilitating the patient to process and speak more about why and how to change then becomes one of the strategies to motivate change. In MI, this is known as change talk.**
- **Once change talk is elicited, the ways the practitioner can respond are: Elicit more (with open questions); Affirm; Reflect; and Summarise.**
- **Once the patient decides to change, goal setting becomes the next important process.**