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Influencing behaviour change in general practice

Part 2 – motivational interviewing approaches

Background

Behaviour change toward achieving a healthy lifestyle is important for all Australians, and general practitioners have a key role to play in assisting patients to make these changes.

Objective

This is the second of two articles on influencing behaviour change in general practice. This article deals with the 'how to' of motivational interviewing in the general practice setting.

Discussion

Motivational interviewing can help build motivation, commitment and confidence to change. General practitioners can use motivational interviewing to help their patients achieve their health goals. Motivational interviewing is not about a set of techniques and questions; it is about creating a climate that facilitates change; it is more about listening than telling, evoking rather than instilling. Motivational interviewing can be done in the brief periods available in consultations over time.

■ **Motivational interviewing (MI) is a collaborative person centred guidance strategy to elicit and strengthen motivation to change.¹ It evolved from Carl Roger's client centred counselling approach which focuses on the person's interests and concerns, but differs by being consciously directive toward resolving ambivalence and moving toward change.² The goal is to increase intrinsic motivation rather than to impose it externally.³ It was initially developed from work with problem drinkers, where in comparison with confrontational directive styles, motivational reflective styles were associated with lower levels of resistance and a higher likelihood of long term change.⁴**

The 'spirit' of MI is collaborative (a partnership between the patient and the clinician), evocative (evoking from the patient's own values, goals, insights, motivation and resources for change), and honouring patient autonomy (acceptance that the patient makes his/her own choices).⁵ It is particularly useful for those who are reluctant to change or ambivalent about changing behaviour.⁶

Motivation is seen not as a personal trait, but as an interpersonal process that results from the interaction between the practitioner and the patient. How the practitioner acts influences motivation to change. Resistance to change and denial is considered a signal to the therapist to alter strategies.³

Ready, willing and able to change

For behaviour change to occur, a person has to want to change, feel that they can change, and feel it is the right time to prioritise this action.³ Motivational interviewing can help build motivation, commitment and confidence to change. Simply knowing that change is needed is not enough. Even if a person wants to change, they need to believe that they can before they take action. According to the protection motivation theory (PMT) developed by Rogers,⁷ if a person believes there

is a serious health threat but does not believe that anything can be done about it, the results are defence mechanisms and denial to reduce the emotional arousal associated with this knowledge of threat⁸ (Figure 1).

The guiding principles of motivational interviewing

The acronym 'RULE' summarises the principles of MI:⁵

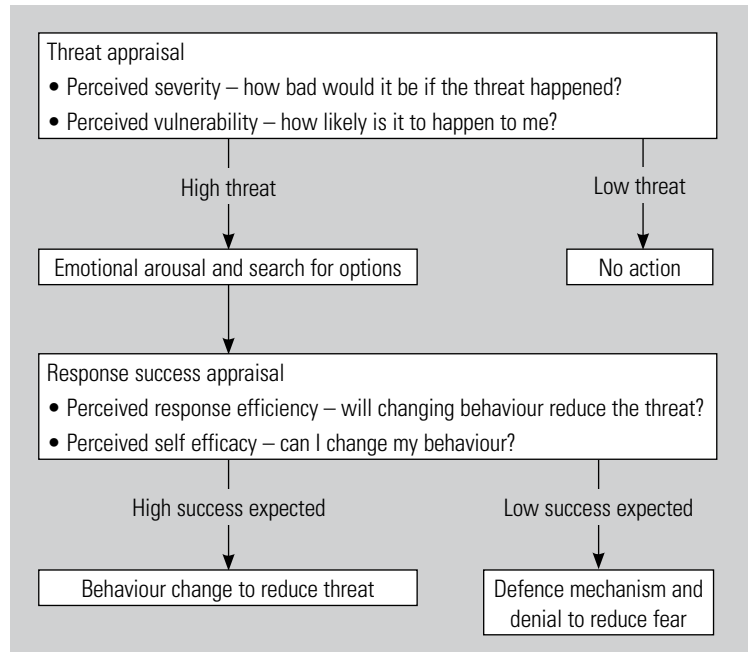
- Resisting the righting reflex – resisting the need to solve problems or tell patients what to do. This may seem at odds with the philosophy of brief intervention in which GPs are encouraged to advise patients to change their behaviour. However, repeatedly advising behaviour change in those who are not ready to change may increase their resistance and therefore be counterproductive
- Understand and explore the patient's own motivations – humans tend to believe what we hear ourselves say.⁵ Bem's self perception theory suggests that what we say and do influences our own attitudes.⁹ Hearing someone else say something is not as powerful as hearing ourselves say it. The goal of MI is to increase intrinsic motivation rather than to impose it externally
- Listen with empathy – in achieving behaviour change a key task is to listen in a way that will draw out the patient's issues so that it can be heard by both the patient and the doctor
- Empower the patient by encouraging hope and optimism – patients know better than anyone else how to change their own behaviour but may sometimes lack confidence in their own ability. A skilled practitioner encourages patients to vocalise why and how they intend to change during the consultation, knowing that this both reinforces the patient's own expertise in their own actions and influences the patient's attitudes.

Asking instead of telling draws out the patient's thoughts, feelings, understanding and motivations. For example, 'Your blood sugar is high. What do you think of that? Does that worry you? Why do you think it's gone up? What can you do about that? Do you think you can manage that? How have you managed to do it before?' The answers to questions give us insights to the person's level of knowledge and beliefs, helping us to provide more relevant information and an appropriate response.

A second acronym, which provides useful strategies during consultations, is 'GRACE'.¹⁰

- Generate a gap – motivation for change happens when people perceive a discrepancy between where they are and where they want to be.¹¹ Raising awareness of the adverse consequences of behaviours by exploring experiences, values and attitudes nonjudgmentally can help generate this gap
- Roll with resistance – if the individual perceives an attack, defensiveness ensues, which evokes resistance. The patient's resistance is not challenged, instead MI 'rolls with' the momentum, viewing ambivalence as normal. In this way resistance is decreased and new perspectives are invited by exploring ambivalence openly.¹¹ For example: 'Oh no, you're not going to have a go about my smoking again!' can be met with, 'Has someone been giving you a hard time

Figure 1. Protection motivation theory⁸



over this? What do you think of that?' These questions can evoke consideration toward change from the individual

- Avoid arguing – it should be the individual and not the clinician who voices the arguments for change.³ The goal of MI is to encourage the individual to hear themselves say why they want to change. If the doctor is perceived as challenging the patient's position and not listening, then the patient will work harder to try to convince the doctor of the arguments for not changing. In the process of vocalising the reasons against change, they reinforce their own resistance to change since humans tend to move toward congruence between external actions (speech and action) and internal attitudes (beliefs and values).^{9,12} Avoid the 'yes, but...' arguments where you and the person argue over change. Instead try, 'I'm wondering if you have any ideas about how you can exercise more, even when you're very busy?' Or, 'It sounds like my ideas aren't very good. Do you have any ideas?'
- Can do – a person convinced of a need to change will not move toward change without self efficacy (belief that they can succeed).¹³ Without this, they are likely to adopt defensive coping (eg. rationalisation, denial) to reduce discomfort instead of behaviour change.¹¹ There is no 'right way' to change, and all previous attempts and learning, as well as pharmacotherapy and psychotherapy options, can be explored
- Express empathy – listening and communicating acceptance, understanding of ambivalence and respect for the individual's decisions.¹¹ Active listening is encapsulated by the acronym 'OARS' (open ended questions, affirmations, reflective listening, summaries).³ Each clinician develops a unique style, which might involve a blend of empathy, humour, 'straight talk', encouragement and other personal touches which can be adapted to the individual consultation.

Eliciting 'change talk'

Motivational interviewing can be divided into two phases: building motivation and strengthening commitment.³ Miller and Rollnick use the term 'change talk' to refer to statements from the individual that reinforce the movement toward change. The aim is to elicit 'change talk' statements through skilful questioning and reflection which express the following desire, ability, reasons, need and commitment (DARN-C)^{14,15}:

- Desire – I want, I so want, I wish
- Ability – I can, I could, it's possible, I know I can
- Reasons – because, since, I'm sick of, I hate it

- Need – I must, I need, important, got to, really have to
- Commitment – I will, I'm going to, it's time now.

In eliciting change talk, instead of giving information, we ask questions and invite comments that draw out the patient's expressions of what, why, how and when to change. Among the 'change talk' statements, 'commitment talk' is the most predictive of change. *Figure 2* demonstrates the uphill process of exploring ambivalence and building motivation while encouraging change talk. Building commitment becomes easier as resistance decreases and motivation increases.

Changing behaviour in general practice

People are often ambivalent about health behaviours and resistance and change are two sides of a coin.¹ It is important to stress that MI is not about a set of techniques and questions; it is about creating a climate that facilitates change; it is more about listening than telling, evoking rather than instilling; and communicates, 'You have what you need, and together we will find it'.¹⁶ Motivational interviewing can be done in the brief periods available in consultations over time¹ (*Table 1, Case study*).

Relapse management

Lapses (a brief return to the earlier behaviour) and relapses (a sustained return to the earlier behaviour) are common. It is important to stress that a lapse is different to a relapse and can result in new behaviour. Both clinicians and patients will often feel a sense of failure when relapses occur. This can be reframed, eg. 'I'm a failure' can be viewed as a partial success in a person who knows what needs to be changed, who is motivated to keep going despite adversity, and is willing to accept

Figure 2. Encouraging change talk: stages and tools¹⁸

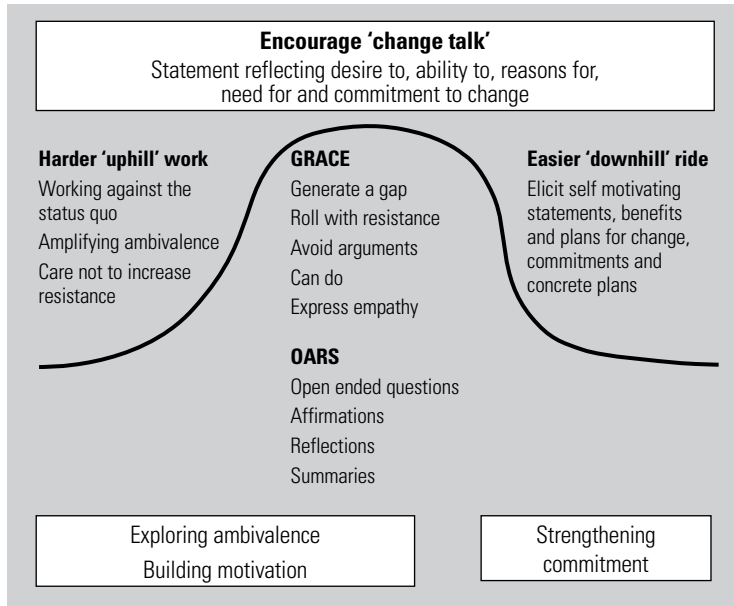


Table 1. Questions to facilitate discussion in motivational interviewing in general practice

Brief: The following questions can be used within a 5 minute discussion	
Question	Rationale
'What do you like about (your smoking or other behaviour)?'	This question is unexpected as most would be expecting a lecture. It gives an opportunity to listen and build rapport. It also gives valuable information that helps to understand the context of the behaviour. It may also be important to consider how to replace this function if the behaviour were to stop
'What don't you like about...?'	This question is critical as it draws out the internal motivation for change
If appropriate you can add your own concerns	If you believe that adding your own concerns about the behaviour might help to tip the balance toward change and not increase resistance, this can be done
Summarise: 'So you like... but you don't like..., so where does that leave you?'	It is up to the patient to decide what needs to be done
Summarise, agree on a plan	Aim to get commitment to a plan which might range from action to change, an agreement to return to discuss further or an agreement for the issue to be raised again later
Briefer: The following questions can be used within a 1–2 minute discussion	
'On a scale of 1–10 where 10 is a lot, how much do you want to... (make the change)?'	The patient will usually pick a number higher than 2. Regardless of the answer, you can usually ask the next question. If the answer is 2 you can ask, 'Why so high, why is it not 1?'
'Why so high?'	The patient then tells you why (s)he wants to change, ie. argues for change
'So what do you want to do about it?'	The patient then states how to move toward change. Again aim to get a commitment to a plan which might range from action to change, an agreement to return to discuss further or an agreement for the issue to be raised again later

help to achieve this goal.¹⁷ The goal is to build self efficacy, strengthen commitment and to support. Behaviour change takes time and people may move backward and forward before achieving longer term change.

Case study

Dr M is running late, trying to get on to her next appointment. Her exiting patient, Kyle, hesitates with his hand on the doorknob, and says, 'I know you've been on at me forever but I think I need to stop smoking'. [Heartsink – 'I do need to deal with this now, but I don't have time'.] Dr M says, 'Tell me the most important reason you need to stop smoking now'. When Kyle answers, she notes these (now understanding his internal motivation), agrees they are very important reasons (reinforcing his motivations) and says she'd like to work with him on this. She asks, 'Are you willing to commit to coming back to talk to me next week to set up a Quit plan?' (builds commitment). That conversation took less than 1 minute and leaves the patient with enhanced motivation and a commitment to return to discuss the change plan.

Note: Providing the patient with a decisional balance sheet to consider at home can help some people to see their dilemma more clearly but the decisional balance technique differs from MI in that it gives equal weight to pros and cons, while MI deliberately aims to influence the direction of change by strengthening internal motivation for change and avoiding reinforcing reasons against change.¹

Conclusion

General practitioners are in a strong position to make a difference to population and individual health outcomes in Australia as they provide continuing primary health care. Each GP develops a personal communication style, which is effective in changing behaviour in a proportion of patients, but having a range of tools such as MI helps achieve greater change.

Resource

The October 2009 issue of The Royal Australian College of General Practitioners' **check** Program, contains case studies that illustrate the practical application and complements the theoretical discussion in this series of articles. Available at www.racgp.org.au/check. Conflict of interest: none declared.

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