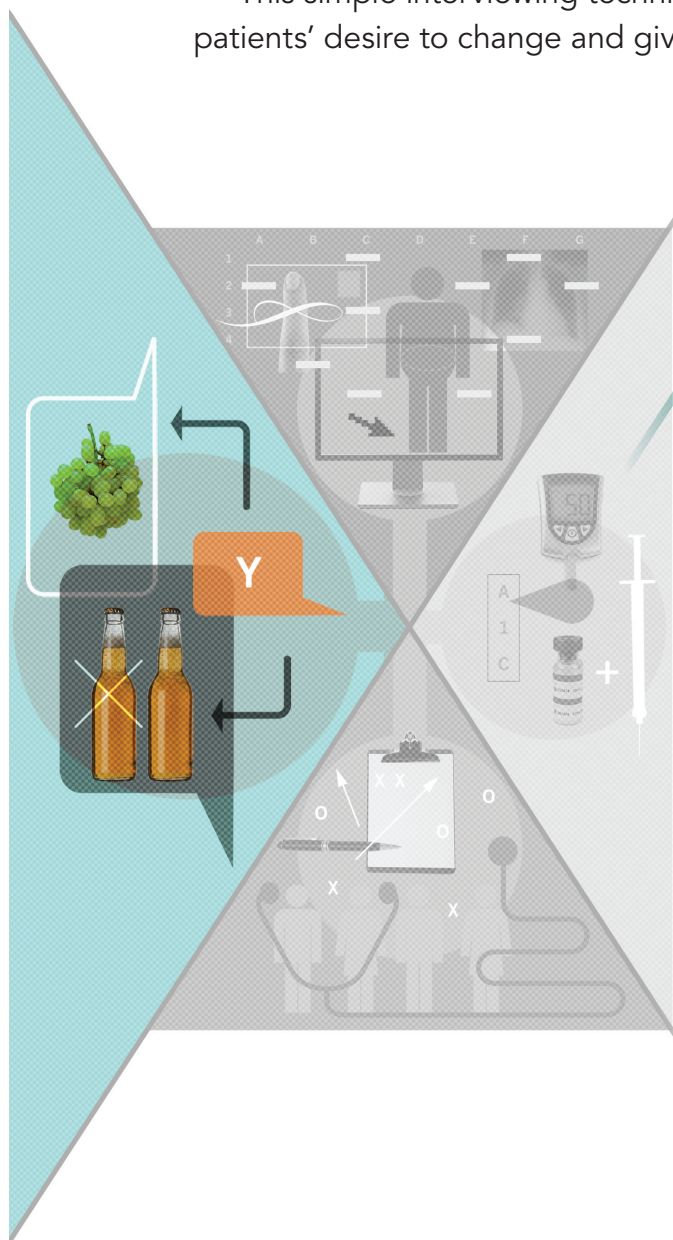


ENCOURAGING PATIENTS TO CHANGE UNHEALTHY BEHAVIORS WITH MOTIVATIONAL INTERVIEWING

This simple interviewing technique is designed to stimulate patients' desire to change and give them the confidence to do so.



Marcus is a middle-aged patient with hypertension, diabetes and hyperlipidemia who came

to see me (CF) for a routine check-up. All of his numbers were getting worse, and as I began to describe this to him, he started to cry.

I had just received training in something called “motivational interviewing” as part of a research study I was participating in, so I immediately stopped the interview and said, “I would like to try something new with you. Let’s forget about your numbers for now and work on small goals that you feel you can accomplish. If you had one eating habit that you could change, one that would improve your health, what would it be?”

“I eat too many fried foods,” he responded, explaining that he went to a certain fast-food restaurant five times a week.

“What do you think you could cut that down to?” I asked.

“I’m going to cut out the fried foods entirely,” he said.

I explained, “That’s not how this works. We want to set a goal that you are sure you can succeed at.”

Marcus insisted that he could do it; he would not eat any more fried foods by the time I saw him next month. He was no longer crying, and he seemed to feel much better about the encounter. I too felt much better about the encounter. In a very short time,

THE GOAL OF MOTIVATIONAL INTERVIEWING IS TO HELP THE PATIENT RESOLVE HIS OR HER AMBIVALENCE, DEVELOP SOME MOMENTUM AND BELIEVE THAT BEHAVIOR CHANGE IS POSSIBLE.

I had developed a sense of closeness and empathy with him that was remarkable to me.

When he came back one month later, he had actually accomplished his goal. He went to the fast-food restaurant only once a week, and when he did he ordered a salad. He reported that he liked this goal-focused approach, was no longer afraid of me and felt like I was his friend. Since that time, he has lost more than 40 pounds and has maintained this loss for more than a year. He is much more active and has reduced his use of pain medicines for chronic back pain.

Nearly every family physician has been there. Patients present with chronic diseases directly associated with their lifestyle habits and choices, yet they feel unable to improve their conditions. Often, what patients “should do” is obvious to the physician – e.g., lose weight, stop smoking or start exercising. What is not so obvious is *where* these patients are on their journey toward change, and *why* they are so reluctant to take the next step. For patients at a crossroads, feeling ambivalence or frustration, this may be the perfect opportunity to introduce the philosophy and technique known as motivational interviewing.

What is motivational interviewing?

Motivational interviewing is not a new concept. It was conceived in the early 1980s when American psychologist William R. Miller, PhD, described a therapeutic approach he had used with some success for people with alcohol problems.¹ Today, Miller and colleagues describe motivational interviewing as “a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.”² Essentially, it is a method for changing the direction

of a conversation in order to stimulate the patient’s desire to change and give him or her the confidence to do so. In contrast to many other change strategies employed by health care professionals (such as education, persuasion and scare tactics), motivational interviewing is more focused, goal directed and patient centered. A critical tenet is that the motivation for change must emanate from the patient rather than the physician. Although the majority of motivational interviewing training and study involves focused therapy, there is evidence that very brief (five-minute) sessions have positive results, particularly when patients are highly resistant to change.³ Thus, motivational interviewing is a strategy with great potential for time-pressed family physicians and their care team members.

Motivational interviewing starts with a collaborative, friendly relationship between the physician and patient. This requires that the physician have empathy toward the patient and recognize that a patient’s resistance to change is typically evoked by environmental conditions rather than a character flaw or the desire to make the physician’s life more difficult. In other words, the physician should not take it personally when a patient struggles to change. Instead, the physician needs to “let go” of the outcome, support self-efficacy,

■ Motivational interviewing is designed to stimulate the patient’s desire to change unhealthy behaviors.

■ The counseling technique is focused, goal directed and patient centered.

■ It requires the physician to first establish a collaborative relationship with the patient and have empathy toward him or her.

About the Authors

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allow the patient to be responsible for his or her own progress, and let the patient identify and articulate his or her intrinsic values and goals. For example, if an obese patient sets a physical activity goal of simply “walking to the mailbox each day,” the physician should show support for that goal, even though it may seem small.

The objective is not to solve the patient’s problem or even to develop a plan; the goal is to help the patient resolve his or her ambivalence, develop some momentum and believe that behavior change is possible. Because of time constraints and medical training, most physicians are quick to propose solutions; however, doing so often denies the patient the opportunity to consider different courses of action and their associated benefits and costs. Many times these courses of action are confusing, contradictory and deeply personal. Allowing the patient to explore these issues increases the chances that the patient may find an acceptable resolution.

OARS: A structure for putting motivational interviewing into practice

You may be ready to embrace the spirit of motivational interviewing, but some structure can help. The OARS acronym offers four simple reminders.³

1. Open-ended questions. Avoid asking questions that can be answered with a “yes” or “no.” Broad questions allow patients maxi-

mum freedom to respond without fear of a right or wrong answer. It can be as simple as, “What’s been going on with you since we last met?” Another question, appropriate for almost anyone, would be, “If you had one habit that you wanted to change in order to improve your health, what would that be?”

2. Affirmations. Never underestimate the power of expressing empathy during tough spots or in celebrating patients’ accomplishments. When you review patients’ goals, take joy in their success and show your joy. One of the authors (CF) even gives patients gold stars – the same ones distributed in elementary school. Patients love getting them and wear them proudly.

3. Reflective listening. Patients often have the answers; the physician’s role is to help guide them. Reflective listening involves letting patients express their thoughts and then, instead of telling them what to do, capturing the essence of what they have said, with the purpose of eliciting conversation and helping them arrive at an idea for change. Here’s an example:

Patient: “I wish I didn’t eat so much fast food.”

Doctor: “You eat fast food fairly often.”

Patient: “Pretty much every day. I know I shouldn’t, but it’s just easier.”

Doctor: “It’s easier because you don’t have to plan and cook meals.”

Patient: “And I can just run over to the drive-through.” ➤

■ The emphasis is on helping the patient consider different courses of action, identify personal goals and take responsibility for his or her progress.

■ Open-ended questions and statements of affirmation are helpful to the process.

■ Reflecting patients’ thoughts back to them can elicit conversation and help them arrive at their own ideas for change.

CAPTURING THE SPIRIT OF MOTIVATIONAL INTERVIEWING

When using motivational interviewing, remember these principles:

1. Motivation to change is elicited from the patient, not imposed from outside.
2. It is the patient’s task, not the physician’s, to resolve his or her ambivalence.
3. Direct persuasion is not an effective method for resolving ambivalence.
4. The counseling style is a quiet one, with a focus on eliciting the patient’s thoughts.
5. The physician is directive in helping the patient examine and resolve ambivalence.
6. Readiness to change is not a patient trait but a fluctuating product of interpersonal interaction.
7. The therapeutic relationship is more like a partnership or companionship; expert/recipient roles can impede the process.

For more information, visit <http://www.motivationalinterview.net>.

Doctor: “So you don’t want to give up the convenience of fast food, but you would like to eat healthier.”

Patient: “Right. ... I guess there are some healthy items on the menu.”

It is also appropriate to acknowledge the patient’s mood about what he or she is telling you. For example, “You mentioned that you won’t go in public in a bathing suit because of your weight. That seems to make summertime very stressful for you.” Reflecting patients’ statements and feelings back to them reinforces self-efficacy, and it allows the conversation to keep moving forward.

4. Summaries. Summarizing involves recapping what the patient has said, calling attention to the salient elements of the discussion and allowing the patient to correct any misunderstandings and add anything that was missed. Summaries can occur throughout the visit but are particularly helpful in bringing the visit to a close. It is often effective to end a summary with an open-ended statement such as “I am wondering what you’re feeling at this point” or “I am wondering what you think your next step should be.”

Using these techniques, you can help the patient identify a specific and achievable goal. The patient must affirm that he or she will actually accomplish the goal, not just try. Ask the patient to state the goal (this helps to confirm agreement), and then write it in the chart, letting the patient know that you will review it together at the next visit, or perhaps by phone or e-mail between visits.

Real-life experiences

Motivational interviewing played an important role in a recent research project, Ameri-

cans in Motion-Healthy Interventions, or AIM-HI (<http://www.americansinmotion.org>). This three-year project gave family physicians and practices a variety of tools and strategies designed to help patients adopt fitness as the treatment of choice for lifestyle conditions. (See “Four Strategies for Promoting Healthy Lifestyles in Your Practice,” *FPM*, January/February 2011; <http://www.aafp.org/fpm/2011/0300/p16.html>.) The AIM-HI version of fitness involves a non-diet approach to healthy eating, physical activity of choice and a balanced lifestyle focusing on emotional well-being. Despite the non-diet approach, 18 percent of patients enrolled in the project had achieved a 10-pound weight loss after 10 months.⁴ Patients also saw improvements in eating habits and increases in physical activity.

One of the physicians participating in the research project, Andy Pasternak, MD, of Silver Sage Family Medicine and Silver Sage Sports Performance in Reno, Nev., practices what he preaches when it comes to fitness. He bikes, skies and qualified for the Boston Marathon. However, being a fitness role model isn’t enough to motivate patients to change. “You really need to get a sense of what their goals and interests are, not what you think they should be. It sounds so simple, but it’s really key. Let the patient set the goals.”

Pasternak recalls a patient who had been a smoker for years. At one visit, he finally asked whether she had ever considered quitting. “When she said she didn’t want to, I just dropped it and moved on,” he said. “Six months later she came back and said, ‘I like the way you approached the topic last time. This time, I think I’m ready to go. I want to quit.’”

One side benefit of this approach is that it takes pressure off the physician. “If someone

is not even in the contemplation stage, you can move on,” he said. “It’s liberating. Berating them or trying to scare them just takes up your time and energy. Let your patients tell you what they want to change.”

Summarizing the discussion during a visit can help the patient focus on the salient points and then identify a specific goal.

Goals should be achievable, written in the chart and reviewed at the next visit.

Motivational interviewing was a key tool in the Americans in Motion-Healthy Interventions research project.

IMPROVING PRACTICE THROUGH RESEARCH

This article is part of a series from the AAFP National Research Network (NRN) and its affiliates, a national collaboration of primary care practice-based research networks. This series is designed to help family physicians put research results to use in their practices.



“IF SOMEONE IS NOT EVEN IN THE CONTEMPLATION STAGE, YOU CAN MOVE ON. IT’S LIBERATING.”



Barbara Clure, MD, a research project participant and family physician in a small Native American community in the Northwest, says motivational interviewing has helped empower her patients. “In the past, my patients didn’t want to see me. They didn’t want the lecture,” she said. “Now they are making changes on their own – baby steps that add up to transformational, life-altering changes. Losing weight, quitting smoking, reducing medication – it’s actually happening.”

She notes that this patient-directed approach is especially appropriate for the Native American culture. “In the past, the doctor visits seemed conflict driven, and this was especially at odds with the native culture. Now they are more like conversations,” she explains. “If someone is not picking up their medications, I simply say, ‘I’d like to get your input on this. Let’s change it if it’s not working.’ It is amazing how such simple changes in tone can radically change the interaction for the better. It’s so satisfying to talk to my patients now. I know their struggles. I know *them*.”

Dr. Clure recalls a patient who had refused to go on a diet, so Dr. Clure simply asked, “OK, what *would* you like to do?” The patient devised her own plan of action and eventually lost weight, got off her medications, left a bad relationship, found a new job and bought a new house – all stimulated by that simple remark in the exam room.

Getting started

While the concept of motivational interviewing might sound promising, the thought of practicing it with patients can be overwhelming. To gain some experience, role play with partners, staff or even family members. Dr. Clure says she practiced the technique with her children and was surprised at how well it worked.

When you’re ready to involve your patients, start small with just one question, such as “If

you had one habit that you wanted to change in order to improve your health, what would that be?” or “What goal would you like to set that you are willing to accomplish?” An open-ended and non-confrontational question usually gets the conversation started.

You will be surprised by the ideas your patients come up with when given the opportunity. You may also find that as patients succeed in one area, they will apply what they’ve learned to other areas. One of the authors (CF) recently worked with a patient to set a goal of reducing bread consumption from six slices a day to four. One month later, she had not only accomplished her goal of eating less bread but had also quit smoking.

Motivational interviewing is less about the specific words or strategies that you use and more about the spirit you bring to the conversation (see “Capturing the spirit of motivational interviewing,” page 23). Don’t be afraid of saying the wrong thing; your patients will sense the rapport. After a few visits, the approach will become more natural to you and you will find, as Pasternak did, that “It actually frees you up.”

Clure adds: “I am excited to see patients again. I love helping patients realize they have the power within themselves to change.” FPM

Send comments to fpmedit@aafp.org.

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By emphasizing the patient’s role in behavior change, this technique empowers patients and takes some pressure off the physician.

Physicians can quickly learn the technique by role-playing with partners, staff or family members.

A first step with patients is to ask: “If you had one habit that you wanted to change in order to improve your health, what would that be?”