Behaviour change and motivational interviewing in the patient with diabetes

Young M, BCur(UP)
Diabetes Specialist Nurse, Centre for Diabetes and Endocrinology, Witbank Branch, South Africa
Correspondence to: Sr Madelein Young, e-mail: 27825780006@vodamail.co.za

Abstract

Motivational Interviewing (MI) is designed to motivate people to change by helping them to recognise and resolve the difference between a behaviour problem and personal goals and values. There are several challenges of health behaviour change in MI, as well as traps that the health care provider and patient can easily fall into. During the MI approach, a patient should be guided through the change model, providing him the chance to participate. There are several general principles in the MI approach as well as different interaction techniques. The efficacy of MI has been widely published in the literature.

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Introduction

A patient's personal motivation for behaviour change can be substantially influenced by the way in which a health care provider communicates with him. No person is completely without motivation. A health care provider can make a difference and have a long term influence on his patient's health. Motivational Interviewing is not a way to get people to do what they do not want to do. Rather, it is a skill to assist the patient by drawing from them their own motivations for making a behaviour change in the interest of their own health.[1]

"Diabetes is a chronic, manageable condition which requires major changes in lifestyle to optimise that management. Motivating behaviour change in people with diabetes is one of the most important but also more frustrating experiences for general practitioners."[2]

Motivating patients to change their behaviour can be very difficult. Patients tend to react against well-meaning efforts to enforce change. We sometimes expect patients to change because we simply believe that is in their best interest! They, on the other hand, may not be ready for change, and we label them as non-compliant…

The approach

There are different approaches in motivating a patient to make behavioural changes. The *informative approach* involves the delivery of predetermined information with a belief that by educating the patient it will lead them to the desired decisions and behaviour change. The *directive approach* makes the assumption that the health care provider will use their authority to tell the patient what he should do and what is best for him. Unfortunately, between behaviour change and receiving information, there is little correlation,[3] and a *prescriptive approach* is likely to attract passivity, enhance resistance or elicit superficial agreement from the patient.[4]

Motivational interviewing (MI) was originally developed to help people with drug and alcohol addiction. Over the last 25 years the MI approach has been used do address many lifestyle or behavioural issues such as diabetes, depression, obesity, AIDS/HIV, hypertension, sexually transmitted diseases, TB, exercise, healthy eating, smoking, sex, taking medication and use of alcohol.

Motivational interviewing is defined as a style or spirit that is essentially co-operative, respectful and guiding rather than confrontational, instructional and authoritative. Essential principles include the need for accurate reflective listening and expressing empathy without judging the patient or necessarily agreeing with what the patient is saying.[3] Behaviour change is understood to be a very difficult process that naturally involves inconsistency rather than a simple decision to change or not to change. The health care provider must seek motivation to change by highlighting contradiction between the patient's present behaviour and personal goals. Reasons for change are elicited from the patient rather that argued for by the health care provider.

The challenge

There are several challenges of health behaviour change in patients such as:

1. Patients who do not comply or who are experiencing a relapse. A system change might be needed. We as health care providers tend to look after the physical system but we are missing the spiritual area/system. How will the health care system change to suit the patient? We have to look at the mind, body and spirit of the patient. Giving responsibility to the patient is crucial. Rewards on change take very long in chronic diseases – and therefore compliance becomes a major issue. For the health care provider it will sometimes feel that the patient doesn't want to get well.
2. Patients do not always feel well after change. For example when a patient quits smoking, he/she will not feel great immediately afterwards as craving for smoking will probably cause them to feel grumpy and uncomfortable. The same applies for patients that attempt to get their blood glucose levels closer to normal

ranges after running high blood glucose levels for a long period. As they get closer to normal ranges they have increased hypoglycaemic events, which can be demotivating.

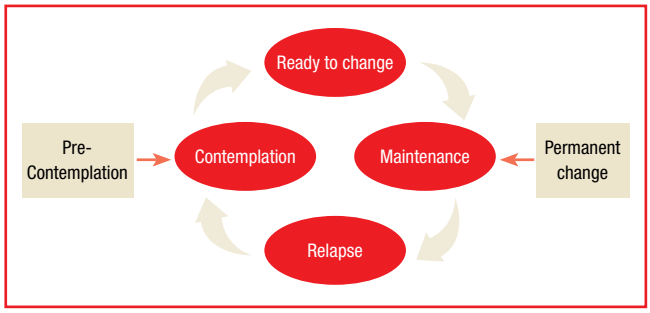
3. There is a great need for leadership. Teamwork is essential in change. A patient cannot maintain change on their own – there is a major need for help and support. Through MI you can uplift their spirits and keep them motivated.
4. The righting or correct reflex is a major challenge for the health care provider. Common practical beliefs explain the lack of readiness to change: don't see, don't understand, don't know how, don't care. We as health care providers need to initiate the decision for change but we miss the process of the decision. Richard Hooker (a theologian and writer from the 16th Century) said "Change is not made without inconvenience, even from worse to better".

Readiness for change

As health care providers, we expect all patients to be ready for change and speak to them about change prematurely. There is a model describing stages that each patient needs to go through before change can occur. This model identifies at least five different stages: pre-contemplation, contemplation, ready to change, maintenance and relapse (Figure 1).[2]

Patients oscillate between these stages constantly back and forth. On one consultation the patient may be at different stages concerning different changes to be made, for example the patient may be at pre-contemplation with regards to smoking (he is not even thinking about quitting), or he may be at relapse on diet (he started to control his diet, but the last few days he has been eating junk food and high fat foods again – ignoring his healthy eating guidelines). The health care provider should determine at which stage the patient is for each area of change needed.

Figure 1: Stages of Change Model[2]



Readiness to change is dependent on different aspects. A patient may feel ready for change, but don't have the confidence to make the change. The patient could feel confident to change, but doesn't feel it is important to change. The MI concept attempts to find where the patient is according to these aspects, and guide the kind of interaction that the health care provider will make.[5]

The readiness to change ruler is a tool that has been developed to use with patients (Figure 2).

The ruler can help the patient and health care provider to identify the reality of inconsistencies and to bring the patient's feeling to a cognitive level.[6]

Pre-comtemplation

The patients that are in this stage are often seen as difficult or non-compliant patients. These patients are not even considering change and have no motivation to change. Part of helping this patient is to gently provide him with information that does not increase resistance because of prescription of solutions or attaching labels to him.[5]

Figure 2: Readiness to change ruler[2]

Contemplation

Patients in the contemplation stage are stuck between two worlds. On the one hand they enjoy or benefit from a certain behaviour, but on the other hand they know this behaviour is counter productive, and they know what complications can arise from this behaviour, but are not motivated enough to make a change. The purpose of MI is to enhance a patient's self-efficacy and not to try to manipulate the patient into the health care provider's idea of what is right and wrong.

Ready to change

These patients are extremely motivated and are ready to plan and make the change. The MI aim in this stage is to help the patient set clear and specific goals/targets for change. The focus must be on practical aspects of how to change. A good idea is to discuss difficult situations which may cause the patient to slip backwards.[2]

Rolling with resistance

Resistance may be experienced at any stage from the patient. The health care provider traditionally gave out advice which was expected to be accepted, although it was mostly rejected.

Health care providers who use the MI approach often experience a better doctor-patient relationship, which becomes a partnership rather than an expert-recipient relationship. This results in a significant decrease in personal frustration and stress when negotiating behaviour change.[2]

The principles

There are four general principles behind MI.

Express empathy

Empathy involves demonstrating warmth, acceptance and accurate understanding of what the patient thinks and feels.[7] If the patient experiences empathy from the health care provider he will open up more easily to his own experiences and share these experiences more easily with others. By having patients share their experiences in depth you can assess when and where they need support, and what may cause problems in the change process. The health care provider's accurate understanding of the patient's experiences facilitates change.

Support self-efficacy

If a patient believes that change is possible, it will be an important motivator to succeeding in making a change. In the MI approach patients are held responsible for choosing and carrying out actions to change, health care providers focus their efforts on helping to keep patients motivated and a good way to do that is by supporting a patient's sense of self-efficacy.[7] The health care provider has to impart the belief in the patient's ability to change. The patient should be given the opportunity to be creative about change – there is no "right way" to change. The patient should be helped to develop a belief that he/she can make a change.

Roll with resistance

In the MI approach, the health care provider does not fight patient resistance, but "rolls with it".[7] Patients are encouraged by the MI approach to define problems and develop their own solutions. The health care provider should invite new perceptions from the patient, not imposing or arguing for them.

Develop discrepancy

"Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be" [7] Using MI health care providers highlights contrasts between current behaviour, values and future goals in an atmosphere of acceptance. When a patient sees that a current behaviour is not leading towards a future goal, change is more likely to occur as they become motivated to make a change.

The Traps

Using the MI approach, the health care provider should avoid certain "traps" when noticing de-motivation in a patient, and then help the patient consider change with therapeutic strategies.

Traps to avoid:

Question/Answer Trap

Here the patient and health care provider fall into a "trap" of question/answer, question/answer etc. This could easily lead to passivity and prevents access to more in depth levels of experience. Exploring issues in depth is thus not encouraged.

Confrontation/Denial Trap

Most health care providers have experienced an interview where the patient is not ready for change at all and for every statement that the health care provider makes the patient replies with a reasonable argument.

Expert Trap

In the "expert trap" the health care provider tends to fall into a trap of providing direction to the patient without helping the patient to determine his own directions, plans and goals.

Labelling Trap

The labelling trap happens when a health care provider tries to label a patient, for example an "addict", "lazy" or any other label.

Premature Focus Trap

The MI warns health care providers in focusing too quickly on a certain problem or aspects of that problem. It can cause resistance and premature focus may cause the health care provider to focus on the secondary or unimportant problem

Blaming Trap

Patients often blame others for their problems. Health care providers may feel it is important to show the patient that he is to blame for the problems arising. In the MI approach, blame is irrelevant. Miller and Rollnick suggest establishing a "no-fault" policy when talking to a patient.[3]

The interaction techniques

In the basic MI approach, the interactions are combined by the acronym OARS: 1) **O**pen-ended questions, 2) **A**ffirmations, 3) **R**eflective listening and 4) **S**ummaries.

Open-ended questions are those questions which health care providers can use where the patient cannot answer with a "yes" or "no" or "twice a day". A good idea is to start your consultation with an open-ended question – "What brings you here today?" There is a definite place for close-ended questions, but open-ended questions create a movement forward in helping the patient explore the possibilities of change.

Affirmations are statements where we recognise the patient's strengths. A way to do this is to focus on a patient's strengths, in areas where he sees only failure. We focus on previous attempts at change. "Previously you were able to exercise twice a week for a month, how were you able to work that into your busy schedule?" We can also use resistance for affirmations: "You said you did not want to be here today, but here you are. It seems that if you decide that something is important to you, that you are willing to sacrifice a lot to do it."

Reflective listening is the key to the MI approach. Listen to your patient carefully. By listening to your patient he will tell you what has worked before. What moved him forward and backward in the stages of change? Whenever you are unsure of what to do next, **listen.** You can actively guide your patient towards certain areas by choosing what to reflect on and what to leave out. Focus on his change talk and give less attention to non-change talk. You will also have to vary your levels of reflection. Empathic reflection is a way in which you can check out meaning and deepen the exploration for both the patient and yourself.

Finally, there are **summaries**. When we summarise we link together what has been said and reinforce the essence of the discussion. Summaries are an effective way to show your interest in the patient, build rapport, call attention to the important areas of the discussion; the can also be used to shift attention or direction.

"People are generally better persuaded by the reasons which they have themselves discovered, than those which have come into the mind of others." Blaise Pascal, Renseés (1670).

Conclusion

People who have been exposed to MI have been found in various clinical trials to be more likely to return for follow-up visits, to do self monitoring of blood glucose levels and improve glycaemic control, to exercise more and eat more vegetables and fruit, to keep diaries of food and blood glucose readings, to lower stress, to improve adherence to medication and to quit smoking.[1]

Health care providers who engage with the MI skills experience a more enhanced provider/patient relationship and a lowering of stress and frustration around negotiating behaviour change.[4]

MI is a very effective tool for the health care provider which can be used in assisting a patient towards behaviour change.[8] MI may succeed where traditional therapy fails because of minimal resources and low client motivation and behaviour changes.[9] The average MI session lasts from 5 to 20 minutes, which makes it a cost-effective way to promote behaviour change in health care settings.[10]

References

Available on request