Assess Readiness to Change

Motivational interviewing: unlocking the patient’s own motivation

Session 5

Acknowledgements
Obesity Canada
Overview – aims

• What is motivational interviewing (MI)?
• Evidence to support MI.
• Four guiding principles:
  o resisting the righting reflex
  o understanding and exploring the patient’s motivation
  o active listening
  o empowering the patient
• Case studies
What is motivational interviewing (MI)?

• MI is patient-centred counselling; it involves agenda-setting, reflective listening and shared decision-making.

• MI is the opposite of finger-wagging; the aim is to explore the problem from the patient’s point of view.
MI can achieve behaviour change

• MI assumes that behaviour change is stimulated by motivation rather than information.

• Ambivalence to change is explored, but so are the benefits of change.

• The answers lie within our patients, not us – our job is to unlock those answers.
Extensive evidence supports MI in a variety of health areas

Low-intensity MI interventions are effective in many health-related areas where patient engagement is key to achieving long-term behaviour change.

- Alcohol, smoking and substance abuse
- Medication adherence – e.g. asthma/COPD
- Cardiovascular health, hypertension, diabetes
- Health promotion, dentistry, obesity, physical activity
- Domestic violence, family relationships, gambling
- Mental health, eating disorders

For further information, see http://www.motivationalinterviewing.org
The Spirit of MI – enabling responsibility to lie with the patient rather than the doctor

MI differs from the traditional “doctor assesses, then informs patient of the problem and solution”. Instead, it aims to:

• collaborate with the patient to understand their perspective;
• evoke – or unlock – solutions that already lie within the patient;
• recognize that a patient’s personal goals, values and aspirations may differ from the health professional’s.
The four guiding principles: RULE

- **Resist** the “righting reflex”.
- **Understand** the patient’s own motivations by exploring feelings behind why a change is wanted and what options the patient wants to try.
- **Listen** – actively and with empathy.
- **Empower** the patient, encouraging hope and optimism.

Develop a “guiding” style rather than a “directing” style:

“How can I help you find your way?” rather than “Go that way!”
The consultation – tools

• Ask open questions.
• Listen by reflecting.
• Help to weigh up pros and cons.
• Set SMART goals.
• Use a ruler “scale of 1 to 10”.
• Use hypotheticals – “What might it take for you to make a choice to ...?”
Resisting the “righting reflex”

• The urge to “correct” problems that patients present to us is very strong.
• Yet humans naturally resist persuasion, especially if they feel ambivalent – for instance, drinkers (or teenagers!).
• Even positive changes require effort – staying put is always easier than making a change.
• Urging a patient to do something obviously beneficial can, paradoxically, produce more and more reasons why the change seems impossible.

Doctor: “I suggest you …”
Patient: “Yes, but …”

“All you need to do is …”
Active listening

• Key moments for active listening:
  o first “golden minute”
  o cues – points when the patient seems confused, anxious, disengaged or annoyed
  o moments after you ask an open question.
• Listening by reflecting – reflect back a short summary of your understanding:
  “You feel very concerned about your weight, but you are not confident about the approaches you’ve tried.”
• Work through ambivalence.
Active listening

• I should …
• I wish …
• I want to …

Help to change these phrases to:
• I will
Roadblocks to listening

Silence is an important part of listening. Interrupting a patient means that they have to deal with this “roadblock” before continuing with their agenda. Limit the following interruptions:

- agreeing/disagreeing
- instructing
- questioning
- warning
- reasoning

- sympathizing
- suggesting
- analysing/interpreting
- persuading
Have you heard this?

- “I can’t see why I need to change.”
- “I can see what you mean but …”
- “Just tell me what to do.”
- “I really can’t cope at all.”
What we can do

Be clear about expectations and minimize the risk of misunderstandings. This will:

• demonstrate respect for patients;
• acknowledge the patient’s autonomy;
• increase engagement in treatment.
Listening by reflecting

• Each reflection is a short summary statement (not question) of what is happening at that moment.

• After you reflect back what the patient means (hypothesis), the patient then confirms or refutes the hypothesis.

  “You find it hard to exercise because of your knee pain.”
  – “Yes, I’m worried exercise will make it worse.”

• Acknowledge the value of what you have heard.
  “You’ve given me a clear picture …”
  “That has helped me understand …”
Listen out for “change” talk and “resistance” talk

- **Change talk** – where the patient volunteers ideas, suggestions and plans about making a change.

- **Resistance talk** – excuses as to why solutions will not work or comments about feeling ambivalent or defeated.
Choose carefully what to reflect

- Where a patient is using change talk, reflect this back to empower the patient.
  
  “You plan to choose smaller portions by using a smaller plate.”

- Reflect back a patient’s ambivalence or resistance talk. This can unlock “the other side of the argument” from the patient.
  
  “Despite your weight you feel your eating habits are quite healthy.”
  – “Well, I suppose they are not that healthy – I have a weakness for cake at teatime.”
  “Your diet is mainly OK but you have some weaknesses.”
  – “I might try making a fruit smoothie or a piece of toast.”
Help the patient (not you) to voice arguments for behaviour change

<table>
<thead>
<tr>
<th>Task is to elicit change talk from patient rather than resistance talk</th>
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<tbody>
<tr>
<td><strong>Desire</strong>: statement about preference for change</td>
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<td><strong>Ability</strong>: statement about capacity</td>
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<tr>
<td><strong>Reasons</strong>: specific arguments for change</td>
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<td><strong>Need</strong>: statements about feeling obliged to change</td>
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<td><strong>Commitment</strong>: statements about likelihood of change</td>
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<td><strong>Taking steps</strong>: statements about action</td>
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The importance and confidence rulers

- Use the **importance ruler** to determine a patient’s level of commitment to making a proposed change.
  
  “How important would you say it is for you to make this change? On a scale from 0 to 10, where 0 is not at all important and 10 is extremely important, where would you say you are?”

  Use the ruler positively: “Why are you at 8, not 4?”

- Use the **confidence ruler** to determine how confident a patient is that they will follow through on a proposed change.
  
  “And how confident are you that, if you decided to make the change, you would succeed? On the same scale from 0 to 10, where 0 is not at all confident and 10 is extremely confident, where would you say you are?”

  Use hypotheticals: “What might it take to go from a 7 to a 10?”
Example: using the importance and confidence rulers

“You are planning to start attending the weight management group each week. On a scale of 0 to 10, how important is attending this group to you?”
– “Well, I’d say it’s about an 8.”
“8 tells me it is important to you, but how confident are you that you’ll make it happen? Again, use the 0 to 10 scale.”
– “Hmm, that’s trickier. I sometimes get held up in the evenings. I’d say it’s more like a 6, as I’m not sure I’ll get there every week.”
“As you rated it as important, what might help you make it happen regularly? How could you push that 6 up to an 8 or 9?”
– “I think I just need to be organized. I sometimes get bogged down with housework when I get home from work, but the club meetings aren’t very long, so there’s no reason why I couldn’t do the chores after the meeting.”
“So, because you feel it is important, you’ll do what you can to make it happen.”
– “Yes, I shall start this Wednesday.”
Informing

“Giving the answers” may produce little or no change in behaviour if the patient has become …

• **bewildered** – too much information or delivered too quickly
• **passive** – glazed over, “switched off”, bored; information seems irrelevant or too complex
• **highly emotional** – angry, frightened, anxious
• **depressed** or **distracted** – poor concentration due to depression or recent events
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<th>Make informing effective (1)</th>
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<td><strong>Ask permission</strong></td>
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| “May I make a suggestion?”
This emphasizes collaboration between you and lowers resistance. |
<p>| <strong>Offer choices</strong>          |
| “There are several ways you could address this. Would you like me to explain some options?” |
| <strong>Talk about what others do</strong> |
| “In this situation other patients have found the following approach quite helpful.” |</p>
<table>
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<th>Make informing effective (2)</th>
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<td><strong>Elicit–provide–elicit</strong></td>
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<tr>
<td>Elicit – “What would you like to know?”</td>
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<td>Provide – give information requested.</td>
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<td>Elicit – “What does this mean to you?”</td>
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<tr>
<td><strong>Beware the righting reflex</strong></td>
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<td>Avoid making patients feel scared, humiliates, ashamed, guilty, etc. Aim to be supportive, compassionate, empathic and inspiring.</td>
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<tr>
<td><strong>What does this information mean to you?</strong></td>
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<td>Relate what you are suggesting to the patient’s specific situation to enable their concerns to come forward.</td>
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### Focusing on the impact of weight on health

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<tr>
<th>Question</th>
<th>GP’s hidden agenda</th>
<th>Patient perception</th>
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<td>Have you sensed that your weight has affected your joints?</td>
<td>What is level of understanding re inflammatory properties of adipose tissue?</td>
<td>Understanding my condition better may help me to help myself.</td>
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<tr>
<td>Were you aware of the link between weight and periods? ... diabetes? ... sleep apnoea?</td>
<td>Weight loss may be the best treatment option, so I want the patient to feel positive.</td>
<td>I didn’t realize the solution may lie with me.</td>
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<td>What things have you tried to improve your lifestyle?</td>
<td>What are the lifestyle priorities for this patient?</td>
<td>I might mention I gained weight after I stopped smoking.</td>
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<td>We know weight can affect the safety of doing an operation – has anyone talked to you about this?</td>
<td>How can I gently broach the fact that you are unfit for an operation?</td>
<td>Understanding the health risks can help me make the right decision about surgery.</td>
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OARS summarizes the overall approach

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<th>O</th>
<th>Open questions</th>
<th>questions that encourage patients to think before answering and allow a choice in how to respond</th>
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<td>A</td>
<td>Affirm</td>
<td>acknowledge patient’s efforts, strengths and volitional choice</td>
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<td>R</td>
<td>Reflective listening</td>
<td>capture patient’s meaning</td>
</tr>
<tr>
<td>S</td>
<td>Summarize</td>
<td>pull together what’s been said</td>
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Exercises: unlocking the patient’s own motivation

Split into pairs

Exercise C1: Importance and confidence rulers
Role play: try using the importance and confidence rulers to challenge Mrs A’s sustain talk in the examples in your workbook.

Exercise C2: Reflecting back sustain talk
Read the example of how reflecting back, or restating, the patient’s sustain talk – rather than offering your own solution – can create a space for the patient to present their own solution.
Role play: try the examples given to see if you can unlock change talk from the patient.
Your future practice

Please consider your future practice.

• How will you balance active listening and empathy with the time constraints of a busy practice?

• Do you have personal examples of utilizing the various styles of motivational interviewing (following, guiding, directing)? If so, please discuss.
Might a health professional’s own shape affect confidence when they mention weight?
Can slim people have any idea of what fighting obesity is really like?

Could a health professional with obesity have credibility in recommending weight loss to another person?
Does our own shape actually matter?

- Self-help support groups run by fellow sufferers are often the most successful formats of all – there is nothing like personal experience to aid empathy.
- Understanding a patient’s perspective can come from active listening – it does not necessarily need to be experienced.

*Answer* – Not if our aim is to help patients *explore their own goals*. 
Group discussion questions

• What is it like living with obesity or a chronic condition? (patient experiences)

• Do weight bias and stigma affect health outcomes and quality of care?