



# THE POWER OF motivational interviewing

Healthcare professionals have an important role to play in guiding and supporting positive behaviour changes among their patients with diabetes. Here, clinical psychologist **Dr Jen Nash**, Director of the training and education company Positive Diabetes, describes how motivational interviewing can be a powerful tool in supporting behaviour change in Type 1 and Type 2 diabetes – but warns that its successful application may require the diabetes team to change their own behaviour and approach

In conversations about behaviour change, motivational interviewing taps into the otherwise unvoiced conversations that are going on in the patient's mind



**A**s NHS healthcare professionals (HCPs), we are aware of the difference between knowing what we should be doing to care for our health, and what we actually do. If we examine our own health decisions, many readers will admit to not eating five pieces of fruit and vegetables each day, not exercising for 30 minutes five times this week, not flossing their teeth daily, and so on.

If NHS clinicians themselves struggle to prioritise health behaviour advice, is it any wonder that people with diabetes find this a challenge, particularly with the additional emotional barriers related to diabetes, such as anxiety (eg, fear of needles, hypos, complications), guilt and shame at the diagnosis and other issues? The self-management tasks of diabetes can require an extra two hours each day to carry out<sup>1</sup>, so it is hardly surprising, given the competing demands of life, that striving for diabetes health may



During motivational interviewing, the traditional medical model of consultation is set aside

be the least important out of a range of competing priorities.

It is against this background that healthcare professionals need to work with their patients on positive behaviour change. In this article, I will look at motivational interviewing (MI), a proven technique that can be integrated into diabetes management practice – however little time you have!

### What is motivation?

Motivation is a reason for acting or behaving in a particular way<sup>2</sup>. Very few people are unmotivated to live a long and healthy life, and people with diabetes share that motivation, despite what their behaviour may otherwise signal. When we use the word 'motivation' in our healthcare contexts, we generally use it incorrectly, as if it is a construct we can simply summon up at will.

Instead, we ought to be asking, 'motivated to do what?' People with diabetes are motivated. They are highly motivated. They are motivated to do exactly the right thing for them, given what they value. If you, the reader, failed to eat five pieces of fruit/vegetables or exercise this week, it was simply because you were valuing something else more highly.

### What is motivational interviewing?

Motivational interviewing is a communication style that has emerged from the addictions field. Miller and Rollnick<sup>3</sup> discovered that there were certain things that they could do as clinicians that were more likely to influence change in the addictive behaviours of the people they were working with.

Thus, MI is the style that emerged to help those people who seemed 'hopeless', to change.

If you, as a diabetes HCP, are already having behaviour change conversations with people, then MI is simply another way that these conversations can unfold.

In a conversation about behaviour change, there are actually two conversations going on. The first is the one that the HCP is aware of – the



actual words that are being said aloud in the to-and-fro exchange. However, less well understood is the unvoiced conversation that is happening in the person's mind. An example of this may be: "I can see my doctor/nurse is really trying to help me, and I do understand why it's important to change. But I'm just so stressed right now, how can I tell her that food/cigarettes are the only thing that's getting me through the day?"

Motivational interviewing is simply a communication style that the HCP can adopt in order to allow these unvoiced conversations to be voiced. Once a person understands a health education message, but you know that they have not yet implemented it, then they are unlikely to by simply listening to more information from the HCP. Instead, they are more likely to change through hearing themselves talk about the pros and cons of change.

This approach often presents a challenge for the medically minded HCP. Trained to fix, offer solutions and set goals, MI conversations may well feel uncomfortable and unfamiliar to those brought up with this model. Your traditional change-talk conversations only feel 'complete' when a goal is set and the person leaves with a plan. But, if the person isn't internally on board with this plan, being prematurely moved towards one only sets the person up for more failure, guilt and shame at not being able to do what they've been advised. For some, there will even be a reluctance to return to the next appointment and face the HCP with their failure.



### MI in practice

One of the major objections that presents in MI training is: “But I have no time for MI conversations!” However, as MI is a style, you can use the spirit of the style in a 30-second interaction, by simply expressing empathy at the difficulty or complexity of the health condition. The time pressures on clinicians is evident, and MI is not designed to replace existing communication styles you are currently using that are enabling behaviour change results.

Motivational interviewing is a particularly useful tool for people you are working with to whom you feel you are continually saying similar things, yet there is little change. The cornerstones of MI are listed as follows:

“Once a person understands a health education message, if they have not yet implemented it, they are unlikely to do so by simply listening to more information”

### 1 Empathy

Empathy and ‘emotional intelligence’ lie at the centre of MI. The ability to understand and share the feelings of another is at the heart of behavioural change.

Empathy improves our conversations which, in turn, can improve our clinical outcomes<sup>4</sup>. Not everyone is naturally empathic, but we can develop our skills of ‘empathic willingness’ as follows:

- Make eye contact.
- Adopt body posture facing towards the person.
- Choose a tone of voice that is neutral but also interested and engaged.
- Consider a lower speaking volume.

- Consider a slightly slower speaking speed than you normally would.
- Use minimal encouragers: nod, say: “Hmm”, “Uh-huh”.
- Summarise what you’ve heard to let the person know that you’re listening.

### 2 Behaviour change advice: be committed, not attached

Acutely aware of the health implications of certain behaviours, HCPs can be attached to reinforcing to the person that they ‘need to’ or ‘should’ follow advice. Let’s imagine for a moment that you do not enjoy running as a way of keeping fit. If I, as a lover of running, started trying to convince you of the great things about running, what it will do for you, your health, etc, you are likely have an unvoiced internal conversation, as follows: “That’s all very well for her, but it’s not me; I don’t like running”. You may become resistant to my message, and want to tell me all the

reasons why running is so terrible.

This is often what happens in our healthcare settings. Instead, if I asked you some questions to find out your experiences of running, what you’d heard, and any experiences of trying it previously, you would perhaps be more open to the conversation.

Be mindful of your tone of voice and emotional response. Stay committed to the person and their experience, not the behavioural goal you think would be best for them. If they know and understand the implications for their health and are persisting with a behaviour that isn’t in their best interests then, whatever your opinion, in this moment they are choosing the exact right outcome for themselves. This doesn’t always sit easy for HCPs, but if we can get comfortable with this we will move much further along in these conversations. Motivational interviewing calls this ‘rolling with resistance’. People have the right to make the decisions they want to about their health, even if we disagree or can’t understand them.

### 3 Explore values

A value is something that is important or beneficial to the person. It is something they choose, that matters to them. It might be family, success, freedom from pain, freedom from stress (see the example of Lisa in the box) or even to get out of your consulting room without a ‘lecture’!

We need to find out what people value, by asking questions like:

- “What matters most to you in life?”
- “What’s important to you in life?”
- “How do you think your diabetes being poorly managed might affect your life and the things that matter to you?”
- “If you were able to manage your diabetes better, how might that benefit you and those that matter to you?”

We might like to preface a values question with: “OK, I can understand that working on reducing your blood glucose results isn’t important to you right now. I’m curious to get to know you, so I can support you better. We’ve only got a few minutes, so can you tell me what is important to you right now?” Once the time has passed, summarise what you’ve heard, eg: “I can hear that

until you are able to manage your stress differently, making changes to your diabetes isn't going to be possible. Can I encourage you to continue to think about this, and can we pick it up again next time we meet?"

This style of conversation may feel uncomfortable to the action/goal-orientated HCP but, remember, these conversations are simply an opportunity for the person to hear themselves talk about their health in a new way. For many, these conversations will continue in their own minds and lives once they've left your room.

#### 4 Explore ambivalence

Behaviour change doesn't occur in a straight line and exploring ambivalence is exploring the mixed feelings, doubt and indecision people have about making a change. The trans-theoretical stage of change model<sup>5</sup> demonstrates that change is a process. The table below shows the stages of change, what you may hear, and a suggested response to consider.

Contemplation is the stage to explore ambivalence. You'll quickly know if someone is ambivalent, as you will hear them say things like:

- "I know I should do X, but I don't."
- "I know I shouldn't do X, but I do."
- "I've got no motivation."

Remember, MI encourages the person's unvoiced conversation to be voiced. Here are some questions to explore ambivalence:

- "What would be good about changing?"
- "What would be bad about changing?"/ "What will you miss if you make this change?"
- "What do you think has held you back from making this change so far?"
- "What might happen if you don't make a change?"
- "What would be difficult for you about changing?"
- "What would you say to a friend in your situation?"

#### 5 Goal setting

In a time-limited consultation, you will likely only have time to use one or two of the MI skills (always from a stance of empathy) and so MI involves many apparently 'unfinished' conversations that will not reach the stage of goal setting. Although this may feel uncomfortable to you, avoid pressuring



“Empathy is the foundation of MI. It is the ability to understand and share the feelings of another and is at the heart of behavioural change”

### The Cycle of Change model of behaviour change

STAGE OF CHANGE	WHAT YOU ARE LIKELY TO HEAR	SUGGESTED RESPONSE FOR HCP
PRE-CONTEMPLATION	"I don't want to change/ I'm not ready to change."	Simply show empathy. Pushing someone towards behaviour change will be detrimental to the trust the person has in you. Encourage them to talk about the health topic in whatever way suits them. Remember, the reason is to give the person the opportunity to hear themselves talk. "I can understand that. Tell me more about (eg what leads you to smoke, not smoke, etc)."
CONTEMPLATION	"I know I should change."	"What would be the good things about making this change?" "What would be bad about changing?"
PREPARATION	"I want to change."	"Great! What do you need to make a change? How can I support you? Who else can support you?"
ACTION	"I've started to change."	Give encouragement. "How can you make the change a part of you/your life?"
RELAPSE	"I've failed/got off track."	"Failure/getting off track [use the word they used] is part of change and it's OK. What was happening just before you got off track?"
MAINTENANCE	"It's me. It's part of my life."	"Great! Is there another health area you'd also like to change?"

people towards a goal. This sets them up for failure. Instead, use a sound bite to end the conversation without a goal (see below for some suggestions).

### In summary

Keep the following tips in mind when embarking upon the MI approach with your patients.

- MI is a conversational skill, so practice with people in your personal life first. This helps you see that you can use the skills of MI even in very short conversations. Practice it with your partner or teenager!
- Stating the boundaries of a time-limited appointment is important, so you both know what to expect. Suggested sound bites could be:
  - \* “We may only have a few/5/10 minutes to talk today, but I hope we can use the time we do have to support you in the area of xxxx.”
  - \* “I’m afraid we’re nearing the end of the time we have together now, but I understand that xxx (summarise what the person has said).”
  - \* “Thank you for talking to me today, perhaps we can pick up this conversation next time we meet?”
  - \* “If you’d like to talk to me about this again, please feel free to make an appointment.”
  - \* If all you have time to do is show empathy, you have still provided an important intervention.
- Seek out training. Find a trainer at [www.motivationalinterviewing.org](http://www.motivationalinterviewing.org) or contact the author at [drjen@positivediabetes.com](mailto:drjen@positivediabetes.com)
- Google ‘Steve Rollnick’ to watch video clips of the founder of MI at work.

“For many people with diabetes, these conversations will continue in their own minds and lives once they’ve left your room”

PHOTOS: THINKSTOCK



MI can still be applied when time is limited

### Case history — Lisa

**Lisa is 42 and has Type 2 diabetes.** Her weight has continued to increase despite having received dietary advice from her HCP, Mira. Mira is confused, as Lisa always nods and agrees with the recommendations made, yet nothing changes. Lisa’s unvoiced conversation is: “I can see that Mira is really trying to help me, and I do understand why it’s important to lose weight. But I’m just so stressed with the kids right now, how can I tell her that food is the only thing that’s getting me through the day?” Mira goes on some MI training and this is how the conversation unfolds:

**MIRA:** “Lisa, we only have a few minutes to talk today, but I want to be helpful to you. When we’ve met before you always seem to understand the need to lose weight, but it seems difficult to make the changes. Can you tell me what

would you miss out on if you followed the advice to eat less?”

**LISA:** “I’d miss my little treats. You know how difficult it is with teenage kids. They drive me up the wall at times, and when it all gets too much, sweets and biscuits really help to calm me down.”

**MIRA:** “I see. So what’s stopped you changing is the stress of the kids, and needing to find a way to calm yourself down?”

**LISA:** “Yes. I think that’s definitely part of it.”

**IF MIRA IS OUT OF TIME:** “OK, well we haven’t got much more time to think about this today unfortunately, but perhaps we can think about this more next time we meet?”

**IF MIRA HAS A LITTLE MORE TIME:** “OK, so if you could think about ways of dealing with your stress, so that food isn’t the only way to deal with it, that may be helpful to you?”

### References

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