

Motivational Interviewing- It's as easy as 1, 2, 3

Introduction

Patients tend to present to their general practitioner in response to symptoms. The assistance they seek is a diagnosis and course of treatment. Most patients do not attend their GP saying they want to change their behaviour. Accordingly, when the best course of action is not a short course of medication GPs can find themselves involved in an exercise of overt persuasion. However, what might seem a convincing argument on the GP's part may fall on deaf ears. Indeed, the patient may counter with arguments of his or her own.

The above is particularly true in cases involving drug and alcohol abuse but is also the case where a skill approach is required in which a patient would benefit from learning new behaviours. This is the case with Anxiety and Mood Disorders.

Treatment Compliance

Poor treatment compliance is well documented across both medical and psychological illnesses. For example, rates of medication non-compliance are as high as 50%. In the area of anxiety, depression and eating disorders, drop-out rates are estimated to be 15-40%. Adding a personality disorder or substance abuse to the mix, increases drop-out rates to as much as 60-80%.

One of the variables predicting clinical outcome is the patient's level of motivation.

Dealing with the resistant, disinterested or ambivalent patient

It is argued that attempts to convince a patient to undergo a particular behaviour change will, at best, result in passive acceptance with little overt attempt to change. Further, although it is tempting to simply leave the ambivalent patient alone or to offer topical remedies, this is not always medically wise and also does not take into consideration that the GP may take an active role in resolving this ambivalence and hence encourage meaningful behaviour change.

Motivational Interviewing

Motivational interviewing is an approach developed to allow for the maximal input by the clinician pitched at the patient's level of motivation. In this model

the responsibility for behaviour change remains with the patient. The GP acts as a knowledgeable contributor and support person.

As Easy as 1,2,3

Although the term *Motivational Interviewing* can seem daunting at first, in reality it involves 3 basic steps.

Step 1: Orient yourself towards the patient

- Create an atmosphere of acceptance and trust
- Allow the patient to do most of the talking
- Respond with empathy
- Avoid jumping in with solutions
- Roll with resistance

Step 2: Identify the patient's readiness to change

Stage of Change	Definition
Pre Contemplation	Unaware or unwilling to change
Contemplation	Seriously considering change
Preparation	Committed to change
Action	Starting to make changes
Maintenance	Sustaining changes
Relapse	Return to previous behaviour

Step 3: Apply the appropriate strategy consistent with identified level of change.

Client Stage	Clinician Task
Pre Contemplation	Raise doubts. Increase perception of problems with current behaviour
Contemplation	Tip the balance. Elicit reasons for change and the cost of not changing
Preparation	Help identify the best course of action
Action	Help clients take steps towards change
Maintenance	Help identify strategies to prevent relapse
Relapse	Minimize demoralization. Help renew process of contemplation, preparation and action.

Interview Traps

In applying the above steps, it is important to avoid a number of strategies that have been shown to be at best non effective, and at worst, destructive. These interview traps are described below.

Traps	Description
Overuse of closed questions	Series of closed questions that lead to a Yes or No answer. "Did you..?" "Have you...?" "Is it..?"
Playing the Expert	Giving the impression of having all the answers, thereby promoting a passive role in the patient
Using Labels	Your problem is.... This may promote resistance
Premature focus / Confrontation	Homing in too quickly on a problem when client wants to discuss broader range of topics
Blaming	Assigning responsibility leading to patient defensiveness

Useful Strategies

In addition to the above, the following interview strategies may prove useful:

1. Opening Strategy

This strategy involves talking generally about the person's lifestyle and stresses, and then raises the specific topic of interest to the GP.

How does depression affect your life?

How would life be different if you didn't feel so depressed?

2. Tell me about a typical day?

The goal here is to simply follow the patient through the sequence of a typical day, focusing on both behaviour and feelings, with simple open questions being the main input from the interviewer.

Pacing is important in this strategy; the interviewer needs to push ahead if the pace is too slow or backtrack if too fast. If the patient raises a specific problem the interviewer acknowledges this, and agrees to return to it later.

3. The Future and the Present

This strategy focuses on the contrast between the patient's present circumstances and the way he or she would like to be in the future. A useful question can be:

"How would you like things to be different in the future?"

This can be followed up by a question regarding what the person will have to do to make the future different.

4. "What do you think you would have to do to make things (specify) different in the future?"

Here the GP can ask for information regarding previous attempts the patient has made. How successful they were and what got in the way.

"Have you ever tried to deal with your depression before? What did you try? How did it turn out? What got in the way?"

5. Exploring Alternatives

This is where the GP can begin to give the patient information about the available treatments and about the strengths and weaknesses of each.

In doing so the GP should be honest in their assessment of each. It is useful to indicate which treatment approach the GP thinks is preferable but in doing so enough room should be made to allow the patient to express any concerns they may have.

When discussing the use of antidepressant medication the GP is encouraged to inform the patient that the inclusion of CBT self-help skills has been shown to reduce the risk of relapse.

CBT on its own has been shown to be effective in the treatment of depression and hence is an option in cases of mild to moderate depression.

For patients who appear reluctant to take medication, the GP may want to ask the patient to comment on what they see as the strengths and weaknesses of using medication.

When discussing CBT the GP is encouraged to emphasise that the individual is learning new skills to manage depression and that these skills will likely last a lifetime. The down side to CBT is that it takes time and effort.

Here again the patient should be encouraged to discuss their concerns.

The GP can ask whether the patient can see anything getting in their way with respect to either therapy.

Can you think of anything which might make medication / CBT difficult for you to do?

It should be clearly communicated that unlike in anxiety, antidepressant medication and CBT are compatible strategies. It should not be the case of "either one or the other". Indeed, in many cases the use of both medication and CBT is recommended.

6. Bite Size Pieces Strategy

It is important not to overwhelm the patient with information. Handing out bits and pieces of information, discussing these with the patient at the next meeting and enquiring whether the patient is interested in learning more about their problem can be effective.

7. "Have a go" Strategy

It is useful to leave the door open to patients. Most of us hesitate if we feel we are required to sign up for something. If we are offered an opportunity to try something out with no strings attached our interest is often stimulated.

It is possible to ask a patient to spend some specific time *having a go* before making a decision.

"Why not give it a try for two weeks and see how you go. Let's set a time now to discuss it."

All of the above strategies can be used to decrease an individual's ambivalence and motivation. In general the initial strategy needs to match the patient's level of motivation at the time of presentation. The strategies presented here are more or less presented in order – which is from poor motivation to higher motivation.

The communication skills of reflective listening, open questions and summarising should be used with all strategies.

Reference: Rollnick, S. et al (1992) *Negotiating Behaviour Change in Medical settings*, J of Mental Health 1, 25-37