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10 – Motivational Interviewing in Family Medicine

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"People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the minds of others."

Blaise Pascal

When we, as family doctors, have to deal with physical ailments, we can offer explanations, good advice and healing treatments and, for the most part, there is a successful outcome for the patients. However, we are often faced with more challenging situations. When the issue relates to dangerous behaviour, such as smoking, alcohol abuse, drug abuse, excessive eating, lack of exercise, not adhering to prescribed treatments etc., we can be faced with a resistance to our best efforts at advice and treatment - where people continue to behave in self-defeating ways.
In this situation, our helper role often proves ineffective: when we have given our best advice and stressed the importance of a change in behaviour, we are often left with the frustrating feeling of failure.
Patients can react in unexpected ways. They sometimes resist our advice and, indeed, argue against it. They can get angry and defensive, thus provoking feelings of frustration in us. We may even think that he/she "has bad will or is too silly to follow our advice".

Motivational Interviewing (MI) was developed more than 30 years ago in the setting of alcohol dependence treatments. The approach to counselling advocates is particularly relevant in the above context (2).
We doctors are trained to use what can be called the "Deficit Model" which implies that "my patient lacks something (insight, information, understanding) and my role is to give him what is missing. The word "docere (to teach)" which is the origin of "doctor" is the basis for this "deficit model".

In MI the approach is different and has to do with "E-ducere (to draw out)". That means search and draw out what is already present which includes what the patient himself may know. With this approach, the doctor and the patient search together, for a solution. Instead of focusing on the failings of the patient (which may be important) we focus on his/her resources, possibilities, wishes, hopes, strengths and capacity to change.

Our efforts are twofold

- First, we encourage our patient to find arguments himself/herself, in favour of change.
- Second, we listen carefully to every element of "change talk" the patient

expresses, we support his/her ideas for change and help develop them into a strategy that he/she will be able to apply. Ambivalence about the problematic behaviour is the starting point for MI intervention. Possibly, our first goal is to reveal this ambivalence. To get to understand the specific nature of our patient's ambivalence, we need to avoid a directional and “expert” driven style. Instead, we should adopt an empathetic, reflective, listening style in order to communicate understanding of the patient’s inner world of conflicts.

Reflective listening involves the following skills:

- Using Open Questions.
- Making reflections aloud to show empathy and to test whether we have understood what the patient meant.
- Affirming the strengths and qualities of the patient.
- Summarising to check that both doctor and patient have the same understanding of what has been said and/or agreed.

Studies show that these skills are easy to understand, but difficult to use in a fluid and easy manner during a consultation. Like the game of tennis - easy to understand, but not so easy to master well! A lot of training and supervision is necessary (3).

The Spirit of MI, is defined essentially by our will to collaborate with the patient and activate his/her own expertise. It means Unconditional Acceptance, Empathetic Reflection and support for the patient's Autonomy and this can be summed up as: “I’m here to help but it’s up to you to decide where to go and what to do”.

An important element of Acceptance is affirming the qualities and strengths we can observe in our patient. This is linked to Compassion which is another important element of the spirit of MI and implies “I want the best for my patient”.

MI usually starts with Engaging: “Do I understand this person’s perspective and concerns? “How comfortable is this person in talking to me?” This is followed by Focusing which is to look for the “goals for change” and questions “Are we working together with a common purpose?” “Does this feel more like dancing or wrestling?”

Next comes Evocation which means: “What are this person’s own reasons for change? Is his/her reluctance more about confidence or the importance of change? What change talk am I hearing? Am I steering too far or too fast in a particular direction? Is the reflex “to be right” making me the one to be arguing for change?”

The last element is Planning which takes in: “What would be a reasonable next step toward change? What would help this person to move forward? Am I retaining a sense of quiet curiosity about what will work best for this person?” (1 - p.311).

MI is described as a style of being with people, an integration of particular skills to foster motivation for change. It is essentially a collaborative partnership that honours the other’s autonomy, seeking to understand the patient’s internal frame of reference. Compassion is added to the spirit of MI precisely to emphasise that MI is to be used to promote the patient’s welfare and best interests, not one’s own.

There are currently a lot of studies showing the efficacy of MI (4, 5, 6,7,8).

The most powerful change catalysts operating in MI include empathic listening, the capacity to strengthen change talk, and the therapists ability to refrain from counter therapeutic responses (1 - p.386).

One last word: there is a benefit for the family doctor himself in MI. My experience in adopting this style of interaction with my patients is that, not only is there a greater degree of satisfaction in the doctor/patient relationship, but it is also an effective preventative measure for ‘burnout’.

Take Home Messages

- When patients resist the doctor’s advice, it’s time for MI
- MI gets much better results than blaming or criticizing
- When patients hesitate to consider behaviour change, it’s time for MI.

Original abstract

http://www.woncaeurope.org/content/ws216-applications-motivational-interviewing-hypertension-treatment

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