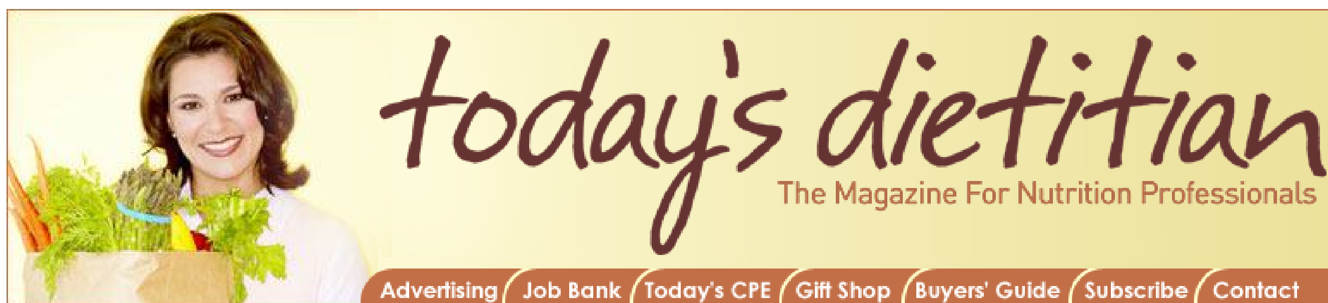

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Motivational Interviewing — A Unique Approach to Behavior Change Counseling

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As healthcare providers, we are often asked to be the agent of change with our patients, students, and colleagues. Our role is often to help people make necessary health behavior changes by instructing them in the whys and hows of making them. We may have been trained to believe that if we simply teach our patients what they need to do to change and do it effectively enough, they will change.

In weight management, however, dietary behavior change is complex, and knowledge is just part of the equation. If the focus is only on teaching the "facts of the case," we have missed important aspects of the counseling relationship. Unfortunately, our listeners may not be ready or able to make the changes we have in mind for them. This often leaves us in the unenviable position of feeling responsible for cajoling, nagging, threatening, or otherwise trying to force patients or colleagues to change their behavior.

An alternative to this top-down approach is motivational interviewing (MI), a style of talking with clients in a constructive manner about health-risk reduction and behavior change.1 Based on the idea that most individuals already have the requisite skills to successfully modify lifestyle and decrease health risk, MI employs strategies that will enhance the client's own motivation for and commitment to change. MI integrates an empathic, nonconfrontational style of interviewing with powerful behavioral strategies for helping clients convince themselves that they should change. As a result, the patient's resistance is minimized, self-motivation is enhanced, and behavior changes are more likely.

Rose, Rollnick, and Lane have proposed that healthcare practitioners use one of three basic styles in their work: instruct (provide information), guide (encourage the person to find his or her own goals and achieve them), and listen (understand the person's experience and feelings).2 Skillful use of each at the appropriate time in the counseling relationship is essential and part of the MI style of counseling. MI is a learned counseling style that is directive but uses instruction as only part of the counseling relationship.

Readiness to Change

Before discussing the specifics of MI, we should address the idea that patients vary in their readiness to change. Motivation, or readiness to change, can be considered an ever-changing state rather than a fixed personality characteristic—that is, the individual is neither motivated nor unmotivated. Patients enter a consultation with a dietitian with a certain range of motivation, and, in MI, the clinician's activity serves to increase or decrease the individual's readiness to change. Motivation, therefore, can be considered a result of the helping relationship.

The idea of readiness to change is described in an intuitively appealing way by the Stages of Change model.3 The model describes the ways in which individuals vary in a predictable fashion regarding readiness to pursue health-related behavior change, such as dietary behavior. It follows, then, that the clinician's counseling style largely determines an individual's readiness to change and, in turn, significantly impacts long-term behavior change. In the case of dietetic counseling, a confrontational or top-down approach tends to increase resistance and leads to frustration for both parties. Conversely, the use of empathic listening decreases resistance and increases readiness to engage in behavior change conversations.4,5

While MI includes a number of techniques, this is only part of the story. The "spirit of MI" is the foundation and refers to some basic ideas that inform the clinician's behavior. Careful, practiced listening skills form the next level of MI. Specific techniques designed to create a productive atmosphere in which the client can decide what and when to change are on the top tier of the MI pyramid.

The Spirit of MI

The basic assumptions of MI differ from traditional or typical dietetic or medical counseling, and this is what is meant by the term spirit. Rather than "the practitioner is the expert and the patient will be taught" approach, MI assumes a "dual expertise" between patient and practitioner.6 MI assumes that the client and practitioner are

experts in the counseling relationship, which is collaborative in nature, and that carefully listening to the patient is essential. The clinician may be the expert in what patients ought to do, but the patients have the expertise in what is important to them and what is possible in the context of their lives. MI assumes that patients have all the answers they need, and our job is to assist in the evocation of this information. The traditional health behavior counseling approach is installation therapy in that we assume patients have a deficit of information, and if we transmit it properly, they will have it and be willing and able to use the information.

Another “spirit point” of MI is that ambivalence is normal when people are confronted with the possibility of changing their behavior—even when the evidence in favor of change is clear or overwhelming. There are almost always compelling reasons not to change, and it is only human to defend the other side of the ambivalence. If we argue for change, clients will naturally argue against it, and passionate arguments for change often undermine clients’ investment in the change process. Rather than fighting the ambivalence and labeling our client as noncompliant or in denial, appreciating, discussing, and honoring this ambivalence is key to fostering change in health behavior.

It may sound counterintuitive, but by understanding and empathizing with clients’ mixed feelings about change, we actually allow them to begin talking about making changes. We can assume that people eat what they eat for good reasons, including tradition, habit, emotional comfort, and foods the rest of the family likes. The idea of changing dietary habits may be perceived as suffering a loss or simply impossible. At the same time, the patient may be convinced such change is important. Helping people begin talking about the reasons for making changes is crucial. We know people are more likely to change when they talk about it themselves. In MI, this is called change talk, and helping bring this about is a critical element.

Key Elements of the Listening Style

The four key elements of MI address what is discussed with the patient and the manner in which it is discussed: express empathy, roll with resistance, develop discrepancy, and support self-efficacy.

Empathy refers to letting the patient know that you understand how they feel about the targeted behavior but are neutral in your attitude about what the patient should do. This keeps the environment in the relationship safe for the patient to honestly express his or her feelings and provides the practitioner with information critical to understanding the patient’s point of view. In addition, an empathic approach creates rapport with patients, a valuable aspect of client relationships. An understanding of the patient’s point of view can help the dietitian work with the patient to determine which dietary aspects he or she is ready, willing, and able to accomplish.

Roll with resistance is related to empathy in that practitioners avoid arguing with patients or trying to convince them that they are wrong or misguided. The goal is to thoroughly understand the patient’s reluctance and ambivalence about making changes. Resistance from clients can take many forms, and dietitians can be trained to hear and respond appropriately. Resistance is a cue to stop pursuing this line of conversation and means the patient is not ready to discuss the topic at this time.

Develop discrepancy refers to helping clients understand the inconsistency between the current behavior and personal values and goals. When these inconsistencies become clear, there is more opportunity for the patient to feel he or she will make a change because he or she wants to. Discrepancy is developed by carefully listening to what the patient means and the encouragement of change talk.

Supporting self-efficacy means that wanting to change is not always enough. People may need help believing that change is possible, and it takes persistence. Helping clients feel empowered to change and offering them choices about how to change are critical.

The Two Phases of MI

Of the two distinct phases of MI, phase 1 is the exploration of patients’ ideas and attitudes about the proposed changes, or opening their ears. This is the dietitian’s opportunity to collect information regarding the client’s ideas about such change and willingness and readiness to make such changes. Instruction occurs in phase 2. It is done with great sensitivity to the client’s readiness to learn about specific topics.

An understanding of these two phases and their existence is crucial in the MI style of counseling. Dietitians and other clinicians are often very focused on the instruction or education of the patient. We are trained as teachers, and the work settings in which we find ourselves often place a heavy emphasis on patient instruction.

For example, in hospital or clinic settings, patients are referred to the RD to learn about the diet to treat a specific condition, such as diabetes, cardiovascular disease, or gastrointestinal disorders. The referring physician, nurse, or other professional expects the dietitian to accomplish the task of teaching the diet so that, of course, the patient will follow recommendations. If we launch into instruction too soon in the sessions, we lose the opportunity to hear the patient’s attitudes and ideas about the proposed change. At that point, we lose their attention and have less chance of actually effecting change in behavior.

Phase 1

Finely honed listening skills are at the heart of MI’s first phase. These skills allow us to develop a true

understanding of all sides of the story from the patient's point of view. They also help to develop empathy in our relationship with the patient, a key element of the MI guiding style. In addition, these techniques offer an alternative to instruction and resistance, a style that may lead to confrontation and a principal source of conflict between the patient and dietitian.2

The acronym OARS is used to describe these listening skills: ask Open-ended questions, Affirm, listen Reflectively, and Summarize.1 The way in which questions are asked is critical, and those that do not have a yes or no answer are best to help the dietitian understand all sides of the issue for the patient. Examples of open-ended questions are "What do you think about making the changes your doctor has suggested?" or "What will make it difficult for you to cut back on fried foods?" Affirmations let the client know we are listening, understanding, and offering them the empowerment necessary to make dietary changes. Affirmative statements help build rapport with clients. Everyone wants to be heard, and letting patients know their feelings and thoughts are acknowledged goes a long way toward building rapport.

Reflective listening is deceptively simple and helps the speaker know that you heard what they had to say by clarifying what you heard them say. A simple, or content reflection, is a restatement of what the patient told you. A meaning reflection adds the next sentence to the story. An example is a patient who says, "I really need to eat better to control my blood sugars. I know what can happen if I don't, and I really want to see my grandchildren grow up." A simple reflection might be, "You're concerned about your blood sugar and what might happen if it stays too high." A meaning reflection might be, "You really care about your grandchildren, and being around for them is really important to you." Summarizations are an opportunity to link material the client has offered and ask whether your understanding is accurate. You might begin with, "So let me see if I understand…"

Phase 2

Once the patient has presented some change talk and readiness to hear about the options for change, phase 2 can begin. The two most important aspects are providing relevant information and maintaining rapport. In the spirit of collaboration, the MI practitioner always asks permission first. For example, "May I make a suggestion?" or "Would you like to hear about the kinds of changes you could make if you wanted to?"

In phase 2, it is critical to keep the provided information succinct and relevant to the patient. We use the formula elicit-provide-elicit, by which we mean offer information, then check in and listen carefully to determine whether this is information your patient is ready to hear.

Three key ideas at this point are the use of conditional language, offering a menu of options, and taking time for short reflection breaks. Conditional language means that instead of sentences that begin with "You should," substitute phrases such as "Other people have found," "You might consider," or "Some of my patients have found." Offering a menu of options may include topics that are very familiar to dietitians, such as ideas for breakfast foods, carrying lunch to work, or eating in restaurants.

Short reflection breaks can be used to maintain rapport, let the patient know that you care what he or she thinks, and avoid information overdose. Techniques to use in such reflection breaks can be similar to the type of reflective listening mentioned previously. These techniques can keep you from falling into the "expert trap," the situation in which the dietitian is instructing in a top-down manner, without realizing that the patient may have already stopped listening.

Conclusion

MI is a powerful style of counseling for many health behavior changes and, in particular, for dietary behavior change. Once learned, the MI style of appreciating the limits of trying to persuade patients to change their dietary behavior makes our job as dietitians much easier. We are not responsible for whether or not they change but for helping them decide if they want to or can change, and if so, how to do so.

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