



Motivational interviewing and adherence in CF

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Introduction

Management of CF depends crucially on an individual's successful regimen adherence and associated health behaviors. Helping people with CF with this is an important part of the work of everyone in CF. After all, it doesn't matter how effective a treatment is if it's not taken.

This can, however, be a frustrating process. Healthcare professionals (HCPs) are often worried about patients who do not follow treatment recommendations and the risks they are taking. Often, HCPs feel responsible for their patients, and this can lead to some very emotional responses, some of which can be unhelpful, such as arguing, blaming, or giving up on the patient. We all need to remember, however, that everyone struggles to follow health advice no matter if it is in our best interests. It's a rare to find a person who has always followed health advice, whether it is not completing a course of antibiotics, flossing our their, or not sitting up straight. Thus there is no difference between HCPs and patients they work with in terms of ability and motivation to change behaviors, other than, perhaps, the importance of the behaviors and the emotional weight they may carry.



What affects adherence? There are many things, but one of the most important factors is the relationship between the patient and the HCP. One approach that has received much attention has been Motivational Interviewing (MI), a therapeutic strategy for enhancing commitment to change.

MI's origins lie in the treatment of people with alcohol problems, where the traditional approach had been confrontation. The belief had been that a person had to admit to a problem to get better. Because no one wants to hear they are an addict, many fought back with reasons the other person was wrong. In such cases the person with a drinking problem was viewed as in denial and unmotivated. The same happens when a person is confronted or scolded about medical nonadherence—they argue why it isn't true or why it isn't a problem for them.

In 1983, Bill Miller suggested that rather than seeing denial as lack of motivation, it might be more helpful to see this as the outcome of confrontation. When we confront someone, we tend to increase their resistance to doing what we want and they argue the opposite side. Miller suggested that motivation is not fixed; instead, it can go up and down in response to confrontive or supportive conversations. Miller suggested a number of ways to avoid confrontation and increase motivation, laying the foundations of MI. These ideas were built upon by Stephen Rollnick, who adapted them for use in healthcare settings.

There are four basic principles of MI:

- Don't impose change on your patients.
- Instead, help them to talk about their ambivalence and resolve it by choosing to change.
- Readiness to change is not a trait, but a fluctuating product of interpersonal interaction.
- Aim for a partnership, not the HCP as expert and patient as passive recipient.

In MI, the goal is to encourage a conversation and direct the patient towards thinking about change. This is important because we know that someone telling you they need to change is far more predictive of actual change than you telling them.

When people are struggling with change, they are struggling with thoughts about what they think they *ought* to do and what they actually *are* doing. This conflict makes people uncomfortable and can produce momentum towards change if handled in the right way. This process was first described by Leon Festinger who named it "cognitive dissonance". MI explicitly explores cognitive dissonance and uses it to encourage change. Basically, if the contrast between the two choices is raised, people feel an urge to resolve the conflict by choosing one way or the other. For example, people who smoke but feel uncomfortable about the risks can resolve their discomfort in one of two ways – continue smoking and minimize their risks, or give up smoking. MI used in a healthcare setting helps people think through their choices and select the healthful behavior.



A guide to motivational interviewing

Expressing empathy and getting a conversation started

The initial goal of MI is to engage the patient in conversation. However, HCPs may feel under tremendous time pressure and feel obliged to work through a long agenda with their patients. The temptation to cover many topics is understandable, but it is usually more efficient to deal with one issue effectively than cover many agenda items with little impact. The key is for the HCP to put the patient at ease and explore the patient's frame of reference, all the while encouraging a conversation about change. The aim is to foster collaboration between patient and practitioner and create a climate to openly discuss change. The patient should do most of the talking. The tools needed to achieve this can be remembered as the "OARS":

- Open Questions
- Affirmations
- Reflective Listening
- Summaries

Open ended questions are impossible to answer with a yes or a no. They are much more effective than closed questions at starting a conversation. Sometimes a closed question is to the point and needed ("did you go to the hospital last week?"), however, many times the question needs to be open to find out what someone thinks ("what do you think about taking this medicine?").

Affirmations help to keep the conversation positive and build the patient's confidence that they can change. It's important that any encouragement and support is genuine. One way of doing this is to recognize strengths and past achievements ("I know you've had a stressfully few months, I'm proud of how you've kept taking care of yourself a top priority").

Reflective listening refers to reflecting back what someone has said. It serves to let the other person know you are listening, to confirm that you indeed understand what the person means, and to take the conversation deeper into topics of interest. Reflection can be simple and intuitive – such as reflecting back the main content of a statement (a content reflection). Reflection can also be complex and powerful too. A meaningful reflection refers to an attempt to state what you think is the meaning behind what someone has just said. For example, a patient might say: "I've been so good at taking the medication then I got fed up and missed them all weekend" to which a meaning reflection might be: "You feel upset because you feel as if you've let yourself down." Though it takes practice, this can be a powerful way of building trust and helping someone to talk about difficult issues.



Finally, **summaries** succinctly pull together what someone has said. Summaries seem such a simple technique, but it is surprising how powerful they are. Sometimes hearing someone else make sense out of what you have said produces novel insights.

Developing discrepancy

Once the conversation is going, the next task is to help the patient think about changing. It may seem odd to specifically focus on change since a HCP asking about the behavior seems to imply they recommend change. However, in situations where the change is charged with emotion – for example, where thinking about increasing adherence to a medication triggers thoughts about the consequences of the disease– the patient’s natural tendency is to try not to think about it. In a sense, then, your job in specifically discussing change is to ensure that there is an honest discussion about the consequences of not changing and changing.

Many of the techniques provided here are designed to raise awareness of the problem, and to focus on the discrepancy between beliefs and actual behavior. In MI, readiness to change is not seen as static. Instead, it is a product of how important someone feels it is to change and how confident they feel in their ability to change. Asking questions around these two beliefs can be very revealing. In MI, scaling questions (ask someone to rate their belief on a simple scale from one to ten) are often used. They immediately focus the conversation. For example, if someone has rated their importance of doing chest physiotherapy a six, for example, you might ask “why six and not four?” to help identify reasons for change and “what would need to happen for you to rate this at eight?” to identify barriers to change.

In some ways, MI can be thought of as a decision aid for whether or not to change a behavior. The job of the HCP is to help the patient weigh the pros and cons of changing, and hopefully encourage them to be open and honest when placing weights in favor of change. A useful technique is to make the pros and cons explicit using a grid (a decisional matrix), which lists the benefits and costs of both staying the same and changing. It is important to discuss the benefits of not changing and the costs of changing. Whether or not you discuss them, the patient will think about them so it is better to have them out in the open where the HCP can integrate them into the discussion.

Rolling with resistance

When the topic of change comes up in conversation, the HCP needs to be prepared for a certain amount of resistance. This is an understandable and common reaction. Avoiding confrontation certainly reduces it, but it doesn’t disappear altogether.

How to respond to resistance? It’s common - but unhelpful - to respond by trying harder to convince someone they are wrong. It is best to avoid ‘the righting reflex’; this is the compulsion we all have to correct someone when they are wrong and to give them advice when we feel responsible for them. Unfortunately, it almost always results in very unhelpful responses (patients saying ‘yes but...’) and does not encourage change.



'Rolling with resistance' is the term MI uses for not responding with persuasion, but to side step an argument and encourage conversation. MI suggests that you acknowledge ambivalence about a decision – and therefore resistance to change – as perfectly normal. Doing this immediately lowers resistance. Use reframing and reflective listening to encourage discussion, and point out alternatives also reduces resistance. The key principles behind rolling with resistance are:

- Don't respond to resistance with confrontation - no matter how frustrated you are!
- Use empathy and reflective listening
- Reframe statements
- Acknowledge ambivalence as normal

When a patient is indicating a willingness to consider change – perhaps using words that indicate desire, ability, reason and need to change – it is then time to look at options for change together.

Supporting self-efficacy

When someone is committed to making a change, a lack of confidence in their ability causes them frustration and possibly distress– they now appreciate the need to change but don't feel able to take the necessary steps. MI therefore explicitly aims to increase confidence and self efficacy – someone's belief that they can achieve a particular goal. One way of achieving this is to consistently treat the patient and their choices with respect. If the decision and plan to change comes from the patients, they are immediately more secure in their own judgment and ability than if change is imposed from outside.

It is a central principle of MI that individuals take responsibility for their own actions, but can be difficult in clinical settings, especially where there is concern for a patient's welfare. In truth, though, if someone doesn't own a decision to change a behavior, any behavior change tends to be short lived.

When options concerning the behavior change are discussed, it's important to be realistic and practical: set small, realistic targets together. The scaling questions discussed earlier can be useful, as can goal setting: making explicit, realistic targets, and breaking them down large goals into smaller, more manageable steps.

Conclusion

MI is becoming more popular as an effective, open and ethical way to approach consultations about behavior change, treating both health professional and patient as equal collaborators. Many of the principles are easy to apply, though it takes some practice to do well. Miller and Rollnick have warned against seeing MI as simply a collection of techniques used in an automatic fashion. Instead, they have talked about "the spirit of MI" to sum up their approach, something more akin to a philosophy of patient care rather than a set of skills - "*a way of being with patients.*"



Suggested Reading

Miller, W. R., Rollnick, S. (2002), *Motivational interviewing: preparing people for change, 2nd Edition*, Guilford Press.

Rollnick, S., Miller, W. R., Butler, C. (2007) *Motivational Interviewing in Health Care: Helping Patients Change Behavior (Applications of Motivational Interviewing)* Guilford Press

Rollnick, S., Mason, P., & Butler, C. (1999). *Health behavior change: A guide for practitioners*. New York: Churchill Livingstone.

There are many people offering short courses on MI, many of whom are part of the Motivational Interviewing Network of Trainers (MINTIES). You can find out more at their website, which also contains a wealth of other information free to download: <http://www.motivationalinterview.org/>