

Research article

Motivational interviewing in musculoskeletal care

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Abstract

Motivational interviewing is a patient-centred counselling method designed to build motivation for behaviour change by resolving ambivalence. It was developed in the addictions field and has since been applied to medical and health promotion settings. This paper will provide a brief overview of the method and will discuss how it may be used in consultations for patients with musculoskeletal problems to increase engagement with treatment and to build motivation for helpful behaviour change. Copyright © 2007 John Wiley & Sons, Ltd.

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Introduction

A common task for all healthcare professionals is encouraging behaviour change that is likely to influence health outcomes, especially with the increasing emphasis on helping patients to take more responsibility for their own care and rehabilitation (DoH, 2004). Traditional approaches to promoting behaviour change involve the provision of 'expert advice'. The wisdom of this is that patients lack insight into their condition and do not know what or how to change. It follows that if information is provided by a credible source then the patient will act on it (Rollnick et al., 1999). Advice-giving alone works for some of the time, but anyone who has tried to encourage their patients to change will be familiar with its limitations.

Motivational interviewing was originally developed in the substance abuse field (Miller, 1983) and it has been defined as a patient-centred, goal-directed method for enhancing intrinsic motivation for behaviour change by exploring and resolving ambivalence (Miller and Rollnick, 2002). According to this approach,

unresolved ambivalence (a conflict between two courses of action, each of which has perceived benefits and costs) is most likely to undermine attempts to change behaviour. Motivational interviewing views patients as having inherent motivation and capacity for change which can be evoked. To achieve this, the professional provides a supportive, empathic atmosphere while gently encouraging patients to express their thoughts and feelings about their ambivalence. The aim is to guide the patient towards identifying an acceptable resolution that favours change rather than no change (Miller and Rollnick, 2002). Once the patient is ready, a specific change plan can be negotiated, itself increasing the likelihood of change.

A number of systematic reviews and meta-analyses have examined the effectiveness of motivational interviewing across behaviours and contexts (Dunn et al., 2001; Burke, 2003; Hettema et al., 2005, Rubak et al., 2005) and have concluded that it is an effective method for enhancing health behaviour change. There is also evidence that adding motivational interviewing to proven treatments can improve outcome through an improvement in adherence and retention.

Motivational interviewing in healthcare

Although motivational interviewing was originally developed in the addictions field, motivation and adherence challenges are not unique to changing drug use or drinking habits. Each day, healthcare professionals consult with patients who would benefit from adhering to a rehabilitation programme or changing other aspects of their lifestyle, but are ambivalent about doing so. Examples include a physiotherapist trying to encourage a patient with chronic low back pain to pace activities and an occupational therapist talking to a patient with rheumatoid arthritis about joint protection. Changing health-related behaviour is complex and, given the level of effort and motivation required by the patient, it is understandable that simple advice-giving alone often fails to achieve sustainable change.

Motivational interviewing has been adapted and applied to a wide range of health behaviours (Dunn et al., 2001; Emmons and Rollnick, 2001; Resnicow et al., 2002; Britt et al., 2004; Miller, 2004). Of particular relevance to healthcare professionals working in musculoskeletal care is the application to physical activity (Harland et al., 1999; Hillsdon et al., 2002), fibromyalgia (Jones et al., 2004; Ang et al., 2007) and chronic pain (Jensen, 2002; Novy, 2004; Osborne et al., 2006).

In its pure form motivational interviewing involves multiple sessions of long duration, delivered by psychologists and highly trained addictions counsellors. In contrast, healthcare professionals working in medical settings rarely have the luxury of extended contact time; more commonly they are limited to one or two brief patient encounters. Furthermore, the context of behaviour change discussions is far more likely to be opportunistic rather than help-seeking, meaning that the

behaviour change issue is not the primary reason for the patient's appointment (Rollnick et al., 2002). Consequently, adaptations of motivational interviewing have been developed to manifest its spirit but in a briefer format for healthcare professionals without psychology or counselling backgrounds (Rollnick et al., 1992; Rollnick and Miller, 1995; Rollnick et al., 1999).

Resolving ambivalence

In motivational interviewing, the key to developing commitment and sustained behaviour change is to resolve ambivalence. The extent to which this is achieved is strongly influenced by the communication pattern between healthcare professional and patient. For example, a patient with chronic low back pain considering structured exercise as part of a rehabilitation programme may be in two minds about it – perceiving both advantages and disadvantages with both the status quo and with change. The patient may be motivated to exercise in order to reduce pain, increase function and live the life he or she wants, but, on the other hand they may perceive exercise to be uncomfortable and be anxious that it might aggravate the condition. The patient may also worry about the sacrifices required in other aspects of their life to find the time to exercise. The more the patient thinks about exercising, the greater the perceived disadvantages appear. Yet focusing on their current situation and the back pain leads to a desire to change and the acceptability of exercise increases. Failure to resolve ambivalence like this tends to lead to frustration and no change.

When faced with patients who are reticent about modifying their behaviour, healthcare professionals commonly argue for the change side of the patient's ambivalence; explaining the benefits and importance of change, the consequences of no change, how to go about it and so on. This so-called 'righting reflex' is a response that stems from a genuine desire to help the patient (Miller and Rollnick, 2002) and is often what patients expect from their healthcare professional. Giving unsolicited advice, however, can be detrimental to the change process. The natural response from the patient is to give voice to the other side of their ambivalence, 'Yes but . . . I'm worried about aggravating my condition' (commonly labelled 'resistance'). The more the healthcare professional ignores aspects of the patient's ambivalence, or assumes greater readiness, importance or confidence for change than actually exists, the more the patient will resist. The problem with this is that attitudes and beliefs are shaped by what we say. In other words, patients are persuaded by their own arguments (Bem, 1972). So if a patient is counselled in a way that results in them defending why exercise might be difficult or unpleasant he or she will become committed to that side of their ambivalence and talk themselves out of change. This explains the research finding that the level of resistance in

counselling sessions is associated with a reduced likelihood of behaviour change (Miller et al., 1993). In healthcare settings patients often feel concerned about 'upsetting' the healthcare professional and may not show overt signs of resistance. In these circumstances, resistance is displayed passively by apparently listening and agreeing to change, but without intention or commitment. This can be just as detrimental to the change process.

Arguably, patients are more likely to accept and act on their own arguments rather than those of another person. It follows that to resolve ambivalence the patient should be encouraged to express their own reasons for change. As patients hear themselves talk positively about change (without being coerced), they become convinced by their arguments. This type of speech is called 'change talk'. There is evidence that behaviour change is predicted by the extent to which patients' speech shows increasing commitment to change (Amrhein et al., 2003; Amrhein, 2004). Over time, as the patient reflects on the change talk, a discrepancy develops in their mind between what they say they want and what they are currently doing. For example, as a patient talks about how undertaking structured exercise will help to develop their fitness enough to bath their young child, and how important that is, they will relate this to their current low level of activity. In other words, if the patient keeps on talking about why exercise is such a good idea, he or she is bound to wonder why they are not doing it. The bigger the discrepancy between what someone says they want and what they are doing, the stronger the motivation is for behaviour change. The aim of motivational interviewing is to develop the discrepancy until it becomes so great that it outweighs the perceived benefits of the status quo (Miller and Rollnick, 2002).

The spirit of motivational interviewing

The essence of motivational interviewing lies in its spirit. It is not about using clever tricks to get patients to do things they do not want to do. Rather, it is a way of interacting that draws on the patient's own motivations and values (Miller and Rollnick, 2002). Although motivational interviewing advocates specific skills and strategies, unless these are employed with the correct spirit the consultation will appear mechanistic. Evidence shows that healthcare professionals' adherence to the spirit of motivational interviewing is a strong predictor of client involvement during treatment sessions (Moyers et al., 2005).

The motivational interviewing spirit has three elements.

- First, it is collaborative. The patient and health professional work together. Both are equal partners bringing special expertise to the consultation. The healthcare professional provides direction and support, elicits the patient's thoughts about change, provides information when requested and negotiates a change plan sensi-

tively. The patient is the active decision-maker (Rollnick et al., 1999). This style of working is quite different from the expert model, in which the healthcare professional is more active than the patient and assumes an authoritarian role. Indeed, an important step in becoming competent in motivational interviewing involves suppressing natural urges to respond with advice and wrestling for control of the consultation (Miller and Moyers, 2007).

- Being evocative is also critical to the spirit of motivational interviewing and refers to eliciting the patient's own answers, values and motivation. Motivational interviewing is not about installing insight, knowledge or teaching skills. Rather, it draws on the patient's perspective and ideas, thereby enhancing their intrinsic motivation and confidence for change.
- Respecting patient autonomy is the third component. There is often a temptation to tell people who show signs of resistance that they 'must change', but in reality it is the patient who chooses whether to change or not. Paradoxically, given a non-judgemental, autonomy-respecting atmosphere, patients feel free to consider the possibility of change, whereas telling someone that they must change conveys non-acceptance and inhibits the change process (Rogers, 1959; Miller and Rollnick, 2002).

The practice of motivational interviewing

A patient-centred approach

Motivational interviewing is a person-centred, goal-directed method. Influenced by Rogers' humanistic counselling (Rogers, 1959) it rests on a foundation of patient-centred counselling skills to elicit, clarify and understand the patient's perspective about change. The basic skills involved are asking open-ended questions, affirming the patient, expressing empathic reflective listening statements which accurately capture what the patient has said or the underlying meaning, and providing summaries. The collective aim of these skills is to provide a platform which enables the exploration of ambivalence without fear of judgement. Motivational interviewing is also goal-directed in the sense that the professional provides a structure which directs the consultation towards the resolution of ambivalence. This is achieved in two phases.

Two phases of motivational interviewing

In the first phase of motivational interviewing the aim is to build intrinsic motivation and confidence for change. This is achieved through the directive use of the

counselling skills to evoke and strengthen change talk as well as minimizing and diffusing resistance. To evoke change talk, questions are asked about why change may be beneficial and how the patient's current behaviour influences the presenting condition. For example: 'In what ways would it be good for you to . . .?', 'What do you hope will be different?' and 'How does [the behaviour] fit into that?' Change talk may also be elicited by asking the patient to imagine the best consequences that would result from making a change and what concerns them most about their current situation (or the option of no change). Using a decisional balance to enquire about the good and less-good things associated with the option of change and no change also encourages patients to talk openly about both sides of their ambivalence.

In behaviour change counselling (an adaptation of motivational interviewing) strategies have been developed to explore ambivalence in a time-efficient way (Rollnick et al., 1999). The following example gives an insight of what is involved. It begins with an open-ended question:

'On a scale from 0 to 10, how motivated are you, right now, to exercise on a regular basis? Zero on the scale is not motivated at all and 10 means very motivated.'

Then the patient is asked how confident he or she is that they can make the change:

'How confident are you that you could stick to a new level of exercise if you decided to do so, where 0 is not confident at all and 10 is very confident?'

After getting scores for motivation and confidence, patients are asked to justify their scores:

'Thinking about the motivation scale, why did you say X and not 0 (or a lower number)?'

The responses will be change talk. A second question that is helpful is

'What would help you move higher?'

This time the responses will be the barriers to change. This exercise can be repeated for the confidence scale.

How the healthcare professional responds to patients' change talk is important in enhancing intrinsic motivation for change. Once change talk emerges, empathic reflective listening statements, which capture what has been said, help patients to feel understood and encourage further exploration of what was reflected. Asking for examples and elaboration ('In what ways?', 'Can you give me an example?', 'Describe the last time this occurred.') serves to increase engagement in change talk and encourages patients to develop their arguments.

As described earlier, resistance during a consultation is often a sign that the healthcare professional has misjudged some aspect of the patient's readiness, confidence or motivation for change and has not fully appreciated the patient's ambivalence. A shift in communication is necessary in order to diffuse the resistance. One way to achieve this is to use a simple reflective listening statement, which acknowledges the patient's thoughts and feelings. This is often enough to reduce any defensiveness and pre-empt further disagreement. For example:

Patient: 'My doctor told me that I should try to do more activity. But he doesn't understand, it hurts when I do too much and I really don't want to make things worse, the pain's bad enough as it is.'

Healthcare professional: 'You're in pain right now and don't want to make it any worse.'

Complex reflections are also used in motivational interviewing to acknowledge what is being said while re-directing the conversation. An example is where the healthcare professional reframes what has been expressed, thereby offering a new interpretation without undermining the patient's experience or understanding:

Patient: 'I can't stand this. Just when things were going so well, I get this flare-up. You know I was walking nearly half a mile every day and I was able to bath my daughter. And now I find it hard to move. It's like I'm back at square one. What's the point?'

Healthcare professional: 'You've noticed by staying active, you've been able to do things which are important to you, but it's really hard to see the progress in light of this setback.'

The reframe is designed to help the patient see things from a perspective that is more conducive to change. There are different types of complex reflective listening statements and other ways to respond to resistance, such as shifting focus and emphasizing personal control. These are discussed in Miller and Rollnick (2002).

The transition to 'phase two' of motivational interviewing occurs when the patient perceives the discrepancy between their current behaviour and future goals to be too uncomfortable to sustain and expresses a readiness to change. Phase two focuses on strengthening commitment to change and developing a plan of action. At this point it would be very easy to assume an expert role and tell the patient what he or she needs to do. However, the risk with a simple prescription is that it may be unacceptable, or the patient may lack confidence in their abilities to do it. It is therefore important to remain patient-centred. Open-ended questions, which encourage the transition from 'phase one' to 'phase two' without evoking resistance are: 'Having thought about your back pain and current exercise level, what is the next step for you?', 'What changes in your exercise level might you need to make to improve your condition?' Such questions reinforce that the decision to change rests with the patient and subsequent plans are more likely to be realistic and result in increased commitment and confidence for change. Reflective listening state-

ments are used in response to the patient's answers and affirmations are used where appropriate. At the end of this phase the patient should have a change plan that has the following features;

- the patient has been actively involved in its development
- the agreed level of behaviour change is specific, measurable and time-bound
- the patient is confident he or she can achieve the level of behaviour change
- the patient has realistic expectations about the outcome of the behaviour change and a clear way to monitor progress towards the goal
- the patient has addressed the key barriers to change.

Information exchange

Although being patient-centred is central to motivational interviewing, this does not mean that providing information is proscribed. Healthcare professionals have a good understanding of what has worked for other patients and what the scientific literature indicates, and they have no need to deny their expertise. Information exchange can occur at any point during a consultation.

According to motivational interviewing, *how* the information is provided is perhaps as important as *what* is said. A three-stage process is used to achieve this.

First, the healthcare professional asks permission to provide the information since unsolicited information or advice risks building resistance. There are three forms of permission: the patient asks for advice; the healthcare professional asks permission to give it, 'Would you like to know . . .' or 'There's something that concerns me here. Would it be all right if I . . .'; and the healthcare professional prefaces their advice with permission to disregard it, 'This may not be important to you' or 'You may not agree'.

The second stage in information exchange involves providing the information in a neutral way that leaves the personal interpretation to the patient. Referring to what has worked for other patients, or what the literature indicates, is a good way to avoid patients feeling as if they have to act on what is being said: 'Other patients I've seen with low back pain find relief after performing a range of specific exercises'.

Lastly, patients are asked to interpret the personal meaning of what they have just heard: 'What do you make of that?', 'How do you think that might help you?'

Conclusion

Motivational interviewing is an evidenced-based method designed to increase patient motivation, which seems well-suited in its adapted forms for use in consulta-

tions by healthcare professionals dealing with musculoskeletal problems. It emphasizes the quality of the therapeutic relationship and relies heavily on the use of patient-centred counselling skills to provide the conditions of support that allow patients develop in a healthy direction. It is also directive – aiming to resolve ambivalence by carefully drawing out and reinforcing the patient's own reasons for change.

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