Motivational interviewing to help patients achieve dietary and lifestyle changes

Obesity and its consequences, such as diabetes and cardiovascular disease (CVD), have significant health and NHS cost implications. Relatively small reductions in weight (around 5–10%) have clinically important benefits (Pietrzykowska, 2016), but long-term weight loss maintenance is challenging. Behaviour change interventions have been identified as key for use in weight loss by authorities such as the National Institute for Health and Care Excellence (NICE, 2014). In particular, motivational interviewing (MI) — a form of behaviour change — has been identified as a successful approach to changing health behaviours (Rollnick and Miller, 2013). There is an abundance of evidence showing that just telling people what to do does not work as a way to change patients’ behaviour in order to achieve health gains (NICE, 2014). Furthermore, there is emerging evidence that MI does work and leads to long-term health gains. This article provides an overview of MI to help general practice nurses (GPNs) in their day-to-day practice.

Motivational interviewing (MI), as a method for achieving change, began in the mid-1980s largely spearheaded by two clinical psychologists: Professor William Miller and Professor Stephen Rollnick. It was built on the patient-centred approach of Carl Rogers from the 1960s and was initially developed in the field of addiction (Miller and Rollnick, 2013). More recently, its use has expanded and, in the healthcare setting, it is proving to have good results in areas that need to rely on patients making changes to their own lifestyle to achieve health gains; such as in patients with heart disease, diabetes and obesity (Hardcastle et al, 2013; Williams et al, 2014; Ekong and Kavookjian, 2015).
The premise of MI is that people are the experts on themselves, and usually know what they need to do to change. MI works by tapping into people’s own goals, values, aspirations and dreams. Ironically, acknowledging a patient’s right to autonomy and their freedom not to change, actually makes change possible. Indeed, trying to make people change usually drives them in the opposite direction. The aim of MI is to evoke what we call ‘change talk’, with the idea that the more you hear yourself say something, the more likely you will be motivated to do it.

MI involves:
- The use of reflective listening skills and summarising/interpreting back to patients what they have said, especially if they have expressed a desire to change
- Humbling oneself as a healthcare professional and allowing the patient to make the decisions about what to do (understanding that they do know what to do in most cases)
- Acknowledging and reflecting back a patient’s strengths and efforts in a non-patronising way
- Asking open questions
- Showing interest and concern; gaining an understanding of the patient’s world and so being able to ‘see’ through their eyes
- Having unconditional positive regard for the patient
- Finally, the process involves quite detailed planning with the patient on how they will achieve the change, including overcoming any perceived barriers (Botelho, 2004; Miller and Rollnick, 2013).

**Why MI may be difficult for healthcare professionals**

In the author’s clinical experience, healthcare professionals often approach patients with a ‘righting instinct’: they tend to want to point out to the patient where they are going wrong and what they need to do to improve their health. It is often the hardest thing to resist doing because it is genuinely born out of a spirit of concern and caring for the patient. However, adopting an MI-style can achieve far more positive results, as it meets with a far more receptive response.

**The ‘Spirit’ of MI**

It is hard to become technical about MI and to lay out steps and elements that should be included. However, there are a few basic ‘ways of being’ when adopting an MI approach, which can be explained in three elements (Fuller and Taylor, 2008; Miller and Rollnick, 2013):

- Collaboration versus confrontation
- Evocation: drawing out, rather than imposing ideas
- Autonomy versus authority

**Collaboration versus confrontation**

MI is about a partnership between healthcare professionals and patients, which should be grounded in the patient’s viewpoints and experiences. Healthcare professionals should not confront the patient, impose their perspective, or tell them what to do. Being collaborative allows for rapport and the facilitation of trust, whereas a more challenging and hierarchical relationship can entrench a patient’s poor lifestyle behaviour even more. This does not mean that the healthcare professional has to agree with the patient’s current behaviour or ideas about how they can change — it is not about the healthcare professional being right, but rather about reaching a mutual understanding.

**Evocation: drawing out, rather than imposing ideas**

In MI, healthcare professionals should aim to draw out patients’ own thoughts and ideas, rather than imposing their own opinions. Motivation and commitment to change is most powerful and durable when it comes from the patient. Trying to reason with a patient usually does not work, nor does the nurse trying to convince the patient how much they want them to change. The patient has to discover their own reasons and determination to change. Therefore, the healthcare professional’s job is to draw out the patient’s own motivations and skills for change and not to tell them what to do and why they should do it.

**Autonomy versus authority**

The true power to change rests with the patient, not the healthcare professional; the patient is responsible for their own actions. Patients can be empowered to make the necessary changes but healthcare professionals should reinforce that there is no one ‘right-way’ to do this.

**MI Consultations**

A consultation with a patient needs to involve four elements, namely:

- Engage
- Focus
- Evoke
- Plan (Miller and Rollnick, 2013).

Stages may need to be repeated, e.g. if the process seems ‘stuck’, or if seeing a patient after a gap.

**Practice point**

MI is a particular behaviour change approach that guides individuals to overcome their ambivalence by exploring their own desire and ability to change. This supports change in a manner congruent with a person’s own values and concerns.

**Giving advice...**

There is a role for giving advice in MI, but it is not the main part of the consultation and it should always be done in a manner that emphasises the patient’s autonomy and choice. An example of this would be asking the patient’s permission before imparting advice or giving information on a range of options.

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**Definition of MI**

A collaborative person-centred form of guiding to elicit and strengthen motivation for change.
Engage
This is the introductory stage. It is often missed due to time pressures resulting in the patient leaving the consultation without even knowing the healthcare professional’s name and making no connection. First impressions are powerful and will help determine whether the patient will trust the healthcare professional and engage with them, or even bother to come back. The engagement process should convey to the patient that they are going to be listened to and not judged.

Focus
Focusing clarifies the goal towards which the healthcare professional and patient will move together; it is the unravelling of whether, why, how and when the patient might change. In this stage, the focus in MI is established through a purposeful conversation that focuses on change. Once focus is established, an ongoing process to seek and maintain direction is required. This is because once found, direction can get buried as the consultation proceeds.

Evoke
Evoking could be said to be the process that distinguishes the counselling process as MI. It involves trying to encourage ‘change talk’ (see below) from the patient. When change talk is heard, ‘evoking’ means working with the patient to strengthen motivation for change. The evoking process also involves addressing ambivalence in patients (where they are not sure if they want to change their behaviour or not), and moving them along so that they believe they want to and can change. It also involves moving patients away from ‘sustain talk’; where they talk themselves into seeing no need to change from the status quo. Evoking does not involve identifying the missing ingredient in a patient and then installing it so that the patient automatically starts to improve their health behaviour. The premise is that patients already have much of what they need within them — it may be deeply buried and untapped, but the role of the healthcare professional is to bring it to the fore.

Plan
Helping patients plan how they will change their behaviour can begin when they are ready and have been talking more about when and how to change, and less about whether to change and why. Planning involves both solidifying the commitment to change and formulating a specific plan of action. Plans may need revisiting as agility is required when obstacles are hit, or there are unanticipated challenges. Again, it should be remembered that the plan of action has to come from the patient; the healthcare professional’s role is to work with the patient and help them to develop plans that are realistic.

Table 1 outlines some reflective questions which may help to make MI progress at the various stages outlined above.

Use of OARS
The acronym OARS (use of open-ended questions) is a way of remembering the basic approach used in MI. This involves asking the patient questions that do not just involve a ‘yes/no’ or short answer, but invite more elaborate and thought-through responses. Thinking and voicing answers to some well-placed questions can set the patient on the change journey (Rollnick and Butler, 2010).

Use of affirmation
Patients respond best when they believe in the power of self-efficacy. Healthcare professionals should be able to boost what is already positive in a patient’s behaviour, but not in a patronising way. There is a need to be congruent and genuine. Open acknowledgement of a patient’s strengths can help them feel that change is possible, even if they have missed due to time pressures resulting in the patient leaving the consultation without even knowing the healthcare professional’s name and making no connection. First impressions are powerful and will help determine whether the patient will trust the healthcare professional and engage with them, or even bother to come back. The engagement process should convey to the patient that they are going to be listened to and not judged.

Table 1: Questions to help MI progress (adapted from Rollnick Cardiff workshop, January, 2016)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Questions</th>
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| Engaging | - How comfortable are you both, for example, are there no distractions so you are free to fully engage?  
- Do you understand the patient’s perspective and concerns?  
- Do you feel in collaboration with the patient? |
| Focusing | - Do you and the patient both agree clearly on what needs changing?  
- Do you and the patient both have a clear sense of direction? |
| Evoking | - Do you know the patient’s reasons for wanting to change?  
- Are you hearing ‘change talk’ clearly?  
- Are you supressing the ‘righting reflex’ that could be leading you to set your and not the patient’s agenda? |
| Planning | - What would be a reasonable next step for change?  
- What would really help this person to move forward and succeed? |
been unsuccessful in the past. This also helps to build rapport.

**Use of reflective listening**

This is often considered the most crucial skill in MI (MINT; Rollnick, 2016), as it brings to life the principle of expressing empathy so that the patient feels the healthcare professional really understands their perspective. Reflecting on the positive aspects of change and also highlighting the negative aspect of the *status quo*, can gently help the patient resolve ambivalence towards change.

As MI is practised, healthcare professionals can learn to use several forms of reflective listening; the simplest of which is just to reflect back the patient’s words. More complex reflection involves paraphrasing what was said which can help solidify any ‘change talk’ that is heard. Other forms of reflection can be used when the patient seems resistant to change.

Summaries involve recapping what has occurred in all or part of the consultation. A summary should communicate to the patient that the healthcare professional has been interested and understanding. It should highlight the important elements of the discussion, especially talk that helps to move the patient along. Summaries can also help to shift direction towards ‘change talk’ (Rollnick and Mason, 1999; Vimeo, 2014).

**EVIDENCE BASE FOR MI**

MI is a relatively new skill, especially in healthcare fields beyond addiction, and yet there is a growing body of research for its use in areas of cardiovascular disease (CVD), diabetes, and obesity. Boxes 1–3 outline recent research studies looking at MI in these areas.

**CONCLUSION**

MI integrates elements of humanistic, patient-centred therapy with those of behaviour therapy. It helps patients identify specific ways they would like to change, while valuing them for who they are as individuals. MI-practising healthcare professionals can talk to patients about aspects of their lives that are dissatisfying, leading to ill health, then look at ways they would like things to change for the better. They can help develop plans alongside the patient in a way that the patient feels confident to implement. In MI, patients are allowed to become more who they are (as opposed to being constrained by the limiting things they may have been told about themselves). This allows them to begin to perceive and act in different more congruent ways. As Terry Pratchet said:

... when you seek advice from someone, it’s certainly not because you want them to give it. You just want them to be there while you talk to yourself. \( \text{GPN} \)

**Box 1**

**MI for cardiovascular disease (CVD)**

Study 1 evaluated the effectiveness of a six-month MI intervention in a UK primary care setting in maintaining reductions in CVD risk factors at 12 months post-intervention. Primary-care patients were randomised to an intervention group that received standard exercise and nutrition information plus up to five face-to-face MI sessions, delivered by a physical activity specialist and registered dietitian over a six-month period, or to a minimal intervention comparison group that received the standard information only. Follow-up measures of behavioural (vigorous and moderate physical activity, walking, physical activity stage of change, fruit and vegetable intake, and dietary fat intake) and biomedical (weight, body mass index [BMI], blood pressure, cholesterol) outcomes were taken immediately post-intervention and at a 12-month follow-up session. There were significant differences between groups for walking and cholesterol: obese and hypercholesterolaemic patients exhibited significant improvements in BMI and cholesterol respectively among those allocated to the intervention group, compared to the comparison group. The authors concluded that an MI counselling intervention is effective in bringing about long-term changes in some health-related outcomes, namely walking and cholesterol levels, associated with CVD risk.

(Hardcastle et al, 2013)

Study 2 looked at the use of MI with 816 workers in the construction industry who were overweight and had elevated CVD risk. Subjects were randomised and given usual care or a six-month lifestyle intervention consisting of individual counselling using motivational interviewing techniques, which was delivered by an occupational physician or occupational nurse. In three face-to-face and four telephone contacts, the participants’ risk profile, personal determinants, and barriers for behaviour change were discussed, and personal goals were set. Participants chose to aim at either diet and physical activity or smoking. Data were collected at baseline and after six and 12 months, by means of a questionnaire. The intervention had a statistically significant beneficial effect on snack and fruit intake at six months. The effect on snack intake was sustained until 12 months; six months after the intervention had ended. The beneficial effect on smoking was statistically significant at six but not at 12 months. The authors concluded that considering the rising prevalence of unhealthy lifestyles and CVD, especially in the ageing population, implementation of this intervention in the occupational healthcare setting is recommended.

(Groeneveld and Proper, 2011)

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MINT: www.motivationalinterview.org. Official website for MI trainers
Rollnick S (2016) Helping patients change behaviour. Cardiff Motivational Workshop, SWALEC Stadium, January 18th and 19th
Vimeo (2014) www.vimeo.com/67088727 (MI video about slowing down pace, keeping calm and letting patients take the lead)

Box 2

**MI for diabetes**

Study 1 was a systematic review that looked at 50 studies on MI in type 2 diabetes. Behaviour targets included dietary changes, physical activity, smoking cessation, and alcohol reduction. MI had significant impact on certain dietary behaviours, including weight loss.

(Ekong and Kavookjian, 2015)

Study 2 aimed to develop and test the effects of an MI self-management programme for use with 42 elderly patients with diabetes mellitus (experimental group: 21, control group: 21). The experimental group took part in a 12-week MI programme (eight weeks for group motivational interviewing and education and four weeks for individual motivational interviewing on the phone). Significant improvement was found for self-efficacy, self-care behaviour, glycaemic control and quality of life in the MI group compared to the control group. The authors concluded that an MI programme is effective and can be recommended as a nursing intervention for elderly patients with diabetes.

(Kang and Gu, 2015)

Box 3

**MI for weight management**

Study 1 took 170 individuals aged 18–70 years, with a current or previous BMI of ≥30kg/m², who could provide evidence of at least 5% weight loss during the previous 12 months. They were divided into two arms, both of which received individually tailored MI, which included planning and self-monitoring and a third control group. The intensive arm received six face-to-face sessions followed by nine telephone sessions. The less intensive arm received two face-to-face sessions followed by two telephone sessions. The control group received a leaflet advising them on healthy lifestyle.

The intensive intervention led to a statistically significant difference in weight above the other arm or control group. The authors concluded that the intensive intervention was feasible and acceptable, and retention and adherence was high and may facilitate long-term weight maintenance. As this was a feasibility study, the authors recommended further research in this area.

(Simpson et al, 2015)

Study 2 was a randomised controlled trial of 54 women that tested the effectiveness of an intervention delivered by healthcare professionals using an MI counselling style to prevent weight gain in non-obese (body mass index [BMI] 18.5 and 29.9kgm(-2)) women in late pre-menopause.

The women were assigned to an MI intervention (five health professional MI counselling sessions) or a self-directed intervention (SDI) (print materials only) (n=26). The primary outcome, body weight and secondary outcomes, which included blood pressure, were measured at baseline and post-intervention (12 months). The weight at 12 months for the MI group of 65.6kg was significantly less than the SDI group of 67.4kg. Also, the MI group had significantly lower blood pressure. The researchers concluded that for this relatively low-intensity intervention, incorporating MI into health professional counselling, not only effectively prevented weight gain, but also achieved significant weight loss and decreased diastolic blood pressure.

(Williams et al, 2014)
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