Telling people to quit smoking or take their medicines as prescribed is easy. Convincing them to do so is not so simple. Is there more that pharmacists can do to help patients lead healthier lifestyles?

How motivational interviewing can help patients change their lifestyles

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Long-term health conditions, such as heart disease, diabetes and chronic pain, are becoming an increasing burden on healthcare resources and are seen as a political priority in the UK. In England, around 15 million adults have a long-term health problem.

The extent to which patients manage long-term health conditions depends, to a considerable degree, on what they do for themselves. Put simply, patients who initiate and sustain meaningful changes to their health-related behaviours tend to experience better treatment outcomes and quality of life than those who do not. Therefore, an important component of long-term care is to encourage and support patients to self-manage their condition.

Pharmacists are frequently involved in encouraging patients with chronic conditions to change their behaviour — such as to take medicines as prescribed, stop smoking, eat more healthily and become more active. Although the benefits of such changes are often recognised by patients, the changes are seldom easy to achieve. A common approach to encouraging change involves advising and educating patients about how and why they should do so. Although advice-giving alone is sometimes effective, there is often a tension between what the pharmacist thinks the patient would benefit from and what the patient is ready, willing and able to do. Attempts to educate or advise, however well-intentioned, can result in unproductive dialogue that is frustrating for both parties and often undermines change.

**Barriers to change**

It might not be a lack of knowledge or the “right” attitude that prevents a patient from making a behavioural change. According to eminent clinical psychologists William Miller and Steve Rollnick, the main reason why people fail to make a behavioural change is the presence of unresolved ambivalence (the normal human experience of wanting something and, yet, not wanting it). For example, patients who are considering quitting smoking may be in two minds about it. On one hand, they want to avoid the negative health consequences of smoking and can see that quitting would mean they have more money to spend on other things. Equally, though, there are motives that serve to maintain their habit (eg, they may be concerned that quitting will result in weight gain).

So what effect does advice-giving have on patients who are in two minds about change? When advised about the reasons and need for change (eg, “You should quit because . . .”), patients typically reply with the other side of their ambivalence (eg, “Yes, but I don’t want to gain weight”). Although it is natural for a healthcare professional to assume the patient is being resistant or awkward, the patient’s behaviour is a reflection of how they have been spoken to. Driven by a desire to be understood and not judged negatively, they justify their current behaviour (“If it were that straightforward, I’d have quit by now”). Furthermore, those who are forced to defend their reasons for resisting change become more committed to the status quo.

**Motivational interviewing**

Motivational interviewing (MI) represents an alternative method for building motivation for change and achieves this by eliciting and reinforcing the patient’s own reasons for changing their behaviour. As the 17th century French philosopher Blaise Pascal said: “People are generally better persuaded by the reasons which they have themselves discovered than by those which have come in to the mind of others.”

Process research has identified two components to the delivery of effective MI: one relating to its empathic counselling style and overall spirit, the other being the skill to elicit and reinforce a person’s own arguments for change and commitment to it.

**Counselling style** MI relies on a foundation of patient-centred...
counselling skills (eg, using open-ended questions, affirmations, reflective listening statements and summaries) to create an environment that encourages change. Of particular importance is the skill of accurate empathy. This involves listening carefully to what patients say, developing a hypothesis as to what they mean and then saying it back to them in different words. For example:

**Patient:** "My doctor told me that I should stop smoking, but he doesn’t understand. I’ve tried to give up before and I couldn’t stick with it."

**Pharmacist:** "Though your doctor thinks you would benefit from quitting, you’re not confident you could."

Complex reflections are used in MI to demonstrate you are listening. They focus on what the person is meaning but hasn’t stated explicitly.

**Patient:** "I am so frustrated. This is not working. I’m thinking about giving up."

**Pharmacist:** "You’d really like things to change."

In this example the pharmacist extracts the patient’s motivation for change without undermining their understanding or experience. Reflective listening statements will help the patient to feel understood and, as a consequence, encourage deeper exploration of the issues influencing change. The statements can also be used strategically, such as to differentially reinforce patients’ arguments for change or to point out discrepancies in what they say they want and what they are currently doing.

**Spirit** MI is underpinned by a spirit of respect for patient autonomy and freedom of choice. The patient-professional relationship is like a partnership in which two people discuss the whys and hows of change in an open and respectful manner. Rather than installing perceived deficits in knowledge, skill or attitude, the practitioner carefully draws out from the patient their own reasons for change and concerns about the status quo.

Inherent in this spirit is a belief that, given the necessary conditions of support, people will make changes to their lifestyle that improve their health. This style of working may run counter to our natural inclinations to install motivation by explaining the benefits and importance of change. Therefore, learning MI is as much about “unlearning” well-entrenched counselling habits as it is about learning new ones.

It is noteworthy that MI is not a way of getting patients to do what you want them to do. It is not a clever trick for getting them round to your way of thinking. It is about making salient patients’ own motivations. Counselling without the autonomy-respecting, evocative spirit is not MI.

**Technical skill** MI focuses on building patients’ motivation and commitment for changing, and strengthening their confidence for this action. The professional should evoke and reinforce the patient’s desire, ability, reasons and need for change and respond to arguments against change in a way that diffuses them. When done well, skilful MI allows for a natural and flowing conversation in which the patient becomes increasingly committed to making the necessary change.

**Pharmacy’s role**

The pain management services delivered at Southampton University Hospitals NHS Trust encourage patients, where appropriate, to become actively involved in their own care. As part of the clinic’s multidisciplinary team, the pharmacist’s role is to review, manage and advise on complex medication regimens. This involves a particular focus on the use of opioid

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**Box 1: Case study**

Emma Davies, highly specialist pharmacist for pain services at Southampton University Hospitals NHS Trust, offers an example of a patient for whom motivational interviewing was particularly effective:

A young female with a four-year history of pelvic pain was over-using analgesics. At times, when her pain increased, she sought strong intravenous opioids from her local hospital. When this treatment was refused, she would discharge herself, return to her accommodation and take excessive doses of oral opioids — often to the point that she felt out of control and, on occasion, came close to passing out. The medication did not alleviate the pain; it just removed her from reality.

Motivational interviewing was used to try to change the way she responded to increased pain — specifically to reduce her reliance on medicines. I invited her to talk about her current behaviour and I responded with reflective listening statements. Doing this allowed me to enquire about the concerns she had about her current behaviour. She discussed how vulnerable she felt after taking high doses of opioids and how she wanted to take lower doses and feel more in control. She also acknowledged that the higher doses did not make her feel any better. She went on to talk about her goals for the future — for example, going back to college — and reflected that she would only be able to achieve these if she changed her use of medicines. She also said her behaviour made her “feel like a drug addict” and this was not how she wanted to feel. All of these issues were catalysts for her deciding to change her use of opioid medicines. Subsequently, we developed a written plan for managing her flare-ups and, over time, she learnt to cope with her pain, use less medication and become less reliant on hospital admission.

Currently, she is undertaking voluntary work and is considering training for a new career in education. Importantly to her, she has not been admitted to an emergency department for over nine months.
medicines at a weekly medication review clinic. Many patients who attend the clinic struggle to make the sorts of behavioural alterations that will improve their pain, functioning and wellbeing. A big challenge from a pharmacy perspective is to help patients view their medicines as one component of a multifactorial pain management strategy and take them more effectively (see Box 1, p29).

**Training** MI is a skilled counselling method that takes time and effort to learn. Although health professionals vary in how quickly they develop proficiency in MI, a two-day workshop is often enough to give an insight into the method and provide opportunities to practise some of the skills. Nonetheless, ongoing coaching and feedback on practice is necessary to develop proficiency. There is good evidence that professionals without backgrounds in psychology and counselling can be taught to use MI effectively (see Box 2). Those interested in training in MI can visit the Motivational Interviewing Network of Trainers (MINT) website (www.motivational interview.org). This website includes a geographical listing of MINT members who offer training aimed at developing MI skills.

**Putting into practice** Integrating MI into routine practice can be complicated. Clearly getting enough of the right training is important so that the MI delivered is of sufficient quality to make a difference for patients. But everyday practice also gives rise to pressures and issues that confuse matters.

**Finding the time** In reality, healthcare professionals undertake many tasks to help their patients and the amount of time that can be devoted to discussions about behaviour change is often limited. That said, MI is a relatively efficient means of promoting change. During a trial to assess how people with alcohol dependence respond to different treatment approaches, those who took part in MI fared just as well as those who received other proven interventions, but did so in a third of the contact time. Part of the efficiency may be related to the emphasis on really listening to the patient. Carefully worded questions and thoughtful reflective listening statements reduce patient defensiveness and help get to the heart of the ambivalence relatively quickly. Sometimes a short, high quality conversation is enough to get the patient to commit to change. However, not all consultations result in decisions about change being made. Using MI in the time that is available can get patients to start thinking about change and can increase the likelihood that they will continue that process after the session has ended. Furthermore, the emphasis on listening carefully to patients means they might be more inclined to agree to discuss the matter further at a future session.

**Opening up** A concern often expressed by health professionals when learning MI is that patients will begin to talk too much. This is a valid concern. Few people experience high-quality listening in their lives and so being on the receiving end of it is extremely positive. This might mean that patients share lots of information with you, some of which is not relevant to the discussion. This is easily managed; summarising what the patient has said then restating the original question is often enough to get them back on track without undermining the rapport you have established. A related concern is that patients might become emotional or share personal information. Listening carefully to what a patient tells you, however, is unlikely to do any harm and is often all they need or want. Of course, it is important to be aware of your professional responsibilities and sphere of competence, and to have appropriate sources of referral to draw on when required.

**Undergraduate teaching** Encouraging patients to make changes in health behaviour is a challenging aspect of a pharmacist’s role and important given the NHS focus on managing long-term conditions effectively. MI is an evidenced-based method for building motivation for behaviour change that is well suited for use by pharmacists. Although it is not a panacea, we hope that formal teaching and assessment of communication skills in pharmacy undergraduate teaching will include this counselling method. This will pave the way for pharmacy graduates to leave university equipped with the sorts of skills that empower pharmacists to become leaders in healthcare communication.

**Box 2: Evidence**

Meta-analyses of motivational interviewing (MI) have shown that the method is effective and efficient for enhancing health behaviour change. Originally developed for people with alcohol problems, MI has since been used in many settings to help promote a range of behavioural changes. Examples pertinent to pharmacy include chronic pain management, diabetes risk reduction and treatment, health promotion (e.g., increasing physical activity), HIV/AIDS risk reduction and smoking cessation. MI is most beneficial when it is used as a prelude to other proven interventions. It appears that people make better use of treatment after MI, with evidence suggesting a substantial improvement in appointment attendance and engagement with treatment, as well as better treatment outcomes.

**References**