Clinical Perspectives on Motivational Interviewing in Diabetes Care

Marc Steinberg, MD, FAAP

Editor's note: Motivational interviewing (MI) is a collaborative counseling strategy that engages people in conversations that guide them toward strengthening their motivation to change behaviors. This article and a subsequent one that will appear in the next issue of *Diabetes Spectrum* explore clinical aspects of using MI in diabetes practice.

During the past two decades, prolific development has occurred in the areas of medication and self-management technology options for people with diabetes. No other time period since the introduction of insulin therapy in the 1920s has seen such significant improvements in diabetes care. However, despite these improvements, there are still sizable gaps in quality outcomes for people with diabetes. These gaps in care are manifested in research reflecting that overwhelming numbers of people with diabetes do not meet guidelines for glycemic control, blood pressure, and lipid levels.[1,2] These care gaps are also accompanied by challenges clinicians experience in facilitating behavior change across the entire spectrum of diabetes care: physical activity, diet, weight loss, regular use of medications, and the use of well-established algorithms linking self-monitoring of blood glucose to medication and lifestyle self-management.

We, as clinicians, experience pain and frustration when our patients with diabetes develop complications that could have been delayed or prevented by enhanced self-management. But few of us received training to prepare us for the seemingly daunting tasks of working with the ambivalence, resistance, depression, and burnout that many experience living with diabetes. Few illnesses affect as many aspects of life as diabetes.[3]

For decades, I practiced in primary care with a special interest in diabetes. After pursuing additional training, I transitioned my practice several years ago to working exclusively in diabetes care with a special interest in the behavioral aspects of self-management. My practice now is populated by referrals from other clinicians to see people who are struggling with or completely neglecting their diabetes self-management. In this article and a second one that will be published in the next issue of *Diabetes Spectrum*, I will share perspectives on motivational interviewing (MI). This collaborative approach to diabetes care offers clinicians who are willing to consider changes in the way they practice the opportunity to more enjoyably and effectively address the most challenging area of diabetes care: facilitating people's efforts to improve their diabetes self-management.

In reviewing the development of MI, Miller and Rose[4] describe Miller's early work in the 1980s using MI as a successful empathic counseling treatment for alcoholism. In 1989, Miller met Stephen Rollnick, and in 1991, they wrote the first textbook describing this successful approach for improving outcomes in the treatment of addictive disorders.[5] Since then, the use of MI has expanded as a strategic approach to helping people with mental health disorders and chronic medical illnesses. It has been used for high-risk behavior prevention and by

corrections officials in many different countries working with people who are incarcerated, paroled, or on probation. MI involves creating a safe setting for people to consider change. It also involves specific skills for guiding people toward the achievement of their goals.

Some of the research evidence for MI effectiveness in diabetes care has been equivocal, but this does not eliminate the usefulness of MI as an approach. Research on behavioral interventions is challenging. Such interventions cannot be applied in double-blinded crossover studies, a model often used in pharmaceutical research. Participants in clinical research studies easily recognize changes in verbal and empathic approaches to care, which compromises the use of blinded studies in behavioral research. And research clinicians may have varied skills in applying the experimental interventions. The research presented here supports this strongly patient-centered process of working with people to facilitate behavior change.

Describing to people the potential complications of their conditions rarely results in behavior change.[6] People infrequently initiate change based on fear tactics emphasizing future suffering when they are already burdened by pain and challenges with their diabetes and with other important areas of their lives. Also, people often disengage from changes when they are subjected to clinician lectures on statistics or facts.

Clinicians using the spirit of MI seek to foster a compassionate environment in which to engage people in discussions that guide toward eliciting their reasons and plans for the changes they wish to make. This process of evoking "change talk" results in patient language relating their desires for improvements beyond the status quo. This trajectory toward changes in behavior can involve broader lifestyle changes, including perspectives on a topic, changes in self-perception, and even basic values.[7] As people increase change talk, the likelihood of change occurring also increases.[8]

MI respects individuals' autonomy. Evoking change talk guides people in their choices about initiating change, in contrast to directing them to what we think they should do. After all, what occurs after a clinic visit is entirely dependent on decisions people make on their own. The unique interactions facilitated by MI supports people in "writing their own prescriptions" from the manifold options available to them.

Engaging patients in the clinical relationship is an essential element of MI. Without engagement, it is not possible to use MI. Exploring disengagement with people and observing how we behave during our interviews in the context of the spirit of MI facilitates engagement.

The Transtheoretical Model (TTM) of behavior change combines numerous psychological theories of behavior change.[9] Miller and Rollnick pointed out in 2009 that MI is not based on TTM.[10] TTM simply facilitates an understanding of the hard work and time people need to undertake change. Also, awareness of the stages of change—Precontemplation, Contemplation, Preparation, Action, and Maintenance—can help to guide engagement strategies with patients.

Many of the patients we see do not come to discuss change. Research on TTM has revealed that 92–96% of health plan enrollees are in the Precontemplation or Contemplation stages of change concerning smoking cessation, healthier eating, and increased physical activity.[11] People in Precontemplation are not considering any behavior changes. Those in Contemplation may consider change for months as they weigh the pros and cons of choices with ambivalence. Engagement involves working with people using approaches tailored for where they are on the continuum of considering change.

In Precontemplation, patients prefer the status quo and use what MI views as "sustain language." People speaking like this are very likely to resist or ignore clinicians' insistences to change. To facilitate engagement, asking an open-ended question about patients' previous experiences initiating beneficial changes in other life areas can be used to affirm their expertise in the challenging work of making changes. Exploring the future aspirations for their life is another opportunity to ask speculative questions. "How does your diabetes fit into this plan?" "Are there any diabetes issues that could have an influence on the desires you have for the future?" "I know you are not interested in physical activity, and I am not trying to force it on you, but can you think of any benefits for you by being more active?"

Change is a process, and it does not occur immediately. It may take months or years. So the most important clinical issue in Precontemplation is patients' willingness to return. Embracing a collaborative spirit, honoring self-efficacy, and avoiding arguments for change can strengthen people's desire for a return appointment. "Rolling with resistance" is an integral part of MI. Arguing with people for change encourages them to defend behaviors that do not enhance self-management, making the process of change more unlikely.

Ambivalence is the hallmark of the Contemplation stage. The challenges of making a decision in the midst of pros and cons can immobilize change. Although value exists in understanding people's barriers (cons) for change, guiding in Contemplation involves eliciting change talk to increase the likelihood of change. As in other stages of change, using MI in conversation consists of rolling with any resistance, offering empathy, and embracing collaborative guiding.

Ironically, our desire to help people can interfere with them initiating healthy changes. In our desire to help, we may resort to trying persuasively to "get them" to initiate a healthier lifestyle. Clinicians fall into this trap, called the "righting reflex," because of their desire to help people. And many of us have seen the common outcome of this approach; people entrenched in ambivalence or the status quo rarely respond to persuasion or the "good reasons" we give them for change. Awareness of our own behaviors in interviews can free us from the righting reflex.

Some people come to appointments ready to make changes. "I am having problems with hypoglycemia around 3:00 or 4:00 a.m. It bothers me and my husband a lot." This patient is troubled by a problem and has been unable to find a solution for it. It should be addressed directly.

People in this Preparation stage are exploring how to change. Having a realistic, achievable plan is essential for success. But MI can be used here, too. Rather than immediately providing solutions, we have an opportunity to confirm engagement and approach this with a truly patient-centered perspective. She knows what would likely work best for her. Ask her permission ("Would it be helpful to review some options for dealing with the lows that concern you?"). She can then confirm her engagement with, "Yes," and open the door to collaboration. When she makes a choice among options, she gains ownership of the decision. This honors both self-efficacy and autonomy. She becomes the expert in choosing new work she will do for her diabetes.

Commitment language is the focus with people speaking about change. In contrast to the desire expressed in change talk, commitment language expresses a person's willingness to begin the difficult work of making a specific change. There are important features of both change and commitment language that can help clinicians judge a patient's strength of desire or commitment to change.

Compare the strength of desire for physical activity expressed in the following statements. "I might be able to fit in 15 to 20 minutes of walking by not driving to work." "I am going to walk to work in the future." "I really need the physical activity of walking to work. I would feel better." Commitment language reveals the similar range of feelings about adopting a change. "I think I can do more pre-meal blood glucose testing so I can adjust my insulin properly." "I will try to do more pre-meal blood glucose testing, so I can avoid highs and lows after eating." "I bought a new meter to keep at work, so my plan for testing will work better." These examples emphasize the importance of careful listening so we can work with people more effectively in the guiding process. In the first two statements in each set of examples, more collaboration needs to occur before changes will succeed. Research confirms that the stronger the commitment language is, the higher the success rate in initiating behavior change will be.[12]

Miller has said, "MI is basically simple, but learning it is not easy" (Miller WR,uUnpublished observations, 27 October 2010). These perspectives on MI offer an opportunity to better understand how this approach to care can work in daily clinical practice. In the next issue of *Diabetes Spectrum*, we will look more closely at some of the skills used in MI, describe some strategies for dealing with resistance, and discuss ways that interested clinicians can gain competency for using MI in their practices.

Acknowledgment

The author wishes to thank Michael Fulop, PsyD, for reviewing and assisting in the editing of this article.

References

[1]Sayadah SH, Franklin J, Cowie CC: Poor control of vascular risk factors among adults with previously diagnosed diabetes. *JAMA* 291:336–342, 2004

[2]McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA: The quality of health care delivered to adults in the United States. *N Engl J Med* 348:2635–2645, 2003

[3]Rubin RR: Facilitating self-care in people with diabetes. *Diabetes Spectrum* 14:55–57, 2001

[4]Miller WR, Rose GS: Toward a theory of motivational interviewing. *Amer Psychol* 64:527–537, 2009

[5]Miller WR, Rollnick S: *Motivational Interviewing: Preparing People to Change Addictive Behavior.* New York, Guilford Press, 1991

[6]Marteau TM, French DP, Griffin SJ, Prevost AT, Sutton S, Watkinson C, Attwood S, Hollands GJ: Effects of communicating DNA-based disease risk estimates on risk-reducing behaviors. *Cochrane Database Sys Rev* CD007275, 2010

[7]Wagner CC, Ingersoll KS: Beyond behavior: eliciting broader change with motivational interviewing. *J Clin Psychol* 65:1180–1194, 2009

[8]Magill M, Apodaca TR, Barnett NP, Monti PM: The route to change: within-session predictors of change plan completion in a motivational interview. *J Subst Abuse Treat* 38:299–305, 2010

[9]Prochaska JO, Velicer WF: The Transtheoretical Model of health behavior change. *Am J Health Promot* 12:38–48, 1997

[10]Miller WR, Rollnick S: Ten things that motivational interviewing is not. *Behav Cogn Psychother* 37:129–140, 2009

[11]O'Connor PJ, Rush WA, Prochaska JO, Pronk NP, Boyle RG: Professional advice and readiness to change behavioral risk factors among members of a managed care organization. *Am J Manag Care* 7:125–130, 2001

[12]Amrhein PC, Miller WR, Yahne CE, Palmer M, Fulcher L: Client commitment language during motivational interviewing predicts drug use outcomes. *J Consult Clin Psychol* 71:862–878, 2003

Marc Steinberg, MD, FAAP, is director of TheGroup4QualityCare and a diabetes physician at Western Montana Clinic in Missoula, Mont.