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MOTIVATIONAL INTERVIEWING:

A Valuable Tool When Discussing Habit Changes with Patients

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The medical field is quickly changing. Patient autonomy is growing in today's technologically advanced society, where an endless amount of medical information and medical provider options are available via computers and smartphones. Patients are in the unique and advantageous position of being able to play a much larger role in their medical and health decisions than previously feasible. This autonomy provides many benefits and increases satisfaction for patients who wish to play an active part in shared decision-making surrounding their health.

Motivational interviewing (MI), which was first described and practiced in 1983, **is not a new technique**. However, evidence of its efficacy has caused it to quickly gain popularity as a method, allowing providers to elicit from their patients how they can best benefit. Patients are asked what motivates their decisions and habits, what habits they would like to change, what difficulty they have when making these changes, and what level of control they would like over their treatment decisions. Increasingly, literature is showing that motivational interviewing is a technique all providers should employ, but may also be specifically advantageous in the primary care setting.

This white paper will examine recent relevant literature supporting a greater role for motivational interviewing in today's primary care environment and why this technique is particularly suited to primary care settings.

Early and Ongoing Support for Motivational Interviewing

As early as 1997, a systematic review of 11 previous studies showed the benefits of motivational interviewing over the traditional model of clinician advice-giving, wherein the provider is expected to make medical decisions themselves without necessarily obtaining their patients' input. Over the years, MI has been studied in many trials utilizing several different populations of patients and different types of MI practitioners.

Although studies have shown varying levels of effectiveness, most have found a significant benefit of MI in promoting habit changes in patients. Further, this efficacy has persisted for decades. **A meta-analysis from 2010** confirmed the efficacy of MI, as seen in many studies up to that point, and a **2014 meta-analysis of RCTs** examining the patient outcomes of health behavior in primary care populations showed a significant benefit.

With so much early evidence indicating MI's usefulness, it is being widely accepted and taught in medical schools around the country. Many schools have a curriculum for motivational interviewing and dedicate some time to teach students what MI is, how it works, and the evidence behind it, even giving them space in simulation settings to practice their MI training.

A meta-analysis from 2020 examining the efficacy of a motivational interviewing curriculum in undergraduate medical education concluded that when properly implemented, it is effective, and medical students can pick it up quickly and introduce it into their early practice. Because of this, a generation of primary care physicians has been using motivational interviewing from the beginning. This should certainly change the landscape of the primary care setting for years to come as this technique is more widely accepted.

Which Patients Can Benefit From Motivational Interviewing?

Since its inception decades ago, research into motivational interviewing has often focused on particular age groups. Many early studies examined the efficacy of MI on young adults and adolescents as this population is often faced with contemplating various habit and lifestyle changes, largely surrounding alcohol and other substance use. Its efficacy in older adults is still being elucidated, but research in this area is picking up.

One of the first studies to specifically examine MI in the older population subgroup, a 2013 article, concluded, "As a proven, cost-efficient treatment, MI should be considered for clinical use in geriatric and primary care clinics providing care to older adults." Just one year later, a literature review from 2014 also supported the efficacy of MI when used with older adults. In 2015, a non-equivalent control group pretest-posttest study showed the effectiveness of MI when used with this population. More recently, in 2019, a two-group pilot study showed a significant benefit of MI when encouraging more exercise in older adults.

This surge of research into MI in older patients is beneficial in the primary care setting. Primary care providers see many older patients, and discussions about lifestyle changes at advanced ages are prevalent. Whether for decreasing substance use, changing alcohol habits, or adding exercise to patients' lives, the research is encouraging, showing MI is an effective tool that PCPs should use with their older adult patients.

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Setting/Clinician Type

As early as 2001, research was being done into the effectiveness of MI, specifically in community health/primary care settings, as it had previously been researched exclusively in specialist settings. This research found that just as it was effective in these specialist settings, it can also be beneficial in primary care settings. These results are important because many overlook the primary care space as a setting where discussions surrounding various habit changes occur.

Perhaps people previously assumed that cardiologists could be the ones to discuss exercise changes in their coronary artery disease patients, endocrinologists could discuss dietary changes in their diabetic patients, and pulmonologists could take on the burden of smoking cessation discussions with their lung patients. But the key is that all of these discussions can occur earlier in the primary care setting before specialist help is even needed. Combined with the fact that many patients (especially older patients) have been seeing their primary care provider for a long time and are more comfortable with them than specialists, it becomes clear that the primary care setting is an ideal place to begin using motivational interviewing.

In addition to location, an additional important aspect of motivational interviewing is the type of provider conducting the interview. A 2015 literature review elucidated significant results regarding what kind of practitioner provides MI. MI produced significant reductions in detrimental habits when delivered by different types of providers, but the effects on modifying habits were highest when primary care providers delivered the MI. Their effect was even higher than when trained counselors provided motivational interviewing. Overall, it showed that primary care physicians created the highest odds of a patient quitting smoking, again suggesting this is due to patient comfort with the primary care provider.

Another important aspect of motivational interviewing and a characteristic that separates many studies from each other is whether or not patients received one or multiple sessions of MI. **The 2014 RCT** did show that as few as one MI session can have significant effects on behavioral change. **A 1993 study** showed that MI had the most significant benefit in reducing alcohol use temporarily, but the effects actually became insignificant after a number of months. Research into the optimal timeframe and length of MI is ongoing, but seeing as primary care providers are in the unique position of being able to see patients once or even regularly for decades, the timeframe of MI is important for them to consider when discussing habit changes.

One of the keys to motivational interviewing is the follow-up; a single session can definitely play a role in habit change, but when a provider is able to track a patient's motivations over months or years, they can get an intimate look at how best they can support that patient.

Suppose the primary care provider finds a method for habit change that works for one aspect of a patient's life. In that case, there is already a wealth of trust developed between the provider — and patient, and the provider knows which techniques work the best and which don't work so well for that individual. Therefore, if down the road that patient decides to undergo a different habit change, they and their provider can begin with the techniques that worked in the past. Motivational interviewing in the primary care setting prevents patients from starting over from scratch whenever they want to make a difficult lifestyle change.

Features of Motivational Interviewing

MI is far more than simply asking patients what they think of their treatments or what they would like to do over the course of their disease. It is a specifically curated method for determining the motivations behind patient decision-making. This is the key to why it is so much more effective than traditional medical decision-making methods.

Analyzing the motivations behind why people do or don't make decisions can help clinicians come up with much more effective plans for them to accomplish their goals. For example, providers might falsely assume that someone with a 50-pack-per-year history of smoking doesn't want to quit or has never wanted to quit; after all, if they have been smoking that much for that long, they clearly have not been previously motivated to quit.

But this fallacy can be easily overlooked, and MI attempts to dive further into this issue. One pertinent MI question a provider could ask a patient like this could be: **"Have you ever tried quitting smoking in the past?"** If the patient responds that indeed they have, the next question would be: **"How did that go?"** The patient might explain why they originally wanted to quit, how long they were able to quit, and the factors that caused them to resume smoking. This is all extremely valuable information for the clinician. The reason they quit in the first place offers a glimpse into their motivations: **Did they quit because they were worried about how their smoking impacted their family? Were they worried about how it would affect their own health? Financial reasons?** Whatever the reasoning, the clinician can use this to build a case for quitting at the present time.

The next important piece of evidence is the reason for the relapse. **Did the patient resume smoking due to overwhelming work stress? No family support? Being surrounded by too many other people who also smoked?** The answer to this is arguably just as important as discerning the reason for quitting in the first place. Once the clinician knows the reason(s) for why a person was unable to stick to their quitting strategy, they can then explore current barriers in the patient's life that mirror their original challenges.

This offers the opportunity to come up with a very individualized plan for how the patient can best set themselves up for quitting success this time around. By specifically addressing what was most challenging for the patient in the first place, the primary care provider sets them up as best they can for success. Additionally, this attention to detail and personalized plan can only improve patients' relationships with their providers. Personalized medicine helps people feel less like cogs in the giant medical system that sometimes values patient censuses over the quality of care.

Lastly, the provider wants to key in on how motivated the patient is and what kinds of things motivate the patient. If the patient indicates that they aren't interested in quitting at all, the provider can explore this. **Why not? What would make them more motivated?** One interesting MI strategy is to ask the patient, **"On a scale from 1-10, how interested are you in quitting?"** If the patient says they are at a 5, for example, the provider can next ask, **"That is great to hear. Now, what would get you to be at a 7 for willingness to quit?"** Such a nuanced question forces the patient into exploring their motivations and emotions from a different perspective.

By identifying what would make them just slightly more willing to quit, they may mentally stumble upon reasons more important to them than they previously realized, furthering the motivation toward the quitting end of the scale. This method also avoids the judgment patients might feel if they are not feeling extremely willing to change a habit at the present time. Rather than reminding patients of how far they might be from wanting to change a possibly unhealthy habit, MI techniques allow for small advances in motivation over time rather than focusing on someone being far away from changing.

If the patient instead indicates they are motivated to quit, then it becomes about providing support and encouraging that motivation. How can the provider and the patient best set up the patient's situation so that they can stay motivated to quit and experience the fewest barriers in the journey of habit change? Support will look different for every patient, depending on their personality and unique social situation. Some patients are surrounded by strong support systems, such as friends, colleagues, and family members, that can help them through the difficult process of habit change. For this type of patient, education on safely sharing their journey with their support system might be beneficial. For patients who either do not have a support system or are dealing with something they wish to keep private from their support system, the provider can be integral in facilitating the changes. Perhaps the provider can set up more frequent visits with the patient to check in on their progress. Once again, it becomes obvious why the primary care setting is the perfect place for providers to use MI. Serial visits are common and normal in primary care settings, whereas frequent appointments may be more difficult to attain in a specialist setting.

Conclusion

Maintaining patient autonomy is vital in today's healthcare environment. Older models of medical decision-making focused on the physician or advanced practice provider as being the wealth of knowledge and thus being in charge of making all decisions for patients. Increasingly, though, this outdated healthcare model has been shown to be less effective and less satisfying to patients than models in which the patient can take an active role in their healthcare decisions. After all, it is their health and their life at the end of the day.

Motivational interviewing, one such example of a shared decision-making model, is gaining popularity in today's healthcare system. It increases trust and improves satisfaction in patients with their healthcare providers. Research has shown that MI is an effective tool for older adults when provided by a primary care provider in a primary care setting. Although this research is early and ongoing, the significant benefits already seen help support its use now. ChenMed uses evidence-based techniques such as MI to help patients achieve the healthiest lives possible.

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