

## MAIN TOPIC



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# Motivating behaviour change in the diabetic patient

**Diabetes is a chronic, manageable condition which requires major changes in lifestyle to optimise that management.**

Motivating behaviour change in diabetic patients is one of the most important but also more frustrating experiences for general practitioners. There is great diversity in patients' acceptance and understanding of diabetes. One's own diabetes is often perceived as less serious than that of others and short-term comfort may be prioritised over long-term consequences.

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Knowledge about diabetes is not well correlated with the personal use of that information and patients' goals may differ considerably from the doctor's. Good continuity of care, patient-centredness in the consultation and the patient's belief in the importance of metabolic control can influence the level of glycaemic control.<sup>1</sup>

Emmons *et al.* have identified a number of inappropriate assumptions that professionals make regarding behaviour change:<sup>2</sup>

- This patient wants to change.
- This patient's health is the prime motivating factor for him/her.
- If he or she decides not to change, the consultation has failed.

- Patients are either motivated to change, or not.
- Now is the right time to consider change.
- A tough approach is always best.
- I'm the expert. He or she must follow my advice.

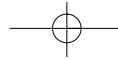
### BRIEF MOTIVATIONAL INTERVIEWING

Brief motivational interviewing (BMI) is an approach which provides GPs with a broader range of communication skills that are tailored to the individual patient's readiness to change. In this article BMI is applied to the diabetic patient, but the principles can be applied to any consultation that involves behaviour change.

There are many possible lifestyle or behavioural issues in diabetic patients that can be addressed through BMI:

- diabetic diet
- obesity
- hyperlipidaemia
- exercise
- smoking cessation
- adherence to medication
- use of alcohol.

BMI is a derivation of motivational interviewing (MI), which was originally developed by specialists working in the context of alcohol addiction. MI is intended to elicit behaviour change by helping patients to explore and resolve their own ambivalence about change. It is based on an underlying patient-centered consultation style. Resistance from the patient is interpreted as a sign that the GP is being



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too confrontational or is incongruent with the patient's readiness to change. The goal is to facilitate patients' self-evaluation and decision making about change rather than to confront patients with the doctor's evaluation and ideas about what they 'must do'. The idea is to have confrontation as the goal rather than the style of the consultation. These principles have been adapted for general practitioners in the primary care context as a menu of quick concrete techniques that can be performed in single sessions as brief as 5 minutes.<sup>3</sup>

### READINESS TO CHANGE

BMI is based on an underlying model of the stages that people go through in deciding whether to change. GPs tend to assume that all patients are or should be ready to change and often speak to patients about how to change before they are ready. This model identifies at least five different stages: pre-contemplation, contemplation, ready to change, maintenance and relapse (Fig. 1).

A menu of specific communication skills can be identified that are appropriate for each stage. Patients may shift over time and even within the same consultation in their readiness to change and of course the categories are not

always as clear-cut as the model implies. Nevertheless the concept that patients can differ in their readiness to change is useful, along with the idea that the GP should assess and respect the stage that the patient is at. In BMI the initial assessment of the patient attempts to identify that stage. It also implies that a particular consultation may have a more limited goal of shifting the patient's stage of change rather than always having actual change as the goal of every encounter. Change is viewed as a process rather than an event that must occur during every consultation.<sup>3</sup>

Readiness to change can be seen as having two key dimensions of importance and confidence. Some patients may feel that stopping smoking is very important, but may lack confidence in their ability to do so. Alternatively some patients feel confident that they could change, but are not convinced it is important. Some of the BMI skills attempt to ascertain where the patient is in terms of these dimensions as this will guide the kind of interaction that the GP makes (Fig. 2).<sup>3</sup>

One tool that has been developed for use with patients is the readiness to change ruler (Fig. 3).

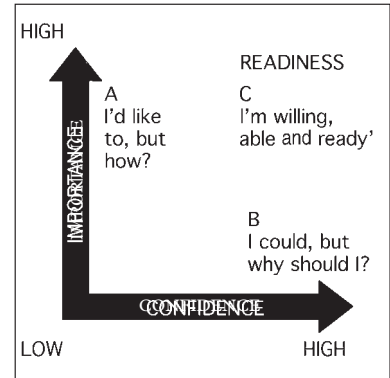


Fig. 2. Dimensions of readiness to change.

*'This is obviously a sensitive area. However you sound as if aiming to lose weight is not really an option today. Some people find it easier to demonstrate their feelings on the "Readiness to Change Scale". Where on the scale would you place yourself?'*<sup>1</sup>



Fig. 3. Readiness to change ruler.

The ruler can help to bring feelings to a cognitive level and identify the reality of ambivalence, even in the face of expert opinion.<sup>1</sup>

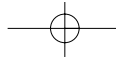
#### General principles of BMI<sup>2</sup>

- The doctor-patient relationship is a partnership more than an expert-recipient relationship.
- Readiness to change is not a patient trait, but a fluctuating product of interpersonal interaction.
- It is the patient's task, and not the doctor's, to articulate and resolve ambivalence.
- The doctor is directive in helping the patient respond constructively to ambivalence.
- Direct persuasion and argument from the doctor is not an effective method to resolve ambivalence.
- The counselling style is generally a quiet and eliciting one.



Fig.1. Stages of change model.





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### DECIDING WHERE TO START

It is important to choose the right time to discuss behaviour change. If a patient is acutely distressed or preoccupied with some other issue it may be inappropriate. Patient-centered consultations may identify important psychosocial issues that may be influencing diabetic control. The doctor should seek permission to discuss behaviour change and set an agenda of which topics to discuss with the patient. In setting the agenda the doctor should also clarify how much time is available for this discussion.<sup>3</sup> A simple agenda-setting chart can be used to structure this discussion (Fig. 4) and is particularly useful where there are a number of equally important topics.<sup>1</sup>

*Dr: 'Mrs A, I wanted to show you this chart because on this chart are things that we talk to people in your situation about. As you can see there's diet, exercise, weight, smoking, drinking, tablets and there are spaces that are left blank for things that you feel are more important to talk about today.'*

*We use this chart just to show people areas they might consider, but deci-*

*sions you make yourself are much more likely to be the better ones. So really today is just to discuss it broadly with you and to see where you feel like starting.'*

*Pt: 'I think I find that one (diet) the easiest to start talking about...'<sup>4</sup>*

Or

*Dr: 'Would you mind spending a few minutes talking about your diet and how you see it affecting your health?'*

### PRE-CONTEMPLATION

Pre-contemplative patients are often seen as difficult patients and may be labelled as 'non-compliant' because they are not even considering the idea of change. They have virtually no motivation to change. The aim of BMI in pre-contemplative patients is to help them shift in their readiness to change without undermining the doctor-patient relationship. Part of helping the patient to shift is exchanging information carefully in a way that does not increase resistance through prescribing solutions or imposing derogatory labels on a patient.<sup>3</sup> One technique for doing this is the 'elicit-provide-elicit' model.<sup>4</sup>

**Elicit** the potential relevance of the information:

*Would you like to know more about exercise and diabetes?  
How much do you know about your cholesterol?*

**Provide** the information in a neutral way:

*What happens to some people is...  
Other people find that...*

**Elicit** the possible impact of the information:

*What do you make of this/these results?  
I wonder how you have been affected by...?*

The final elicit is important in getting patients to process and personalise the information for themselves. This approach may also enable patients to obtain more relevant information rather than the standard 'lecture' on losing weight or smoking.

*Dr: 'Last week we did a blood test and what we've found is that your blood sugar is a little bit high. Do you know anything about blood sugar (elicit)?'*

*Pt: 'No, not really.'*

*Dr: '(provide) Well, what it means if your blood sugar is too high is that your body is not taking in the sugar from your blood. This can affect the way you feel and it can even damage your organs actually. Do you know the name of the condition that comes with a raised blood sugar (elicit)?'*

*Pt: 'It sounds like what my Mum had - diabetes.'*

*Dr: '(elicit) Yes, thinking about it do you have any questions?'*

*Pt: 'Am I going to be ill? Is it serious? I know my Mum used to get trouble with her feet.'*

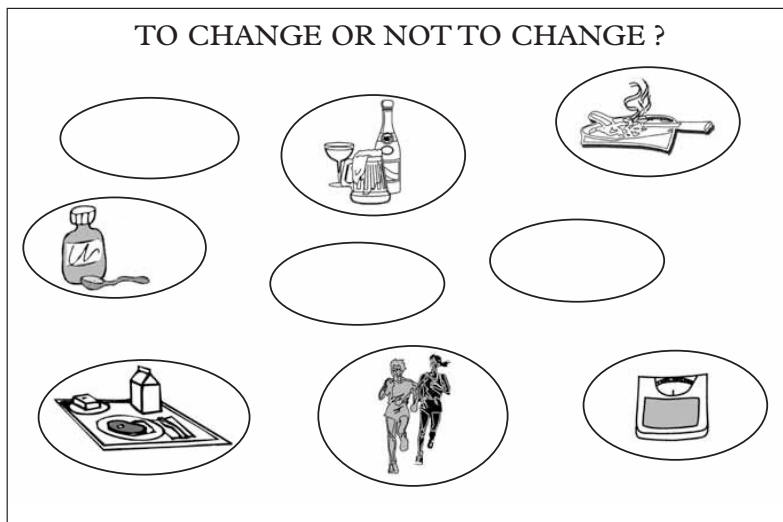
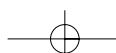
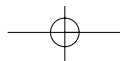


Fig. 4. Diabetic agenda-setting tool.





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*Dr: '(provide) You're quite right it can cause problems with your feet. Do you know anything about how your lifestyle or diet can influence the course of diabetes (elicit)?'*<sup>2</sup>

### CONTEMPLATIVE

Contemplative patients are pulled in two directions — on the one hand they enjoy or benefit in some way from their behaviour, but on the other hand they have some concerns about the negative consequences of not changing. They have mixed motivation to change. In BMI the aim is to help patients examine and evaluate their own ambivalence and for them to make a more conscious decision about change. The purpose of the skills is to enhance patients' self-efficacy and not to manipulate patients into agreement with the doctor's agenda.<sup>3</sup> In more educated patients scaling questions can be used.<sup>4</sup>

*Dr: 'If 0 were 'not important' and 10 was 'very important' what number would you give yourself?'*

*Dr: 'You said that it was fairly important to you personally to change. Why have you scored 6 and not 1?'*

*Dr: 'What would have to happen for your score to move from 6 to 9? What stops you moving from 6 to 9?'*

Alternatively more general questions on pros and cons can be used:

*Dr: 'What are the good things about your smoking?'*

*Dr: 'What are the less good things about your smoking?'*

### READY TO CHANGE

These patients have a high motivation and are ready to plan and

implement change. The BMI aim here is to help the patient set concrete and specific goals or targets for change. The focus is on the practical aspects of how to change and discussion of difficult situations which may tempt the patient to slip backwards. It can be useful to identify one supportive relationship that the patient can engage with to help them change. Communication skills aim to build confidence and brainstorming with the patient is a collaborative process of deciding on a few specific actions that are realistic and feasible. For example, the goal may be to lose weight by eating less fatty food and the specific target to not buy full-fat milk. This recognises that there may be several possible actions and while the doctor can advise what has worked for other people, ultimately patients must commit to a course of action they have chosen for themselves. Don't push patients into accepting a particular option if they are not ready as sometimes the exercise itself may enable them to take action after the consultation.<sup>3</sup> The dialogue below illustrates the value of brainstorming:<sup>4</sup>

*Dr: 'Mrs A I wonder what sort of changes you feel most ready to make about your diet?'*

*Pt: 'I suppose I do eat a lot of fatty foods, cooked breakfasts on the weekend and I like eating at steakhouses.'*

*Dr: 'I wonder what or where you might start?'*

*Pt: 'As far as cooked breakfasts are concerned, is it enough simply to grill rather than fry?'*

*Dr: 'Wherever you feel most confident to make a start is a good start — so grilling breakfast on the weekend is one thing.'*

*Pt: 'A steakhouse on Saturday — I don't know. I'll get rows about that from the children. Maybe I could bribe them with something else.'*

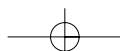
*Dr: 'I wonder if there is anything else — family conference? Sitting down with the family is what some people have done. I don't know yet which way is best to go and neither do you. So we've got 3 things. I'm trying to think of what else you could do?'*

*Pt: 'During the week it's a lot easier when it's just myself. I could buy a roll rather than chips?'*

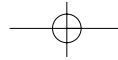
Past successes and failures may provide valuable information about what will work this time and what may prove difficult. The doctor should build confidence by affirming the patient's persistence and courage involved in previous attempts to change rather than wallowing in the apparent failure.

### ROLLING WITH RESISTANCE

Resistance from the patient may be experienced at any stage. BMI is based on the belief that direct persuasion or advice-giving can reinforce the patient's resistance to change. Traditional advice-giving combines facts and their interpretation in a single message by the GP and puts the patient in the position of either accepting or more often rejecting the advice. Rejection may be indirect through non-adherence. Resistance may also be experienced when the doctor fails to understand the social context within which behaviour change occurs (poverty, unemployment, etc.). Traps that may increase resistance include taking control away from the patient, misjudging the patient's readiness to change and meeting 'force with force' by arguing, coercing or pun-







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ishing the patient. Be aware of verbal and non-verbal signs of increasing resistance in the consultation.<sup>3</sup>

*Pt: 'Yes doctor, but I can't because...'*

Awareness of increasing resistance should lead to a change of tack rather than increased confrontation. Emphasising personal choice and control can reduce resistance:

*Dr: 'What do you think about your weight at the moment?'*

*Dr: 'I was wondering what would suit you best — changing your medication or looking again at your diet?'*

Personalising risk factors:

*Dr: 'How would you know if your sugar were a problem for you?'*

And carefully assessing the patient's readiness to change:

*Dr: 'Having discussed your smoking in more detail, how important would you say it is for you now?'*

The consultation style should be one of 'dancing' rather than 'wrestling' with the patient.

General practitioners who engage with these BMI skills often experience an enhanced doctor-patient relationship and a decrease in personal frustration and stress around negotiating behaviour change. BMI expands the range of skills available to the general practitioner and allows more realistic goals in the consultation. A more holistic, respectful and deeper understanding of the patient's dilemma may also result. Having read this article, where would you rate your own readiness to change in terms of brief motivational interviewing?

### FURTHER READING

[www.motivationalinterviewing.org](http://www.motivationalinterviewing.org)

### References

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4. Rollnick S, Butler C, Allison JA. *New Videotape for Trainers: Health Behaviour Change: A Selection of Strategies*, 2001. University of Wales College of Medicine. ([www.jeffallison.co.uk](http://www.jeffallison.co.uk))

## IN A NUTSHELL

Brief motivational interviewing (BMI) is an approach to behaviour change which provides GPs with a broader range of communication skills that are tailored to the individual patient's readiness to change. General principles of BMI are:

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## SINGLE SUTURE

### Mediterranean diets and mortality

Do people who regularly consume a traditional Mediterranean diet experience a lower mortality rate? Between 1994 and 1999, as part of the European Prospective Investigation into Cancer and Nutrition, 22 043 people living in Greece completed a validated food-frequency questionnaire and were traced through official death registries (people with coronary artery disease, diabetes mellitus or cancer were excluded). Patients were followed for a median time of 3.7 years. This observational study showed results suggesting that the health benefits of a Mediterranean diet are real and that eating a daily diet of unrefined cereals and grains, beans, legumes, nuts, vegetables, fruits, olive oil and yogurt or cheese with moderate alcohol consumption is associated with longevity and a reduced number of deaths from coronary artery disease and from cancer.

*(Editor's note: My only concern is how do I find the time to fit in all those different food types, exercise and have a couple of glasses of wine every day?)*

(Trichopoulou A, et al. *N Engl J Med* 2003; **348**: 2599-2608.)

