Motivation to Change Health Behaviour

Health promotion forms part of many primary care consultations, be it advice about exercise, weight loss, smoking or alcohol. These consultations are often fraught with difficulty, as many patients are resistant to being told what to do or what is good for them. Moving from this direct style of consultation to a more guiding style that encourages patient motivation is thought to increase the success of health promotion.

Motivational interviewing was originally developed in the field of addiction counselling, but has also been used to promote behaviour change in a wide range of healthcare settings, such as smoking cessation, weight loss and promoting increased physical activity.

There is increasing evidence of its effectiveness, with 80% of 72 studies finding that motivational interviewing outperformed traditional advice-giving. It is associated with a more respectful and less combative consultation – this feels professionally better and is certainly more enjoyable for both clinicians and their patients.

Motivational Interviewing (MI) by Prof S Rollnick

A consultation that leans on MI has one strong characteristic that supersedes all else: instead of adopting an expert position and using a directing style to persuade the patient why or how they might get more exercise, you adopt a guiding style. It is a more collaborative process of helping the patients to say why and how they might get more exercise. You structure the consultation and provide information (with permission) but most of the time you are eliciting their own motivation to change. This is often expressed in the form of change talk.

The more change talk you can elicit from the patient, the better the outcome is likely to be. There is emerging evidence to support this focus on the language used by the patient.

One useful aid might be the recently developed framework for MI that describes four processes in a constructive conversation about behaviour change:

- Engaging
- Focusing
- Evoking
- Planning

They do not always emerge in a linear sequence, but the logic is this: step one is to engage with the patient and establish an agreed focus for the conversation; then the central task is evoking the patient’s own motivation to change, followed by planning if the person is ready for this. These processes are highlighted in the example below, alongside other key skills.

Example MI Dialogue, by Prof S Rollnick

This example is based on a fictitious consultation between a 51 year old male and his clinician. He is overweight, with borderline raised BP, who gets short of breath when walking secondary to his poor cardiovascular fitness and sedentary job. He travels to work on the bus and works on the third floor of an office.

Clinician (Cl): OK, so that’s your tablets sorted out, and now I wanted to ask you whether it’s ok with you to spend just a couple of minutes talking about something completely different…. Would that be OK? (Asking permission will help a lot)

Patient (Pt): Yeah OK, what’s that then?

Cl: It’s about exercise. Would you mind if we chatted about that if I promise not to nag at you about it?

Pt: Yeah OK, as long as you keep to that promise (laughs).

(The focus is clear. Engagement is not strong, yet.)

Cl: So rather than me talk about it, could you? Could you tell me how you feel about getting more exercise?

Pt: Hate the thought to be honest with you.

Cl: You’re not persuaded about this one (That’s a reflective listening statement, not a question)

Pt: Well I do know that it would help my health (change talk), but the effort is really too much.

Cl: You get quite a lot done each day, and adding exercise doesn’t seem like it could fit (another reflective listening statement)

Pt: Yeah you guessed right, I don’t just sit around all day and the thought of going to the gym just doesn’t fit for me.

Cl: Going to the gym isn’t for you, you are busy enough and yet you know it would be good for your health to get more exercise, have I got you? (A summary that also includes the change talk)

Pt: Yeah you’ve got me for sure. (Engagement is now much better, as a result of listening and then summarising).

Cl: Can I ask you how do you see the benefits of just a slow and steady increase in exercise? (A question that allows the Dr to start evoking change talk)

Pt: Me? Well if it was slow, and I didn’t have to go crazy like at a gym, it might help me (change talk).

Cl: It would help you to feel healthier (a listening statement again, to reflect the change talk and it’s also a guess about why it might help)

Pt: Sort of, but at least I could fit it in, and I might succeed, and I could feel good about that. (More change talk)

Cl: Because you don’t want to take on some big task like the gym. What suits you more is something smaller to start with. (Reflecting again, trying to understand how he really feels)

Pt: If I decide to do it and I haven’t yet. (Patient backs off)

Cl: You don’t want to be pushed into this (Dr doesn’t try to win the argument or be clever – just uses a listening statement)

Pt: Exactly, but it might be worth thinking about. Thanks for not lecturing me Dr (laughs)

Cl: Dr summarises how patient feels and keeps the door open for another time.
Six weeks later the patient returns for another check on his borderline blood pressure.

Cl: Well thanks for coming back again. I saw you six weeks ago, didn’t I?
Pt: Yes, you asked me to come back to check the blood pressure.

Cl: (Doctor checks BP) Well it’s still on the high side, so we could now ask the question what will help you to get it down and avoid this becoming a cause for concern in the future?
Pt: Well I know I don’t want any of those tablets for blood pressure if possible Doc.

Cl: Sure, that’s fine for now. Can I raise the subject of exercise again, if I promise not to lecture you?
Pt: You told me that last time, but fair game, you didn’t lecture me, so yes fine (laughs)

Cl: I promise again!
Pt: I believe you again, but what now?

Cl: My question would be: are there some simple small steps you can take to introduce a little more exercise into your daily life?
Pt: I’m glad you are not on about the gym.

Cl: Sure, that’s too drastic for you (reflective listening)
Pt: I don’t do drastic, my life’s busy enough.

Cl: Small things might be possible (reflective listening again – a guess about what might work)
Pt: Yes, maybe but I’m not sure what you mean by small things?

Cl: Presents a range of options, not a single idea, with the aim of encouraging the patient to select thus: So that’s a number of possibilities. You will be the best judge of what might work for you. (Reinforcing autonomy is a critical aspect of skilful consulting about behaviour change).
Pt: Well of all those things you mention, there’s only two that make sense to me: walking up the stairs rather than the lift and getting off the bus 2 stops before work and walking the last part (patient emits change talk).

Cl: You can see a way of doing these simple things (the best response to change talk is a simple reflection).
Pt: I guess I can, and if it works I might try walking that same distance after work again (more change talk).

Cl: You want to experiment and see what works for you (more reflection).
Pt: Yeah I am happy to try those two things (change talk).

Cl: Summarises all the change talk that has emerged. So you don’t want tablets, and you think you might be able to walk up the stairs at work, and get off the bus two stops early, and walk into work. 
Pt: Knowing me, I’ll give it a go. It might help me to feel better about myself (change talk).

Cl: And would you mind coming to see me for a brief catch-up in six weeks?
Pt: Sure......Etc etc

Watch this dialogue on YouTube describing the behavioural change dialogue

In addition to motivational interviewing, Allied Health Professionals (AHP’s) may have their own favourite method of motivation to elicit behaviour change that they wish to use. In promoting exercise, alternative socio-behavioural approaches have also been developed to help people change physical activity patterns.

The following case study is an example of such a technique:

Edith

In recent years, 50 year old Edith has experienced more and more bouts of prolonged unhappiness. She has not been diagnosed with clinical depression, but her GP has recommended she becomes physically active. She has done little if no purposeful exercise since her teenage years when she used to hate sport and physical education at school, finding it threatening and embarrassing. Edith is on the borderline between overweight and obesity with a BMI of 29 and has been recently been diagnosed with mild hypertension. She has a family history of type 2 diabetes.

The start point for Edith is to construct an activity programme with the help of an exercise professional using a person-centred approach.

The first step is to discuss with Edith her past history in sport and exercise and help her to work out which activities she might be interested in starting. During this discussion, we discover she has not been involved in any sport or exercise since leaving school (her 7-day recall of activity revealed less than 10min of activity- only walking–each day) and that she never enjoyed team games such as hockey at school. She says she might enjoy some group activity, but feels she is not confident to join a group at the moment. She would like to think she could join a group of women with similar kinds of issues at some point.

The second step is to weigh up the pros and cons Edith perceives in becoming more active. Edith agrees that being more active is important for her and might help her feel more positive about herself and life in general, as well as help her lose some weight and get her blood pressure down. However, Edith does not feel very sporty or athletic and finds it difficult to see ways in which she can be more active, so the conversation turns to walking as a starting strategy.

The next important task is short-term goal setting that can provide a sense of steady but safe improvement. Short term goals have to have a flavour of where, when, and what. They need to be specific and agreed (following the SMART principle of being Specific, Measurable, Agreed, Realistic and Time phased).

The discussion moves to time difficulties, as Edith perceives in becoming more active. Edith agrees that being more active is important for her and might help her feel more positive about herself and life in general, as well as help her lose some weight and get her blood pressure down. However, Edith does not feel very sporty or athletic and finds it difficult to see ways in which she can be more active, so the conversation turns to walking as a starting strategy.
The key motivational issue, then, is to ensure small goals for the early weeks that are achievable but that will move her forward. Goals that are too demanding at this point may undermine confidence and disappoint if they are not reached.

It is important to emphasize that mental health or mood benefits may be experienced fairly quickly and there will be changes in exercise capacity in a matter of a few weeks. (Case study reference 7)

**Summary**

NICE guidelines recommend using techniques that create attitude and behaviour change within health care interventions. Whilst no single method can be universally applied, a combination of motivational interviewing and written physical activity on prescription has been used effectively in Sweden for the past 15 years. A follow up study there has shown a majority (65%) still adhering to the advice after 6 months, with partial adherence at 19% and non adherence 16%. This, as they point out, "is as good as adherence to other treatments for chronic diseases. This is significant because even a small increase in physical activity is important both on an individual level and for public health".  

**Take home message:**

Behaviour change techniques are an important part of any consultation on lifestyle advice.

**Consider:**

1. Attending a course on behaviour change.
2. Read more on this topic [here](#).

**Benefits to health professionals:**

Greater success in supporting behavioural change with all lifestyle issues, leading to reduced appointments drug costs and healthier patients.

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**REFERENCES**