Psychwire

Giving Advice and Motivational Interviewing: An Integration

Motivational Interviewing in Health Care

For Medical and Health Professionals

8 hours | Self Directed (access for 6 months)

8 CE / CME Credits

This is the first effort in writing to lay out what skilful advice-giving and motivational interviewing look like as a merged activity. A more detailed account can be found in the 2nd edition of "Motivational Interviewing in Healthcare" by Rollnick, Miller & Butler, due out in 2022. The section on "High Demand Scenarios" below is new and unpublished. You can review videos and demonstrations in the Psychwire course called ***Motivational Interviewing in Healthcare***

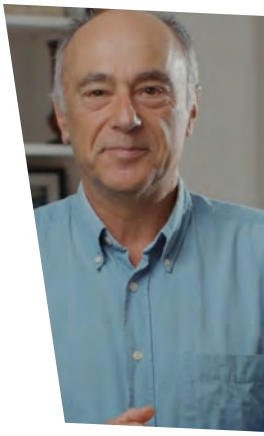
You might think of giving information and advice as a task that is as simple as kicking a soccer ball. Maybe this is how it is viewed in everyday practice where it is probably the most commonly executed intervention in healthcare (let alone in schools and the wider world): see a patient who needs advice, give it and that's the job done. After all, if one is trained to acquire expert knowledge then it makes complete sense to dispense of this as needed. Or does it?

But then how come people so often don't listen to or take the advice that's delivered? Is this always their fault? The fact are clear enough: adherence rates to prescribed medication are surprisingly low, as is frequency with which patients fail to respond to advice to quit smoking, take a vaccination, lose weight, and so on.

Then another puzzle: if a treatment or intervention has poor success rates wouldn't people be trying to improve things? I have looked and failed to find research on advice giving, examples of what good practice looks like, or transcripts of consultations that show the skills involved. Maybe people feel it's not our problem to solve because and if patients don't respond that is their fault? It is hard to avoid this conclusion.

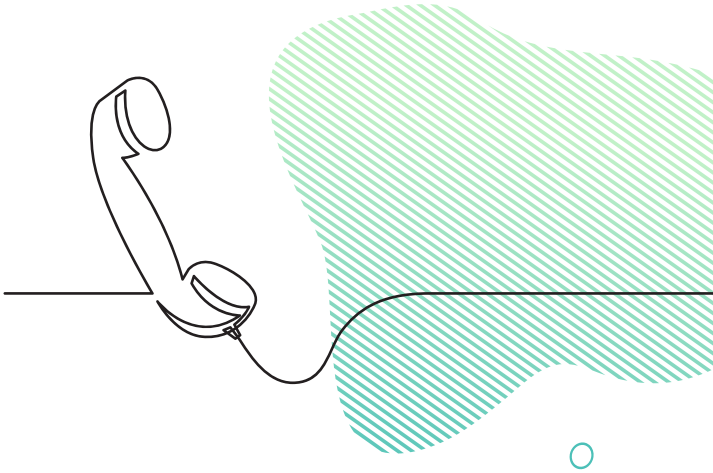
A Short History of Motivational Interviewing (MI)

The inclination to blame the patient was an observation that prompted the development of motivational interviewing. I observed this when working as a nurse orderly in an addiction centre in Cape Town in the middle-1970s, as did William R Miller 6000+ miles away in American treatment centres. The most predictable response to strong advice to quit alcohol use was what they called “denial”, a refutation of our best efforts to help people see the error of their ways, usually in the form of a reply like, “Yes but you see it is not as bad as you are making out because ….”; or, “I drink the same as all my friends so what is the problem?”. In the staff coffee room the conversation made it clear that the fault for poor motivation, denial and low success rates lay with the patient.



William Miller made a simple suggestion in his first paper on MI in 1983: try to withhold judgement, come alongside the patient, step down from the expert role, and listen with compassion and curiosity as they explore why and how change might be a good idea. That’s MI in a nutshell. Outcomes seemed to be better. People were less inclined to “resist” and more motivated to make changes in their lives. Of particular interest to clinicians and researchers has been the way people express “change talk”, their positive motivations for changing. If they do, outcomes are better, so the skilful MI practitioner seeks to ask the patient why and how change might come about and their replies usually take the form of change talk.

We wrote the first edition of a textbook together, began training others and joined them in forming a network called MINT (Motivational Interviewing Network of Trainers). As the research efforts got underway, mostly producing positive findings, so interest in MI spread across mental health, social care, general healthcare and criminal justice settings. After retiring from my day job I explored the relevance of MI in schools and among sports coaches, both very relevant settings for looking at advice-giving.



A Wake-up Call

As MI evolved as a style with skills for helping people consider change I more or less forgot about advice-giving, or even worse I thought of it - even wrote about it - as the polar opposite of MI. After all, if MI involves eliciting peoples' own ideas about change, advice-giving involves inserting, telling people what to do, and so the two approaches to change cannot be reconciled. That was a mistake. A few years back I had this wake-up call. Here's what happened.

I was supervising a team of home visiting nurses, highly skilled in MI, working with pregnant teens in deprived communities. One of them said, "I am fine with my MI practice but don't know what to do when I need to give advice." She proceeded to describe a young mother who was force feeding a 2-week infant with yogurt in order to make it sleep more. "Surely I must give advice here?", she asked. When I agreed 100% with her she replied, "But we were taught not to give advice but to draw out solutions from the mother". And so I proceeded to demonstrate using the ASK-OFFER-ASK framework described below - to give this young mother advice about feeding her infant a more healthy diet.

What we observed in that demonstration was an integration of advice-giving with MI, most notable when after hearing the advice this mother started saying for herself how she could improve things, the change talk that is the hallmark of success in MI. It was possible to both offer advice and practice MI in the same conversation.

Simple and skilful: I finally got it!

What then might skilful advice-giving look like? The answer came to me on the side of a soccer field.

I was working with a soccer coach who turned to me as a match unfolded in front of us and said, “It’s not just what they do with the ball, its how they do it. That’s my job, to help them see this!”. Then he reminded me of the statement attributed to the famous coach, John Cruyff: “Soccer is a simple game. Playing simple soccer is one of the hardest things to do.” In a flash I saw the relevance to advice-giving. It might be as simple as kicking a soccer ball, but it requires skill to do this well, and that’s not easy and it takes practice. Simple does not mean easy, and how you offer advice is as important as what you offer.

What I outline below is just one way of describing what skilful advice-giving looks like, a first stab if you like.
I am sure that other practitioners could improve on this.

Information and advice: what's the difference?

I assume that advice is information with an added element – a suggestion that the patient should change their behaviour.

Skilful Practice

There is no shortcut to skilful practice in the absence of listening skills. So please consult any text or course on MI to learn about why and how listening statements are so very useful. When you ask an open question, it is best to follow this with one or more listening statements.

Getting going

I have found it useful to let go of a few things when giving advice and take on a few things in their place.

To let go of .....

I don't see you as just another patient with a pathology that needs addressing. I am not trying to correct your thinking or persuade you to change at all costs. I am going to let go of the righting reflex where I see myself the expert fixer who tells you what's best for you.

To take on....

I come alongside you. I see you as a person first, patient second, someone with strengths who is capable of making sound decisions. I am offering you advice, not imposing it, and you have your own good reasons to accept or reject this. I am curious and compassionate messenger, interested in your views.

Ask-Offer-Ask

This framework below was originally developed as a patient-centred way of giving patients feedback and information, and has been described in other books on Mi as the "Elicit-Provide-Elicit" framework.

ASK

Ask permission first, especially if the patient seems reluctant or uninterested. Then, if the patient agrees, engage with them and find out what they know or would like to know. Doing this not only helps set a collaborative tone for the conversation, but also saves time otherwise spent giving information the patient might already know. Examples of useful questions include, "How do you feel about xyz?" "What do you already know or have tried?" and "What would you really like to know about this?" Listening well here, even briefly, will be well worth it

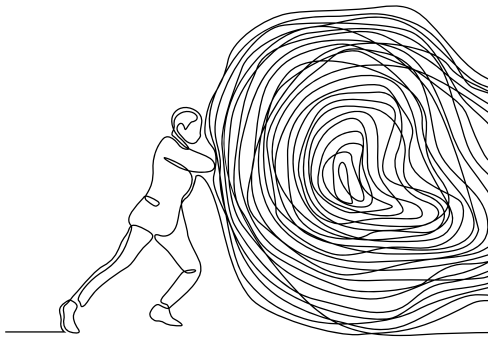
OFFER

Present your idea as an informed suggestion, an offering rather than an instruction. Keep to facts if you can, and leave it to the patient to clarify their relevance. Stay positive and offer ideas about what to do rather than what not to do, for example, “Consider eating healthier food,” rather than, “Don’t eat so much fatty food.” Offer choice as much as possible. Use language like “might” rather than “should”; and “I wonder whether . . .” rather than “Something you really have to do is . . . .” You can see “offering” as akin to “showing,” rather than “telling.”

ASK

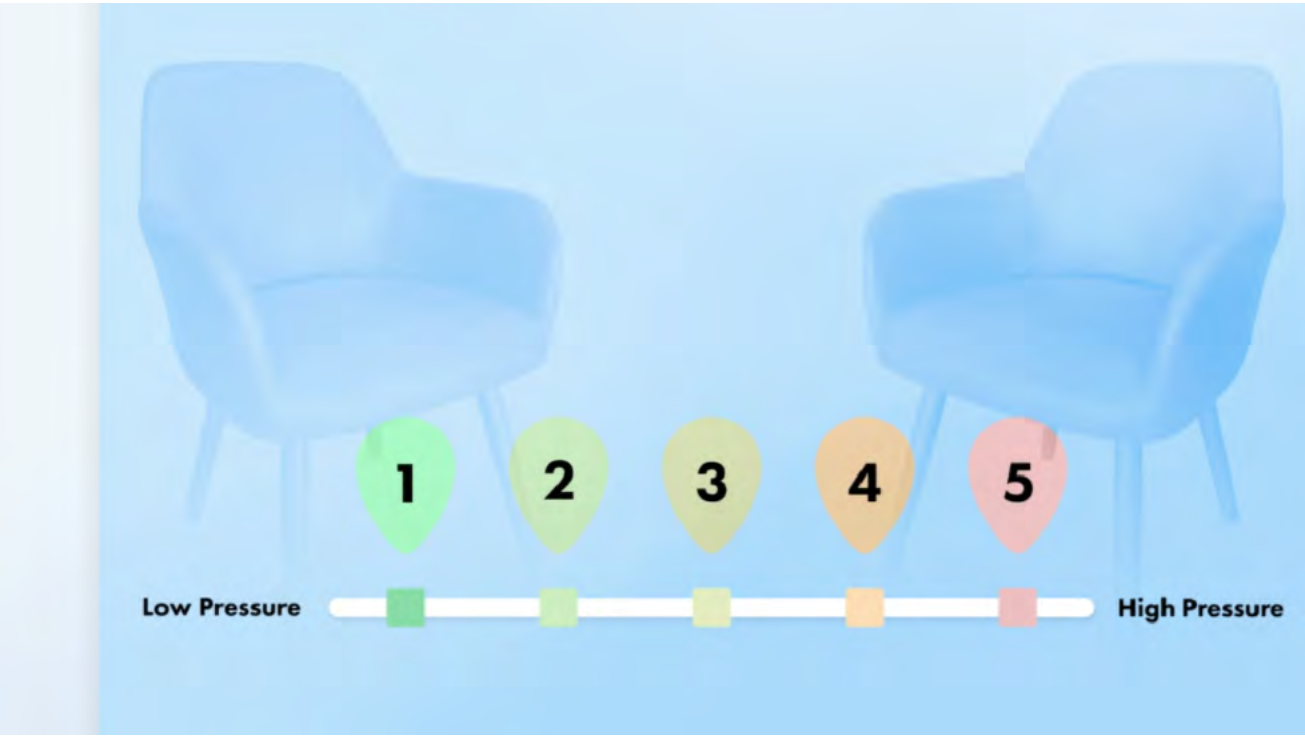
Here’s the really productive moment: ask the patient what they think about your advice or information, and listen for all you are worth, because here you might notice change talk and find yourself right in the heart of good MI practice. Useful questions include, “What do you think of my suggestion?” “How does my idea fit with your plan?” “What will work the best or the worst here?” “How could you improve given what we’ve talked about?” “Could you see a way to fit any of this in your busy life right now?” and “How does this information/advice fit into your everyday life?”

High Demand Scenarios



The situations you encounter vary, and some can be more tough than others. Giving someone information about a really good blood pressure reading will be a lot easier than advising someone, for example, that they can no longer drive their car, or if a patient demands medication that you need to tell them they cannot have.

FIGURE 1: Low to High Demand Situations



The five points on the continuum in Figure 1 are rough approximations of scenarios of increasing pressure on you the practitioner. At the lower end will be something like a simple request from a patient for information (No. 1), followed by a decision you make to provide information about a straightforward procedure (No.2), a patient who asks you for advice (3), you *needing* to give

and unsure how it will land and (4) that situation where you must give advice to someone whom you know will not want to hear it (5).

The more high-pressured the scenario the more you will want to bear these guidelines in mind:

- Take a step back and take a few breaths before proceeding.
- Ask permission by way of introduction and flag up your intention to give advice in your opening remarks.
- Engage well in the early ASK phase, and after you have given the advice.
- Champion choice. Even if there is no choice about the advice you are giving, there might be choice about how to deal with it.

An example

In the illustration to follow, notice how important are the use of open questions and listening statements.

The scenario chosen is one where a practitioner is giving the patient some advice that they don't really want to hear: the result of a blood test suggest the need to reduce their alcohol consumption or even stop altogether. It's about at No. 4 in Figure 1.

There is no one best way to proceed, and this practitioner has chosen to take a fairly direct route - to give the patient some clear advice.

Practitioner: Thanks for coming back for this test result.

You are looking a little worried.

Patient: Well I don't feel well, and I wish I knew why I always get these stomach pains you helped me with last week.

Practitioner: How has the antacid medicine been for you? [Open question]

Patient: It helps but then the pain comes back again, and my wife says that I must find out what's going on here.

Practitioner: You are both not sure about why this is happening. [Listening statement]

Patient: I guess so.

Practitioner: [Starts with the first ASK phase of the strategy] Well I want to give you the result of that blood test now if that's OK with you? [Asks permission]

Patient: Yes that's fine what does it say?

Practitioner: Before I do that, what do you know about how drinking alcohol affects your health and your stomach?

Patient: Is this my drinking that's causing the stomach pains?

Practitioner: It might well be yes, and you look a bit surprised [Listening statement]

Patient: Well I drink the same as all my mates

Practitioner: and you struggle to see the link with your stomach pains [Listening statement]

Patient: I never thought about that. I mean after a really heavy night my stomach does act up a bit [Change talk], but then I usually sleep it off and I'm fine. As far as I know, my drinking is fine [sustain talk], and its only on the weekend that I drink a bit, otherwise its just a beer or two each day.

Practitioner: So you are not sure what is going on here [Listening statement]

Patient: No, I mean you are not saying I am an alcoholic because I don't believe that

Practitioner: Well that word means different things to different people and for me now this is about your health and your stomach. Can I share the test result with you now? [Proceeds to the OFFER phase of the framework. Provides test result and notes a clear link between drinking and gastric symptoms]

Patient: What? Why, is my drinking that bad?

Practitioner: You look surprised or a bit shocked [Listening statement]

Patient: Me stop drinking? I cant see a problem with the way I drink like I say I drink the same as all my mates [Sustain talk]

Practitioner: It's a puzzle for you how come you now have a problem with your stomach [Listening statement]

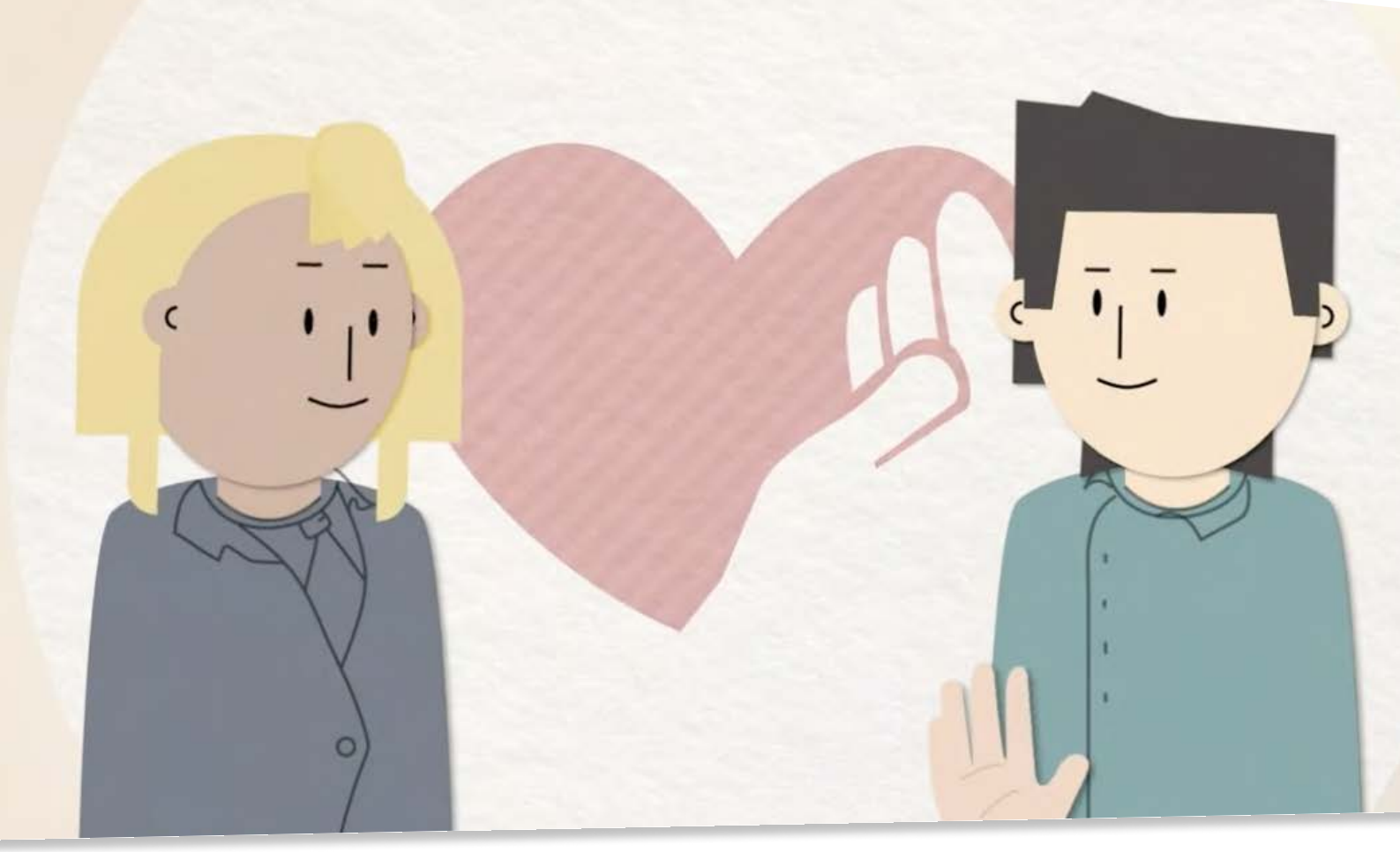
Patient: Yeah none of my mates do [Sustain talk]

Practitioner: This is your choice in the end, I just want to be honest and clear with you about my advice [Doctor is open and authentic and also emphasises choice].

Patient: Thank you, I see that. Now I must speak with my wife, because she mentioned my drinking a few weeks ago. I cant let this stomach thing get on top of me, it is painful I can tell you that Doctor [Change talk]

Practitioner: So the link between your symptoms and alcohol might be for real for you [Listening statement].

Patient: It might [Change talk].

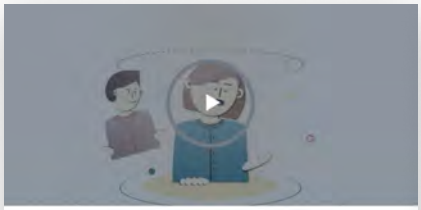


The aim of that illustration was to show how if you follow the above framework it is possible to move seamlessly from giving advice into the practice of motivational interviewing. The MI was most readily apparent in the segment after the advice was given, where the doctor use listening statements to elicit change talk.

If you Imagine that news and advice being delivered without the first ASK phase it might have been a quite different experience for both parties, especially if the practitioner was only able to ask questions. The listening statements clearly made a difference to keeping the conversation going in a constructive manner.

Motivational Interviewing

Additional Resources



What is MI? Stephen Rollnick explains.

The righting reflex

Stephen Rollnick explains the righting reflex in MI.

Engaging in MI

Stephen Rollnick on why engaging is a critical foundation of MI.

Online Course

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MI co-founder Dr Stephen Rollnick teaches the core skills and process of Motivational Interviewing that have been found to be highly effective in health care.

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