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Consultations about changing behaviour

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Persuading patients to change behaviour that is damaging their health can be difficult. Changing the style of consultation could improve the experience for doctors and patients

Health threatening behaviours are the commonest cause of premature illness and death in the developed world, affecting the sustainability of our health services and society.[1] Almost every healthcare worker interacting with almost every patient has an important opportunity to change health behaviour. Examples include a general practitioner talking to a patient about smoking or exercise, a health visitor engaging a mother about her child's diet, an accident and emergency house officer talking to an injured patient about alcohol, a renal nurse discussing fluid intake, and a dental hygienist discussing flossing. These consultations can be difficult to navigate, however, and practitioners often make a cursory attempt to satisfy external guidelines or end up avoiding the subject altogether. Here, we consider how the flexible use of a guiding style could make health promotion more satisfying and effective.

Skilfulness makes a difference

The challenges of changing health behaviour have parallels in everyday life. For example, the more we raise the stakes in telling a child to do something, the more likely conflict will follow. "Please get into the bath, now!" is often followed by, "But I am not dirty!" In the more polite confines of the consulting room, weariness is a common reaction. Doctors feel pressure to do more to prevent the effects of health compromising behaviours on their patients. Yet, doctors say they are not social engineers, cannot dictate the lives of their patients, and were trained primarily for diagnosing and treating medical conditions not monitoring and modifying their patients' behaviour. When they raise health behaviour, clinicians usually default to a directing style of interacting with their patients.

It is not difficult to distinguish discussions that go well from those that go badly. When the discussion goes well, the patient is actively engaged in talking about the why and the how of change and seems to accept responsibility for change. When the discussion goes badly, the patient is passive, overtly resistant, or gives the impression of superficially agreeing with the practitioner. These reactions are measurable, predict outcome,[2] and are influenced by the behaviour of the practitioner; confrontational interviewing, for example, predicts high levels of patient resistance.[3] Therefore, practitioners might have greater potential to raise or lower patient resistance than many assume. If this is true, skilful consultation about behaviour change, like the skilful and compassionate breaking of bad news, is worthy of every effort to give patients the best quality of care possible.

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Try guiding instead

The process of changing behaviour

Just telling people they are at risk of developing a disease is rarely sufficient to change behaviour.[4] People change if they come to believe that it is both of value and achievable.[5] Maintaining change is not easy, and successful change often requires multiple attempts.[6] Decisions about change can be finely balanced and linked to other behaviours, as with the smoker who gets irritable and puts on weight each time she quits. Information about risk is but one of several influences on this process. We can help patients weigh up the value of change and set realistic targets, but ultimately the patient must decide whether to change and how.[7 8]

This rather obvious conclusion probably accounts for the enthusiasm with which motivational interviewing has been adapted from psychotherapy into healthcare settings.[9–12] Since patients often feel ambivalent about change, they are sensitive to well intentioned efforts to persuade them one way or the other. Resistance and denial are common reactions, but these can be overcome, and outcomes improved, if the practitioner elicits the case for change from the patient rather than imposes it.

Directing or guiding?

So, how might everyday healthcare practice be improved? It is useful to contrast at least two styles of consulting about behaviour change. When practitioners use a directing style, most of the consultation is taken up with informing patients about what the practitioner thinks they should do and why they should do it. When practitioners use a guiding style, they step aside from persuasion and instead encourage patients to explore their motivations and aspirations. The guiding style is more suited to consultations about changing behaviour because it harnesses the internal

P+ *Sample research questions are on bmj.com*

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Use of listening, asking, and informing in directing and guiding styles

Directing style
Clinician: Your test result shows that the levels of glucose in your blood are raised today. This means that you really need to watch your diet (*informing*). Have you thought about adjusting this (*asking followed by listening*)?
Patient: Well, it's not that easy. I have tried, but you know what it's like. I mean, it's not so easy with my job, driving around in a rush and you know you just have to grab some food at lunch and keep going.
Clinician: You could bring your own lunch with you (*informing*).
Patient: I could do that, but it's so busy in the morning, just getting us all out of the house, and then I stop in a cafe anyway at lunch, so I would then have to avoid the easy option of just getting a roll and feeling full and ready for action.
Clinician: Well, my advice to you is to treat this as your top priority (*informing*).

Guiding style
Clinician: Your test result is high today (*informing*) and I wonder what sense you make of this (*asking followed by listening*)?
Patient: I don't know. I am not surprised because it's hard enough getting by day to day without worrying about this as well.
Clinician: Everyday life can't stop because you have diabetes (*listening*).
Patient: Yes, exactly, but I know I do need to be careful.
Clinician: In what way?
Patient: I need to watch my diet and get more exercise. I know that, but it's not so easy.
Clinician: What might be manageable for you right now?
Patient: It's got to be exercise, but please don't expect great things from me.
Clinician: Well, a change in diet or exercise will be a great help (*informing*). How might you succeed with more exercise (*asking*)?

motivations of the patient. This was the starting point of motivational interviewing,[9] which can be viewed as a refined form of a guiding style.

Core skills

Asking, informing, and listening can be thought of as core tools or skills used by practitioners in different combinations and in the service of either directing or guiding. Asking involves the use of questions. Paying careful attention to choice of words, timing, tone of voice, and the ambiguities and contradictions often elicited in replies will engage patients more actively. Informing involves providing information, advice, feedback, or a demonstration. Focusing attention on clarity, evidence, purpose, and congruence with patients' needs is likely to achieve efficient use of time and reduce the likelihood of resistance. Listening involves hearing what patients say and ensuring that their meaning is understood. Responding appropriately, sometimes by conveying understanding through empathic or reflective listening, engages patients constructively. The box shows the use of these three core skills in the service of either directing or guiding.

Directing and behaviour change

In the directing style, informing is usually the dominant mode. This is appropriate in many circumstances—for example, when a patient has acute appendicitis. However, to be effective in changing health behaviour this style requires a particularly well timed and personally relevant quality. More often, the directing style manifests in a rigid routine in which, for example, the first question to a smoker, "How much do you smoke?" is followed by a series of closed questions before the delivery of advice to quit. Informing then becomes telling patients what they already know (or have considered, tried, and rejected) and presenting them with a single, apparently simple solution. Resistance is a common reaction, and this dysfunctional interaction can leave practitioners blaming the patient for lacking motivation or being in denial.

Perceived lack of time is a common explanation for the almost reflex use of a directing style when trying to change behaviour. Contractual obligations to discuss certain subjects may lead to a raw, number crunching approach that loses sight of individual needs. Similarly, guidelines may also unwittingly reinforce an oversimplified approach by encouraging practitioners to advise patients about lifestyle change in an unhelpful manner.

Guiding and behaviour change

The three core skills are also used in the guiding style, but here asking often involves eliciting from patients why or how they might change and listening is used to convey understanding of their experiences and to encourage further exploration. Even the use of informing is different. Informing is combined with asking to encourage choice and promote autonomy rather than to tell the patient what to do (see box). Challenges for the practitioner include being restrained, conveying the conviction that solutions lie within the patient, and handing over responsibility about decisions to the patient while retaining control over the time and overall direction of the consultation.[13]

The style being used can be reflected in small things like the phrasing of a question, the offering of an invitation to consider change, or the seating arrangement. Everyday life provides other examples. Parents commonly use both styles. Directing seems essential and appropriate in some situations but quickly generates resistance if clumsy or wrongly timed. To avoid resistance, parents and teachers use scaffolding or guided participation, adjusting the level of support according to the needs of the individual. This occurs consistently across cultures and predicts later success for the learner.[14 15]

Everyday practice

Shifting from a directing to a guiding style requires doctors to change their attitude about who is responsible for solving the problem and how the momentum and the direction of the discussion are controlled. One practitioner described it thus: "It's a shift from 'Do this, do that' to 'Nudge, listen, summarise; nudge, listen, summarise.'" The ability to switch between the skilful use of these styles, even within the same consultation, is a marker of good practice.

Giving advice is often viewed as the delivery of expertise within a directing style,[16] and characterises much of what is known as brief intervention in addiction and elsewhere.[17 18] However, by integrating skilful informing with listening and asking, a guiding style could be used to deliver brief interventions. This approach seems in tune with wider developments—for example, the recent white paper *Choosing Health*, which encourages the move from "advice from on high to support from next door."[19]

Patients themselves are probably the best teachers when it comes to learning how and when to use the

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Summary points

Patients' behaviour contributes considerably to variation in disease outcomes and mortality

Consultations about changing behaviour are important, common, and provide special challenges

Clinicians typically use the three core skills of listening, asking, and informing

Change is more likely if patients are helped to make decisions for themselves rather than being told what to do

Use of a guiding style, which is a simplified form of motivational interviewing, may facilitate such decisions.

directing or guiding styles. For example, if a patient shows resistance in response to directing it might be a signal for the practitioner to shift style. Conversely, impatience or other evidence of lack of progress with a guiding style may lead the practitioner to switch to directing.

The guiding style can also be used to change practitioner behaviour, avoiding the didactic approach assumed in evidence based guidelines and incentivised targets.[20 21] The goal is to enable practitioners to adjust their routine approach to talking about behaviour change and engage the patient more in decision making.[22] Despite the subtlety of processes, it seems possible to measure skilfulness,[23 24] to identify improvements associated with training,[25] and to identify ways of maintaining changes in practitioner behaviour.[26] While motivational interviewing itself might take time to learn, the guiding style on which it is based is well within the reach of busy healthcare practitioners.

Moving forward

Effective brief interventions in routine clinical care have enormous potential to improve public health. Research into consultations that aim to change behaviour is therefore likely to be worth while, and the box on bmj.com provides a list of sample questions. We already know that adaptations of motivational interviewing are generally more effective in changing single behaviours than no or minimal interventions, and they are usually as effective as more intensive alternatives.[10–12] It is now worth testing the hypotheses that brief interventions informed by the guiding style result in greater change than directive advice across multiple behaviours.

Helping patients change health threatening behaviour could be a routine component of most healthcare consultations. Given the scale of potential health gains, pressure is increasing to do more of this work.[1] Enhancing motivation and encouraging change is a complex task that demands skilful consulting, and practitioners might benefit from refining their existing skills, particularly in the use of a guiding style. Patients deserve a sensitive response to difficult decisions about behaviour change. At the very least, we should be sure that we are doing no harm with our well intentioned interventions aimed at changing their behaviour.

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1 Goldstein M, Whitlock E, DePue J. Multiple behavioural risk factor interventions in primary care: summary of research evidence. *Am J Prev Med* 2004;27(2 suppl):61-79.
2 Amrhein PC, Miller WR, Yahne CE, Palmer M, Fulcher L. Client commitment language during motivational interviewing predicts drug use outcomes. *J Consult Clin Psychol* 2003;71:862-78.
3 Miller WR, Benefield RG, Tonigan JS. Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. *J Cons Clin Psych* 1993;61:455-61.
4 Marteau T, Lerman C. Genetic risk and behavioural change. *BMJ* 2001; 322:1056-9.
5 Kok G, van den Borne B, Dolan Mullen P. Effectiveness of health education and health promotion: meta-analyses of effect studies and determinants of effectiveness. *Patient Educ Couns* 1997;30:19-27.
6 Prochaska, JO, DiClemente CC, Norcross JC. In search of how people change: applications to addictive behaviors. *Am Psychol* 1992;47:1102-14.
7 Schneider CE. *The practice of autonomy: patients, doctors, and medical decisions*. New York: Oxford University Press, 1998.
8 Stott N, Pill R. Advise yes, dictate no. Patients' views on health promotion in the consultation. *Fam Pract* 1990;7:125-31.
9 Miller W, Rollnick S. *Motivational interviewing: preparing people to change*. New York: Guilford Press, 2002.
10 Burke BL, Arkowitz H, Menchola M. The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. *J Consult Clin Psychol* 2003;71:843-61.
11 Britt E, Hudson S, Blampied N. Motivational interviewing in health settings: a review. *Patient Educ Couns* 2004;53:147-55.
12 Rubak S, Sandbaek A, Lauritzen T, Christenses B. Motivational interviewing: a systematic review and meta-analysis. *Br J Gen Pract* 2005;55:305-12.
13 Pill R, Stott N, Rollnick SR, Rees M. A randomized controlled trial of an intervention designed to improve care given in general practice to Type II diabetic patients: patient outcomes and professional ability to change behaviour. *Fam Pract* 1998;15:229-35.
14 Conner DB, Cross DR. Longitudinal analysis of the presence, efficacy and stability of maternal scaffolding during informal problem-solving interactions. *Br J Dev Psychol* 2003;21:315-44.
15 Hustedt JT, Raver CC. Scaffolding in low-income mother-child dyads: relations with joint attention and dyadic reciprocity. *Int J Behav Dev* 2002; 26:113-9.
16 Rollnick S, Mason P, Butler C. *Health behavior change: a guide for practitioners*. Edinburgh: Churchill Livingstone, 1999.
17 Lancaster T, Stead LF. Individual behavioural counselling for smoking cessation. *Cochrane Database Syst Rev* 2005;(2):CD001292.
18 Hodgson R, Rollnick S. How brief intervention works: representative cases as viewed by health advisors. In: Babor T, Grant M, eds. *Project on identification and management of alcohol-related problems: a randomized clinical trial of brief intervention in primary health care*. Geneva: WHO, 1992: 172-89.
19 Department of Health. *Choosing health: making healthy choices easier*. London: DoH, 2004.
20 Gabbay J, le May A. Evidence based guidelines or collectively constructed "mindlines?" Ethnographic study of knowledge management in primary care. *BMJ* 2004;329:1013.
21 Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, et al. Impact of payment method on behaviour of primary care physicians: a systematic review. *J Health Serv Res Policy* 2001;6:44-55.
22 Elwyn G, Edwards A, Kinnersley P. Shared decision making: the neglected second half of the consultation. *Br J Gen Pract* 1999;49:477-82.
23 Lane C, Huws-Thomas M, Hood K, Rollnick S, Edwards K, Robling M. Measuring adaptations of motivational interviewing: the development and validation of the behaviour change counselling index (BECCI). *Patient Educ Couns* 2005;56:166-73.
24 Elwyn G, Hutchings H, Edwards A, Rapport F, Wensing M, Cheung W-Y, et al. The option scale: measuring the extent that clinicians involve patients in decision making tasks. *Health Expect* 2005;7:1-9.
25 Lane C, Johnson S, Rollnick S, Edwards K, Lyons M. Consulting about lifestyle change: evaluation of a training course for specialist diabetes nurses. *Pract Diabetes Int* 2003;20:204-8.
26 Miller WR, Yahne CE, Moyers TB, Martinez J, Pirritano M. A randomized trial of methods to help clinicians learn motivational interviewing. *J Consult Clin Psychol* 2004;72:1050-62.

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