Engagement, motivation, and changing behaviour

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This chapter will help you to achieve competencies in:

- ⊙ Actively helping people to identify and use their strengths to achieve their goals and aspirations.
- ⊙ Using appropriate strategies to empower and support patient choice.
- ⊙ Promoting health and well-being, self-care, and independence through teaching and empowering people to cope.
- ⊙ Discussing sensitive issues in relation to public health and providing appropriate advice and guidance to individuals, communities, and populations.
- ⊙ Working within a public health framework to assess needs and plan care for individuals, communities, and populations.
- ⊙ Supporting people in making appropriate choices and changes to eating patterns.
- ⊙ Discussing in a non-judgemental way how diet can improve health and the risks associated with not eating appropriately

Introduction

This chapter builds on the health promotion strategies addressed in Chapter 8 by considering how the underpinning theories support the delivery of health promotion and behaviour change in practice settings.

When we consider health promotion interventions, one important feature of the process is identifying and understanding the attitudes, beliefs, and values that our patients have regarding their health and well-being. Ideally, exploration of these variables should

be done with the patient or groups that we are working with. Once we have identified these, we can then tailor our interventions to meet their motivation needs to change behaviour. First we need to consider the theories behind health beliefs.

Theories behind health beliefs

The health belief model

An established theoretical model of health beliefs is by Rosenstock (1966) and Becker (1974). The theory underpinning the Health Belief Model is that the perceived threat of disease serves as a motivator for the patient to take action. In other words, it is about communicating to patients that behaviours like smoking, lack of exercise, and poor diet may lead to coronary heart disease and stroke, in an effort to motivate the patient to modify such behaviours and reduce their risks of disease (Figure 15.1).

The Health Belief Model can be an effective framework with which nurses can evaluate patients' health behaviour and deliver interventions. Nurses can use this model effectively for health promotion for breast-cancer screening (Medina-Shepherd and Kleier, 2010), smoking cessation (Schofield *et al.*, 2007), mapping and improving sexual health behaviour (Browes, 2006) and treatment choice for obesity (Armstrong *et al.*, 2009).

The model in Figure 15.1 is based on the individual's beliefs as to how they consider themselves to be.

Perceived susceptibility (am I going to get the disease?)

Most of the time people tend to think that they are less likely to develop a health problem compared to other people. Therefore some people do not think health informa-

Figure 15.1 The health belief model

tion is relevant to them. An example of this is health promotion campaigns on the increasing risks of HIV transmission amongst heterosexuals.

> Nurse: Jenny, here is the prescription for the contraceptive pill. You have mentioned that you don't have a steady partner at the moment so I would really like to advise you that it's better also to use condoms to protect you against a number of sexually transmitted diseases including HIV.
>
> Patient: Oh I don't need to worry things like that don't happen to people like me.

Perceived seriousness (how bad would it be?)

Some patients believe that it is better to leave things alone at the moment and perhaps return to thinking about it in the future.

> Nurse: Sam, your blood pressure is a little on the high side. We need to think how we might help to reduce this. I wonder if you might consider losing some weight as there is significant evidence that losing even 10% of your weight helps to lower your blood pressure. What do you think?
>
> Patient: I'll give it some thought maybe but perhaps later when I get back from my holiday or after Christmas maybe. Besides, my dad was fat and lived to a ripe old age and his mother was thin and she died in her 50s. Anyway nurse, when your time's up that's it. You've got to go sometime.

Perceived barriers and benefits (will it be easy to get something done about it? What will it cost me?)

Here the person weighs the pros and cons. It is based on the fact that the person must believe that a change in behaviour will benefit them. These costs are weighed up not just in financial terms but to other areas of their lives.

> Nurse: Reducing your lithium medication when you're so stressed Joe is putting you at risk of becoming manic.
>
> Patient: I know, but the stress is down to the amount of work I have to get through right now and being just a bit high helps me get through it quickly.

Self-efficacy (Is it possible for me to do something about it? What are the things that might stop me?)

Patients will consider whether the time is right for them and the possible negative outcomes.

> Nurse: Mary, we have discussed the fact that if you carry on smoking 30 a day you are at risk from developing smoking-related diseases. Do you think you could consider how you might stop smoking using one of the therapies we have discussed?
>
> Patient: I'm not sure I can do it. I know, you see, the minute I give up I will put loads of weight on and I don't want that.

Cues to action: take action (ok I am ready to make a change)

This model proposes that some patients need cues in order to change some health-related behaviour such as a change in their appearance, a death of a close family member, a comment from a close friend or relative or significant other. As nurses, we can sometimes be the significant other. Once this happens, the patient is ready to make a change based on having the correct information and an improved motivation to change. See case study 1.

Case study 1: giving information to facilitate change

Alan is staff nurse on a paediatric ward caring for Jimmy who is seriously ill with measles. Jimmy's mother visits every day after dropping her other two children off at the nursery. She tells Alan that none of her children have been immunized against measles as she doesn't believe in immunizations anyway. After getting to know her, Alan asks about her concerns regarding vaccination, and he is able to allay some of her fears. He asks whether she would now consider having her other two children immunized to protect them from the terrible effects that the disease has had on Jimmy. She agrees and he arranges an appointment for her in the local clinic.

As nurses we have a responsibility to communicate the need for our patients to consider healthier lifestyles to prevent disease. Understanding our patients' beliefs about their health and well-being is an important factor in communicating health promotion. It enables the patient to feel valued and listened to. The Health Belief Model is not a model which can predict behaviour or identify those factors which are important in

influencing behaviour change. However it does enable us to consider overall the complex range of factors which influence a person's health behaviour.

⊕ **Learning point 1**

Think back over your placement experiences so far and about some of the patients you have recently cared for. Can you use the main aspects of the Health Belief Model to identify the range of factors which may have influenced their health behaviour?

- Perceived susceptibility (Am I going to get the disease?)
- Perceived seriousness (How bad would it be?)
- Perceived barriers and benefits (Will it be easy to get something done about it? What will it cost me?)
- Self-efficacy. (Is it possible for me to do something about it? What are the things that might stop me?)
- Cues to Action. Take action. (OK, I am ready to make a change.)

If you were to meet these patients on placement again, how might you respond differently in conversations you had?

One of the identified barriers to more effective use of the Health Belief Model is that, while nurses are in a good position to deliver health promotion, they feel uncomfortable translating their knowledge into practice. Across six Western countries, Lally *et al.* (2008) found that only 50 per cent of oncology nurses considered discussing smoking with their cancer patients. Schofield *et al.* (2007) similarly found older smokers unable to sustain healthy changes in their smoking habits, and considered lack of sustained encouragement from health professionals to be a key factor. This evidence suggests that the model helps nurses identify patient behaviour change problems, but still need to change their use of health promotion to make sustainable changes in their patients.

The behaviour change model

Another useful model is offered by Prochaska and Di-Clemente (1984, 1986, 1992). The model considers how patients make health-related behavioural decisions, the stages they go through, and how they move from one stage to another. The model focuses on *how* people change rather than *why*. The model is based on sequential stages:

- pre-contemplation;
- contemplation;
- preparation to change;
- action for change;
- maintenance;
- relapse.

The model is characterized very much like a revolving door and the length of time spent in each stage varies. Throughout each stage people are occupied in different physical and mental processes (Figure 15.2).

Pre-contemplation

A patient in the pre-contemplative stage does not intend make any change to their health behaviour in the foreseeable future. Patients may be in this stage because they are uninformed or not really interested about the consequences of their behaviour, or they may have tried to change in the past and been unsuccessful.

> Patient: Sorry nurse but, before you start about my smoking, I've tried nicotine gum but it didn't work for me. Nothing really works for me so I just have to face it I will always be a smoker. Anyway my dad was a smoker and lived to a good age.

Contemplation

Patients here are thinking about their health and lifestyle behaviour and intending to do something about it, usually in a given time scale, and can often stay in this stage for a very long time or may never actually move forward at all.

> Patient: I am sick of being out of breath all the time and I know it's smoking that's causing it. I'd like to do something about it but don't know what.

ease provide

Figure 15.2 The behaviour change model

Preparation to change

This is the stage in which the patient is intending to take action in the immediate future. Again this may be measured in time, for example in the next month. Some patients we work with may already have made a move to taking action such as joining a gym.

> Patient: I have thought about cutting down on my cigarettes but I think I need some help to do this. I have heard about nicotine patches. Do you think they will help me?

Action for change

This is the stage in which patients have made specific obvious changes in their health behaviours and lifestyles within the past six months. This stage involves clear and realistic time-planned goals which are supported by others to ensure success.

> Patient: I feel so much better. I haven't had a cigarette for three weeks now and that nicotine gum you suggested has really helped. It's difficult though and sometimes after tea I really crave one.

Maintenance

Patients in the maintenance stage are working to prevent relapse and returning to their old health and lifestyle behaviours. The new health behaviour therefore becomes a normal pattern. Many patients find this a difficult stage and many people relapse and revert back to any of the above stages.

> Patient: It's been a year now since I smoked. It feels good when someone says are you a smoker and I say no. It's difficult sometimes but I get tempted less and less and if I do, I immediately get on with doing something to take my mind off it like we discussed.

Relapse

A patient may relapse to an earlier stage. It is important that we provide positive support and not allow the patient to consider themselves as having failed, but are encouraged to review their action plans and recognize that relapse is a part of the process of change.

> Patient: Oh I feel so annoyed with myself! I was doing so well and then I went to a party and an old friend offered me a cigarette and I just took it to be sociable and before I knew it I had smoked three and then bought a packet on the way home. I am back to square one now, it's hopeless.

Prochaska *et al.* (1994) modified the model and added a further stage described as 'termination or final stage' in which people experience no temptation to return to their old behaviour patterns.

The behaviour change model in action

Let us consider how both of the above models can be applied to our work in communicating with patients about health issues. It is useful to have a guide on how to get started and Ewles and Simnett (2005) and Rollnick *et al.* (2007) provide us with some tips on how to do this (Figure 15.3).

Using the case scenarios from the previous page, let's consider each of the steps (in Figure 15.3, labelled A–D) in working with a patient from the pre-contemplation stage through the whole cycle and how we communicate with patients to effect change.

Step A

Nursing is a very busy job but it is important that we do not just skip over or ignore this stage as it is in the early interaction that the nurse–patient relationship is formed. It is at this stage that the patient gains the first impression of us as professionals and how interested we are in them as individuals. It is difficult sometimes to rectify this at a later date. In getting to know the patient we need to ensure that we are in the correct environment. A patient's bedside on a noisy ward or a busy waiting room may not be the best place to initiate a discussion with a patient. The physical setting is therefore important and being able to add other interesting materials which communicate health issues such as posters, leaflets, and reading materials may prompt cues for discussing change. We need to get to know the patient, what their beliefs and knowledge about their health and well-being are, and whether they are ready to change. One useful way of getting to know the patient is by using narratives or stories, for example getting the patient to talk about what a typical day is like for them.

When using this approach the nurse asks the patient to take them through a journey of their typical day in relation to a health behaviour or health problem. In other words the patient is painting a picture that we can use to try to better understand the patient. The following is a scenario about a patient called John whose heavy smoking is contributing to his chest problems and breathlessness.
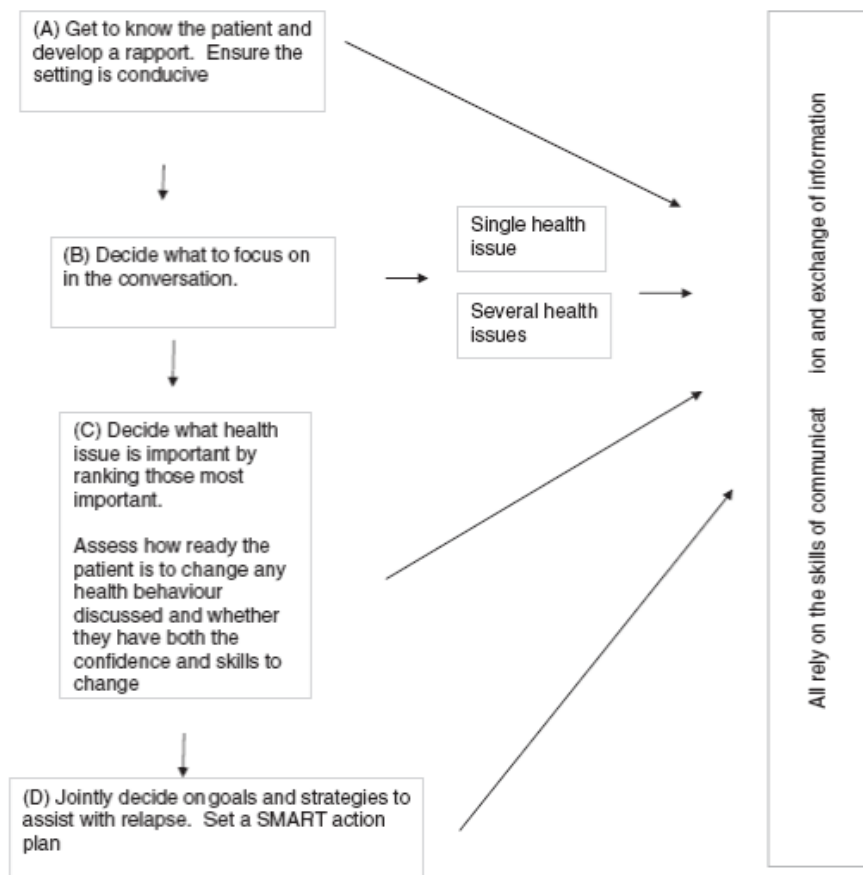
Figure 15.3 The behaviour change model in action. Adapted from Ewles and Simnett (2005) and Rollnick *et al.* (2007)

The pre-contemplation patient

Nurse: Hello John, my name is Nurse Jones and I am hoping to help you with why you have come here today. Particularly the problem you're having with your chest.

Patient: Sorry nurse but before you start about my smoking I've tried nicotine gum in the past but it didn't work for me. Nothing really works for me so I just have to face it, I will always be a smoker. Anyway my dad was a smoker and lived to a good age.

Nurse: OK John, I understand, but perhaps we'll just begin by getting to know each other a little. Maybe you could tell me what a typical day is like for you with your chest from when you get up in the morning. How does that sound?

As nurses, the skill we need to apply here is one of listening and following the story and only interrupting if really necessary and with very simple questions. Rollnick *et al.* (2007) suggests that you will know that you have got the balance right if you are only doing 10–15 per cent of the talking.

Step B

Some patients will have a number of health behaviours that they want to discuss and this can make it difficult for both the nurse and the patient to know where to start.

> Nurse: John, it seems that there are a number of things you are concerned about. These are your chest, weight, and that you cannot get out and exercise. Perhaps we can look at which ones are most important to you and begin there? How about we list the problems which cause you problems in your day-to-day life and you put them in order of importance?

Step C

The skill here is that the nurse does not rush into the discussion but ascertains what is (are) the most important issues that the patient can focus on at that time. It is important to note that a patient may only be able to focus on one behaviour change at a time. Also, it is worth remembering that a change in one health behaviour may have a positive effect on another which can act as a powerful motivator.

> Nurse: I know that you have had a poor experience with nicotine gum in the past John and this has put you off thinking about how you might give up smoking. How about we begin by looking at this again and seeing how we might help you to consider giving up smoking. If we can improve your chest it will help you to get out and about and exercise more, which will help with your weight loss. How does that sound?

Once you have begun to talk about health behaviour with the patient it is important to assess how ready they are to change their health behaviour(s). Patients may feel willing but not actually have the confidence to change. Rollnick *et al.* (2007) propose adopting a curious approach to this rather than a question–answer manner.

> Nurse: OK John, because of what you initially said when we first talked about the nicotine gum I am unsure *how* you feel at the moment about stopping smoking and how important is it to you. Can we chat about this for a moment and then we can decide what to do next?

From contemplation to preparation

> Patient: I am sick of being out of breath all the time and I know it's smoking that's causing it. But now you have explained to me the different things that I could use to try to stop smoking, and that I can get help with this, I think I may be able to give it another go. Especially if it will help me to lose weight as well. So I have decided that I am definitely going to quit smoking after my holiday next month.
>
> Nurse: That's great and sometimes it's a good idea to have something to focus on. How about we set a date to follow this up when you get back from your holiday?

It is important to remember that we can apply the model of behaviour change to any nursing setting and that patients may present to us at any stage in the cycle. For example the patient and nurse scenario above could occur on a hospital ward, outpatient department, or in a community setting. The key is that a follow-up opportunity has been discussed and arranged with all the necessary details communicated to those involved so that, when the patient returns, both can continue to work through the process of moving the patient to the next stage. Once the patient has a real commitment to change then we need to discuss with them strategies for achieving goals and coping with relapses.

Specific	Measurable	Achievable	Realistic	Timescaled

Figure 15.4 SMART principles

Step D

Once the patient has a clearer view of the need for behaviour change and the benefits it is important to discuss how they are going to achieve their goal(s). One of the techniques used is motivational interviewing using SMART principles (Figure 15.4).

In our case John has set a goal to quit smoking after his holiday and on returning has managed to cut down on the number of cigarettes he smokes in a day. At present the prospect of a whole life without smoking may be overwhelming for John but a day without smoking may seem far more realistic. The key is to build up goals from this.

> Nurse: Hello John I hope you enjoyed your holiday? I understand that last time you were considering stopping smoking once you returned from your holiday. Shall we look at how we can help you with this?
>
> Patient: Well nurse, I have managed to cut down on my cigarettes but not given them up completely. I think I need some help to do this and I have heard about nicotine patches. Do you think they will help me?
>
> Nurse: That's already a great start John, well done. What we need to do is to enable you to reduce the number of cigarettes you smoke even further now and I think that it might be a good idea to try nicotine patches. Let's set some small goals at first so that it doesn't seem impossible. How about trying to cut down again by three cigarettes a day for the first week? Then, in two weeks' time, see how the patches help with a short-term goal of a whole day without smoking? Remember that as you reduce your smoking you will also see the benefits in your breathing which will help you to get out and walk a bit more to increase your exercise.

Notice the SMART principles in this example. Decisions and goals agreed between the patient and the nurse are Specific, Measurable, Achievable, Realistic, and Time-scaled.

Maintenance

Devising coping strategies are important for success as many people have to cope with a number of difficulties until their new changed behaviour becomes the norm. Patients will adopt a variety of coping strategies and these should be explored with the patient as they may have very individual ideas and ways of doing this. Examples would include:

- changing routines;
- finding substitutes.

> Patient: I feel so much better. I haven't had a cigarette for four months now and that nicotine gum you suggested has really helped. It's difficult though and sometimes after tea I really crave one.
>
> Patient: It's been a year now nurse since I smoked. It feels good when some-one says are you a smoker and I say no. It's difficult sometimes but I get tempted less and less and if I do I immediately get on with doing something to take my mind off it like we discussed.

Relapse

The experience patients undergo when changing health behaviour(s) can be life-changing for them. However many do not exit the cycle the first time around and they relapse back to their old unhealthy habits. Indeed Prochaska and Di-Clemente found that, in the case of smokers, many had to take three journeys through the whole process before they were successful. It is important that we communicate to our patients their success and encouragement when things do not go to plan.

> Patient: Oh I feel so annoyed with myself! I was doing so well and then I went to a party and an old friend offered me a cigarette and I just took it to be sociable and before I knew it I had smoked three and then called and bought a packet on the way home. I am back to square one now it's hopeless.
>
> Nurse: It's okay! It's inevitable that you will slip back from time to time. We are all human! The important thing is to realise that you have been able to not smoke for such a long time, and you will be able to improve on this.

This chapter has tended to focus on working with an individual, however the same principles can be applied to working with groups or communities. The National Institute for Health and Clinical Excellence (NICE) offer a useful booklet for professionals with key points and examples of how to apply change on a larger scale and this can be found at the following web page.

http://www.nice.org.uk/media/D33/8D/Howtochangepractice1.pdf

Applying behaviour change skills in different settings

We've seen how people can be at different stages of engaging in the process of health behaviour, and that the professional has a role at every stage of the process. There are some specific communication skills that the professional can adopt to help people in this process, especially those who are not engaged in change or are disheartened by perceived failure.

Motivational interviewing

Motivational interviewing (MI) was developed by two psychologists, Miller and Rollnick in the 1990s particularly to tackle the motivation problems of people with alcohol dependency (Miller and Rollnick, 1995). There used to be an assumption among clinicians in this field that alcohol dependency treatment works for those who want to change, but if someone isn't motivated to stop drinking, no treatment in the world will work! So for Miller and Rollnick to develop a technique of interviewing people that develops motivation was quite a step forward. Motivational interviewing has been demonstrated to work in many trials now, particularly the Project Match study for alcohol dependency (Project Match Research Group, 1998), HIV and sexual health (Dunn *et al.*, 2001; Burke *et al.*, 2003; Wolfers *et al.*, 2009), accident risk among adolescents (Johnson *et al.*, 2002), and cancer and diabetes (Wahab *et al.*, 2008; Leak *et al.*, 2009). In general, it is often recommended for conditions that have poor treatment adherence such as addictions, bulimia, obesity, and psychosis, but potentially it can be used for any situation where poor treatment adherence or engagement is a problem. It is also shown to be effective in a range of applications when delivered by nurses with some skills in its use (Brodie *et al.*, 2008: Brodie and Inoue 2009) but evidence also suggests that, where nurses lack skills in communication to motivate patients, opportunities are missed to affect improved patient care (Hambly *et al.*, 2009; Lai *et al.*, 2010). This evidence suggests that nurses taking on the health promotion role need to be equipped with communication skills that support motivation and behaviour change.

Motivational interviewing uses the principles of the Prochaska and DiClemente's behaviour change model as illustrated above and fuses it with four principles taken from cognitive behavioural therapy (CBT) and Rogerian counselling. The nurse's intervention is pitched at the stage the patient is at in the model, and adopts two specific principles to target the motivation stage of the patient.

CBT—cognitive dissonance

Cognitive dissonance is a phenomenon identified in cognitive psychology whereby anyone feels psychologically uncomfortable when in a state of ambivalence; that is, when their behaviour and their values, attitudes, or beliefs don't match. The principle of cognitive dissonance is that something has to change to relieve the person of that psychological discomfort; either they change their behaviour or they change their beliefs. For example, a woman who continues to drink excessively and discovers that her children are being harmed by her drinking behaviour will either have to stop drinking to stop feeling guilty or will develop beliefs and excuses for her behaviour. For example:

> Patient: It's an illness that I have no control over.
>
> Patient: My dad was a drinker and it didn't do me any harm when I was growing up.

Using MI, the nurse targets the belief system to develop and enhance the discomfort, or 'dissonance'. This is called developing the **discrepancy** between behaviour and values.

Rogers's core principles of person-centred counselling

It sounds a bit cruel to just make someone feel uncomfortable about their behaviour but such therapeutic communication needs to be delivered in an ethical way, that is, person-centred. So the relationship is based on Rogerian principles of expressing empathy and genuineness, working with the person to develop their self-efficacy and avoiding confrontation.

Boxes 15.1 and 15.2 outline the four principles of MI and specific techniques identified by Miller and Rollnick for practice application.

Box 15.1   Miller and Rollnick's four principles of MI in practice

1. Express empathy—use reflective listening skills to demonstrate understanding of the person's problems and dilemmas in a non-judgemental way.
2. Develop discrepancy—between the person's deeply held values and their current behaviour.
3. Roll with the resistance that inevitably occurs—don't be confrontational or get into an argument.
4. Support and promote self-efficacy—help the person to believe they can effect change for themselves.

Box 15.2   Specific techniques in MI

1. Strive to understand the person's point of view and experiences, and make it clear to them that you accept their unique condition
2. Focus on statements that encourage change and don't focus on negative and stable statements: 'I can't change—there's no point trying.'
3. Ask questions that elicit statements (self-statements) of problem recognition and desire to change: 'If you stopped drinking now, what would your life be like in five years' time?'
4. Match your questions to the person's stage of change—don't jump ahead of the patient
5. Support and promote self-efficacy—help the person to believe they can effect change for themselves.
6. Constantly refer back to the patient's freedom of choice and ability to choose their own path.

Chapter 6 gives a fuller description of Rogers's principles of person-centred counselling and CBT and Chapter 12 outlines MI in chronic illness.

Anyone in healthcare can use MI skills when faced with patients with poor compliance and poor prognosis. Often, such patients are seen as 'heart-sink' patients, because nurses become frustrated with trying to persuade them to change their behaviour. Such patients may be good candidates for MI.

Let's look at some of the new skills mentioned above. There are examples of others in Chapter 6. The techniques must of course be based on an empathetic and cooperative style of relationship-building.

How to develop discrepancy

A person with a serious health problem due to their behaviour or lifestyle is often in denial about the reality of their situation. They have already closed their minds to the facts and developed defences such as a set of beliefs that protect them from feeling uncomfortable. Just telling someone won't get very far as they have been told enough times before. It is up to the interviewer to highlight the reality of their situation. We can highlight some of the negative points whenever the opportunity presents, and create those opportunities by getting the person to state them for themselves. This is called eliciting a **self-statement**. See the example in Box 15.3.

Box 15.3   A sexual health nurse is interviewing a sex industry worker

Patient:	I suppose I would like to know whether I'm HIV positive or not.
Nurse:	What's stopping you?
Patient:	Well, because they might say I am HIV positive!
Nurse:	And what would be bad about that?
Patient (*laughs*):	Well it would mean I'm going to die wouldn't it!

Notice the nurse gets the patient to make the statement about this fear herself, even though the answer is easy to anticipate. That way, the person is 'owning' her own values rather than having them thrust upon her in a confronting way.

This style of questioning is called **Socratic questioning** where the nurse persists in asking even obvious questions in order to get the person to make the obvious statements of fact or belief themselves.

Chapter 4 also addresses Socratic questioning.

Roll with resistance and avoid argumentation

Direct advice and confrontation with someone who is ambivalent about change will simply create resistance and defensiveness. See Box 15.4.

Box 15.4 Creating resistance

Nurse: Have you thought about cutting down on your smoking? It will help reduce your blood pressure.

Patient: Yes, I've tried but frankly, I enjoy smoking. It helps me relax and that probably reduces my blood pressure too.Nurse: But you could relax in other ways, in the long term your blood pressure will reduce if you stop smoking.

Patient: Yes, I know smoking is bad for me in all sorts of ways. But quitting isn't as easy as you make it sound.

Nurse: What about trying nicotine patches?

Patient: Yes, but . . .

This interviewer has got into an argumentative dialogue with this patient and the patient is responding with lots of statements about why he won't stop smoking.

Look at the next example (Box 15.5).

Box 15.5 Rolling with resistance

Nurse: I guess you've tried cutting down your smoking?

Patient: Oh yes, but as soon as I feel stressed or go out socially, I want a cigarette.

Nurse (*avoiding a confrontational question*): What do you think makes you smoke in those situations?.

Patient: Just habit, I suppose, but when I'm stressed I don't care about my health.

Nurse (*in response to the negative stance by the patient*): I can see on those occasions it is hard. Let's look at when you find it easier.

Here the nurse has spotted that they are about to fall into an oppositional relationship, so he agrees with the patient about it being hard (because it is!) and moves

toward talking about success instead of failure. This will also highlight the patient's sense of self-efficacy—what he *can* do.

So the relationship is about 'being on the same side' as the patient in making changes rather than being in a professional–patient relationship and resorting to advice and persuasion. Evidence indicates that treatment dropout is higher when the professional adopts a dictatorial style (Stott and Pill, 1990).

Resistance in the patient can be spotted by the development of:

- arguing;
- interrupting;
- denying;
- ignoring.

The key to dealing with resistance is to recognize it and move away from the topic or shift the focus, ensuring that the patient knows it is about their choice. We can then go back to the topic once we feel that the time is right and the patient is much more open to discussion. Rollnick *et al.* (2007: 34) offer a useful checklist for us to adapt and use to check all is going well and we are getting it right:

- The nurse is speaking slowly.
- The patient is doing much of the talking and is actively talking about behaviour change.
- The nurse is listening carefully and directing the interview at appropriate stages.
- The patient is 'working hard' with evidence of realization of issues and asking the nurse for advice and information.
- The process is like both the nurse and the patient putting the pieces of a jigsaw together to reveal the full picture.

Support self-efficacy

The main aim of MI is to promote the patient's perception of their own abilities to make changes. A good strategy to adopt when meeting any resistance is to acknowledge and empathize with the patient's view and focus on the achievement the patient has made, even if it seems small. A resistant patient turning up for a clinic appointment is often a positive sign of motivation and hope, and can be explored. See Box 15.6.

Box 15.6 Encouraging self-efficacy

Patient: I can't alter the way I am, I'm just fat and that's that.

Interviewer: You sound really fed up about it, but I think you are already making changes by coming here. You've made a very positive start.

Notice the nurse emphasizes that the patient has done something positive, implying that the patient is already making choices about change. The nurse could have emphasized how much attending clinic will help the patient—but that takes the power

to change away from the patient, suggesting that it is the clinic that will make the difference. Instead the nurse gives the message that the patient will make the difference by choosing to attend the clinic and use the help on offer.

Brief intervention

With pre-contemplative patients, it is hard to get as far as even discussing the problem without meeting instant resistance and disinterest. However, there is another evidenced technique we can employ which aims to move someone toward contemplation of change. This is called brief intervention therapy (BIT).

Brief intervention aims to raise the patient's awareness of the problem and reduce any misconceptions. It adopts a similar strategy to MI by avoiding confrontation and helping the patient 'own' their beliefs by eliciting self-statements. Look at the example in Box 15.7.

Box 15.7 Brief intervention

An underage teenage girl presents at A&E with alcohol poisoning. She indulges in heavy binge-drinking most weekends. Her understanding of her risk is epitomized by her statements.

Patient: Everyone I know drinks like I do, there's nothing wrong with them. I'm young and fit, my body can cope.

Nurse: I see you are due for a liver scan in a bit. Do you know what that's for?

Patient: Just to check that my liver's OK I guess.

Nurse (*looking serious*): Well, it's a bit more than that really. There may be liver damage, judging by your level of alcohol intake. A female of your age is particularly vulnerable to liver damage.

The nurse in Box 15.7 is being quite dramatic but not unrealistically so and not 'preaching'. The message being given is that this person in particular is at specific risk of liver damage. This indirectly challenges the patient's existing beliefs of being invulnerable at her age and in comparison with others.

Brief intervention is about sowing seeds of doubt or hope, giving people 'food for thought' and making even a small change to how he or she views their situation and behaviour. When someone presents with an acute problem, it is very often a good opportunity to highlight the reality of their behaviour. However, it is more effective if it is personalised––the message is: it is *you* who are in hospital/clinic, *you* who is having immediate treatment, and *you* who has chosen this course of action.

Another strategy in BIT is to elicit a statement about what the person would like to change if they could. A person who believes they are predestined to fail can still have dreams or have a wish list. See Practice example box 1 for a real example of BIT with a female heroin user.

Practice example box 1: working with a drug-using sex worker

Nurse:	If you had a magic wand, what would you change?
Patient:	Oh, I'd go back in time and not start taking heroin.
Nurse:	If you could do that, what would you have done instead?
Patient:	I'd have gone to college and perhaps been a nurse or something, instead of prostitution.
Nurse:	Going to college sounds like something you could do in the future.
Patient:	But I've ruined my life already.
Nurse:	Not yet. You're still alive. Some of your friends aren't. They have ruined their lives. You haven't.

With BIT, the seeds sown often need to be left to take effect. The health professional has no control over what people do with the intervention given during the short opportunity that presents. But, evidence indicates that BIT can be the first prompt that gets someone to think about things, seek more information, and perhaps approach health services for support (Watson, 1992; Freemantle *et al.*, 1993).

✚ Learning point 2: self-assessment

Test yourself on what you have learnt about MI and BIT by trying the multiple choice questionnaire.

1. Motivational interviewing:
   a. Is about confronting the person about their health risk behaviour.
   b. Is only relevant for drug and alcohol problems
   c. Requires the health professional to be specially trained
   d. Should be delivered with a person-centred approach
   e. Was found to be less effective than ordinary CBT by the project MATCH study
2. Strategies in motivational interviewing include:
   a. Directly challenging the patient's beliefs
   b. Agreeing with the patient at all times
   c. Looking for arguments
   d. Taking on the role of the expert professional
   e. Looking out for resistance

3. Brief intervention therapy:

    a. Is a form of psychotherapy

    b. Is complicated to deliver

    c. Aims to elicit negative statements from the patient

    d. Aims to elicit hopeful statements from the patient

    e. Aims to show the patient how their beliefs are wrong

4. In practising MI or BIT, the practitioner needs to:

    a. Encourage the patient to make choices

    b. Challenge the patient's defences

    c. Tell the patient when they are wrong

    d. Advise the patient how to behave more healthily

    e. Teach the patient how to change

Responses to Learning point 2

1 (d); 2 (e); 3 (d); 4 (a).

Conclusion

Modern nursing is not just about caring for the sick patient. Nurses are now health promoters and expected to help patients improve and maintain healthier lifestyles. To do this, we need the communication skills that encourage people to engage in healthier behaviour. Encouraging patients to change their health behaviour can be a challenge, especially when we consider the many factors that contribute to why patients adopt unhealthy lifestyles and behaviour. Using a theory to guide our communication with patients about their health beliefs and health behaviours is useful as it enables us to work with patients in a logical way and to plan interventions with them that target their individual needs. As nurses we need to be aware of the impact that our position can have on our patients' ability to consider healthy behaviours and use this in a way that facilitates and encourages healthy behaviours. This process requires effective communication skills if we want to achieve positive outcomes for our patients.

See the interview with 'Peter' in which motivation skills are applied. To find more resources to aid your learning please now go online to www.oxfordtextbooks. co.uk/orc/webb

Further reading

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