Applying motivational interviewing strategies and techniques to psychiatric pharmacy practice

Michael Biglow, PharmD, BCPP,

Clinical Pharmacy Specialist-Psychiatry
Kingsbrook Jewish Medical Center
Brooklyn, NY

ABSTRACT

Motivational Interviewing was developed to address patient resistance or ambivalence. As a directive, patient-centered counseling style for eliciting behavior change through patient exploration of ambivalence, it can be widely applied to the treatment of patients with mental health conditions.

KEYWORDS

Motivational interviewing, pharmacy practice, psychiatric

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Statements such as, ***"I just don't think the medications are working so why should I take them?"*** or "***I don't have a problem so why do I need treatment?"*** are very common from patients who may not have good insight into their condition or may be hesitant or even ambivalent to initiate/continue treatment particularly in the field of psychiatry. The concept of Motivational Interviewing (MI) was developed for addressing these types of patient barriers and was first described by William Miller in an article he wrote for Behavioral Psychology in 1983.[1] It was a technique that evolved from his experience in dealing with problem drinkers but found application in a number of patient subtypes. The approach was elaborated on and refined with Stephen Rollnick resulting in their work, ***Motivational Interviewing: Preparing People for Change***, where they describe the fundamentals of MI as a directive, client-centered counseling style for eliciting behavior change by helping patients to explore and resolve ambivalence.[2]

There are four general principles to this method of interviewing:

- **Express Empathy** – putting effort towards relating to the patient and their perspective. Patients who feel they are better understood will be more willing to "open up" or express themselves to the clinician.
- **Support Self-Efficacy** – in order to elicit a long-lasting change in a patient's behavior, the patient has to first believe that they can make that change. Directing the patient to look at previous changes they have made can reinforce that belief.
- **Roll with Resistance** – challenging a patient's resistance to therapy can put them on the defensive, slowing progress. Utilize these situations to explore the patient's reasoning and develop solutions to the problems they have presented.
- **Develop Discrepancy** – highlight individual patient goals and bring to the patient's attention how their current behavior is preventing them from achieving those goals.

While there are many techniques to elicit this change in behavior (e.g., reflective listening, normalizing, decisional balancing) Miller & Rollnick[3] emphasize that it is the ***spirit*** of the approach that is central to MI's success. The following points, adapted from their work, characterize that spirit:

1. Motivation to change is elicited from the patient, and not imposed from without
2. It is the patient's task to articulate and resolve their ambivalence
3. Direct persuasion is not an effective method for resolving ambivalence
4. Counseling should be done in a quiet and eliciting style
5. The counselor is directive in aiding the patient to examine and resolve ambivalence
6. Readiness to change is not a patient trait but a fluctuating product of interpersonal interaction
7. The therapeutic relationship is more akin to a partnership than expert/recipient roles

How we apply these methods to our own practice is generally up to the clinician. As mentioned before, a number of techniques[4] are available to the practitioner to

elicit the desired response but how and when to use a particular technique is difficult to determine without first developing a relationship with the patient. For example, a patient is referred to you for medication assessment and the patient notes compliance issues with their antidepressant but is unwilling to talk about their depression. One of the first steps is to ***ask permission*** using a statement like:

"Do you mind if we discuss the reasons why you don't want to take your medication?"

The question communicates a level of respect to the patient and should reduce the feeling of being pressured to participate in the conversation. This can be followed up by ***eliciting change talk*** such as;

"How does not taking the medication help you achieve your desired outcome?"

This strategy can help the patient understand the reasons why changing their behavior can be of benefit to them, since it also allows the patient to voice their motives for behaving as they do. Once a good discussion of the issues regarding medication compliance has taken place, a clinician can choose to utilize ***reflective listening*** to help build a sense of empathy with the patient and let the patient know the clinician understands their point of view. This can be reflected in statements such as:

"It sounds like you don't want to take the medication because you are concerned that if you do you will have a bad reaction."

Or

"I get the feeling that you want to change but are concerned with the side effects of the medications making things worse"

Following up with ***normalizing*** and ***decisional balancing*** strategies where the clinician can emphasize how these feelings are common, weighing the pros and cons of adhering to the medication, and allowing the patient to become more comfortable with the idea of change even if they are still unwilling.

Once a patient begins the change process, it is important to be supportive and give strong affirmations to their progress. Finally, summarizing the session while providing advice and feedback allows the clinician to communicate their involvement with the patient and build on that connection.

While there are a number of techniques and strategies utilized in MI, two basic approaches can be remembered by their acronyms[2,5]:

- **OARS**: **O**pen-ended questions, **A**ffirmations, **R**eflective listening, and **S**ummaries; and
- **FRAMES**: **F**eedback, emphasis on personal **R**esponsibility, **A**dvice, a **M**enu of options, and an **E**mpathic counseling style

In the three decades since its inception, Motivational Interviewing has shown impressive results in eliciting change behavior and has been used in combination with other active treatments such as cognitive behavioral therapy or 12-step facilitation programs.[6] A number of clinical trials, efficacy reviews, and meta-analyses have been published evaluating MI's application in areas outside of alcohol dependence, such as cardiovascular rehabilitation, diabetes management, dietary change, hypertension, HIV infection risk, gambling, and many other conditions requiring patients to make difficult lifestyle adjustments with positive results.[6] A review of four meta-analyses evaluating the effectiveness and applicability of MI noted that MI was particularly effective for alcohol abuse (***Cohen's d:*** 0.03-0.43), improving diet and exercise (0.53-0.78), and gambling (0.24-0.46).[7] It should be noted, though, that not all trials have shown benefit. Some studies show MI having limited efficacy in patients with eating disorders, drug abuse, and smoking as well as having variability in patient populations.[8-11] Given the wide variations in clinician practice and style in approaching patients, the technical attributes of MI can vary considerably and this may affect individual outcomes. However, the main focus in therapy should be keeping true to the "spirit" of Motivational Interviewing.

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