Talking about behaviour change: Is guiding more effective than directing?

Motivating others to change their behaviour is often not straightforward. People tend to react against well-intentioned efforts to persuade them to change. This common approach to the challenge of patient behaviour change is pragmatic, for sure, but probably not good enough.

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Inside the consultation, what often unfolds is an effort to be clear and helpful, and to avoid frustration and conflict. "I give them my best advice, and then it's up to them to keep to their side of the bargain". And it's often a hard bargain for the patient to keep, to make adjustments in lifestyle, medicine use, tackle an addiction or perhaps disclose HIV status to an angry family. "How can I have a good diet and take my ARVs when I don't know where the next R100 is coming from?" The busier one is as a practitioner, the easier it is to slip into a sort of information dump mode and assume that behaviour change will or should follow. And it often doesn't.

William R. Miller, the psychologist who first developed "motivational interviewing", became disturbed by the degree to which advice, persuasion, coercion and confrontation were integrated into apparently sophisticated treatment methods for promoting behaviour change in the addiction treatment field in the 1970s and 1980s. I developed a similar distaste for an "experts know best" approach which culminated in a traumatic event: I was working in a South African addiction centre when a patient walked out of a confrontational group meeting and shot his wife and then himself. Miller and I met, developed what we felt was a softer and more humane approach, and then realised that efforts to encourage behaviour change were widespread in health and social care, hence the emergence of a book like **Motivational Interviewing in Health Care** (reviewed in this volume).[1] The method has been subjected to over 150 controlled trials (listed in the above volume). Does it work? The answer appears to be "yes", not always, and not without a good dose of humility: no "talking cure" can ever directly address the social and economic conditions that make change so difficult for people.

Motivational interviewing is not a technique for making people do something they don't want to do. It's simply the reverse of direct persuasion: instead of telling, advising, warning or cajoling someone to change, you elicit from them their own good reasons to change.

Ambivalence is a common and normal phenomenon, and patients seem to respond better to being given a little time to say how they feel and consider why and how they might change. In its most sophisticated form, this process of guiding the patient to consider change is driven by the use of empathic listening statements that capture the patient's dilemma, and explore how change might be compatible with their core values. Over the last 20 years, we have developed and evaluated a range of brief strategies that assist the busy health care practitioner to address behaviour change in the course of everyday consultations.

Simple as this may sound, the paper by Mash and colleagues[2] in this issue reveals quite how difficult it is for practitioners to shift their approach from one of telling patients what's best for them to guiding them to come up with their own solutions. It requires restraint and a delicate touch in conversations often surrounded by shortage of time and a feeling of being under considerable pressure. The rewards, however, can be considerable. Routine advice-giving, which often feels boring and ineffective, can be transformed into a powerful process of harnessing the unique strengths of the individual and having a consultation that is much more rewarding. Many skilled practitioners do this naturally. Motivational interviewing is merely an effort to clarify why and how this happens.

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