CHAPTER 1

Why Don't People Do What We Tell Them to Do?

Diabetes involves challenging work for both caregivers and patients. Few conditions are associated with such a complex array of lifestyle and medical treatment issues. The health consequences of uncontrolled diabetes are both serious and preventable (Diabetes Control and Complications Trial Research Group, 1993; UKPDS Study Group, 1998), and there are clear metrics and target values for quality diabetes care (hemoglobin A1C, low-density lipoprotein [LDL] cholesterol, and blood pressure). Yet, despite best efforts, the majority of diabetes patients (49–99%) in both developed and underdeveloped nations have *uncontrolled* diabetes according to these standards (Casagrande, Fradkin, Saydah, Rust, & Cowie, 2013; Gakidou et al., 2011).

In prevention and treatment of diabetes, a key challenge is health behavior change. Medical interventions can partially alleviate or delay complications, but the course and outcomes of diabetes are heavily determined by patients' behavioral and lifestyle choices that are beyond the control of caregivers. Curricula for diabetes education focus on these health behavior changes that most patients find challenging to implement (Diabetes Control and Complications Trial Research Group, 1993; UKPDS Study Group, 1998). Yet, few health care professionals are trained in evidence-based methods for helping patients to change.

Much of health care, especially care for chronic conditions like diabetes, seems to operate from a deficit model aimed at providing people with what they are lacking. Diabetes medications appropriately compensate for metabolic deficits such as insulin insufficiency or resistance. Clearly needed behavior changes are often addressed in the same manner as a deficit in knowledge or motivation—the presumption being that patients don't change because they either don't know enough or care enough. This view

encourages providers to persuade patients to change by attempting to provide enough knowledge, insight, or fear to make a difference in how they live their lives.

This book offers an alternative way of thinking about and addressing the behavioral challenges of diabetes care. It is based on behavioral science principles, and the specific method it describes—motivational interviewing (MI)—now has a large evidence base of controlled clinical trials conducted across many areas of health care. MI's application to diabetes care is more recent, with most studies appearing since 2005. To be sure, there is still much to learn in this area, but this book provides a starting point.

Ambivalence

Beyond its shock value, a new diagnosis of diabetes immediately presents people with a daunting list of recommended lifestyle changes to make in the long-term interest of their health:

- Eat more vegetables and cut carbohydrates.
- Decrease your fat intake to better manage lipid levels and weight.
- Regularly monitor your blood glucose levels.
- Increase your physical activity—exercise at least 150 minutes a week.
- Decrease your stress levels and avoid depression.
- Take your medications regularly, as prescribed.
- Monitor your blood pressure.
- Check your feet daily.
- Cut back on your drinking and stop smoking.
- Have regular eye exams.
- Visit your physician's office quarterly for medical check-ups.

The sheer volume of such changes and of new information can be overwhelming—even before considering the emotional impact of a diagnosis that threatens one's life and well-being. This distress is further compounded by the limited time that health care providers typically have with patients, creating a great sense of urgency to meet all clinical practice guidelines while also providing patients with solutions to these challenges.

Then there is the very human phenomenon of ambivalence. The status quo is familiar and carries a certain inertia with it, whereas change requires effort. One part of a patient wants to be healthy and knows that change is needed, while another part may be comfortable with how things are and therefore the patient is reluctant to make changes. Both arguments are constantly at play within the patient.

Ambivalence is like having an internal control committee. There are members of the committee voicing the urgency and advantages of change, and there are conservative members who oppose it. Left to one's own devices, the patient usually listens to an argument from one side and then the other side for a bit, and then stops thinking about the matter altogether because such internal conflict is unpleasant. The stopping of debate means, of course, the status quo prevails, at least for the time being.

The Righting Reflex

Enter the helper, the health care worker who went into this profession with the desire to make a positive difference in the world and in the lives of others. When you see someone heading down a road that leads to suffering, you want to get right in front of that person and say: "Stop! Go back! Don't you see where this road leads? There is a much better way over there. Take that road instead." And you do this naturally and with the very best of intentions. It is, after all, part of your job to alleviate suffering. It's just a gut instinct, a reflex built into those of us who go into the helping professions. You naturally want to fix things. You want to make things right.

Now, consider what happens when someone who is ambivalent meets a time-pressured helper with the righting reflex. Remember that the ambivalent person has both prochange and counterchange voices on that internal committee. To illustrate, we will use the example of problem drinking, which is the area in which the method of MI originally began (Miller, 1983). The helper asks some questions about the patient's drinking, listens patiently, and after a few minutes says, "Well, I'm concerned that you have a serious drinking problem, and I recommend that you stop drinking, at least for a while."

You don't have to think hard to know what the patient's immediate response is likely to be: "No, I won't." There is nothing pathological or out of the ordinary about that. It's just human nature that whenever someone takes up one side of an ambivalent topic, a normal reaction is to voice the other side. Both views were already represented on the patient's internal committee, and the helper sided with one view. This could easily lead to a debate, with the helper defending the need for change and the patient defending the status quo. In a way, they would be acting out the patient's internal ambivalence.

That kind of interaction might be engaging, even therapeutic, except for another fact of behavioral science, namely, that people tend to believe their own arguments more than those of others. Experiments show that when people are caused (but not coerced) to argue on behalf of one perspective on an issue—even if it is opposite to their own prior position—their

attitude and behavior tend to shift in that direction. People can literally talk themselves into (or out of) change.

Research bears out this last perception. When consultation sessions are recorded and coded, the likelihood of subsequent behavior change can be fairly accurately predicted by the levels of "change talk" (arguments for change) and "sustain talk" (arguments against change) that the patient voices spontaneously. The more change talk relative to sustain talk, the more likely change is to happen (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Moyers et al., 2007; Moyers, Martin, Houck, Christopher, & Tonigan, 2009). The more a patient argues against change, the less likely it is to occur.

So, there is the irony. When a helper tries to persuade an ambivalent patient by voicing the reasons for change, the patient's natural response is to argue against it (either overtly or silently while being passive). The more the patient voices the counterchange arguments, the less likely change becomes. Thus, persuasion can actually have the opposite effect of what was intended. It is the patient, not the helper, who should be voicing the arguments for change.

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Directing, Guiding, and Following

Now, we want to acknowledge that sometimes it *is* helpful for you to express your concern and offer advice from your professional expertise. When an antibiotic is needed, the physician gives clear instructions about how it should be taken ("Be sure to take this two times a day with food, and take all of the pills until they are gone—don't stop taking them as soon as you start to feel better."). Injured limbs can be fixed and warrant clear advice for self-care ("Keep the leg elevated, and don't put any weight on it for 10 days."). Giving information and advice reflects the clinical style of *directing*, and it is a natural part of health care, particularly in the treatment of acute conditions. Even when the goal is patient behavior change, directing sometimes works. A small proportion of smokers actually do quit smoking in response to simple physician advice, enough to make it worthwhile to try (Bao, Duan, & Fox, 2006; Lancaster & Stead, 2004).

At the opposite end of the spectrum is the clinical style of *following*—simply listening to your patient in an empathic, compassionate manner. By listening for a while, you may learn important things that you would not have discovered by reviewing a decision tree of questions. When you have

done all you can to alleviate a dying patient's suffering, it is most humane just to listen for a while, following wherever the patient leads. Here it is the patient who provides the direction, and careful following on your part is another natural part of good health care.

In between these two extremes lies the interesting terrain of *guiding*. A good guide does not just bark orders. If you hire a guide in another country, he or she does not direct you as to when you will arrive and leave or what you will see. Rather, the guide's function is to understand what your interests are, what you would like to see and experience, and then to help you get there safely, efficiently, and enjoyably. To be sure, you rely on the guide for expertise, to offer direction as appropriate. You also rely on him or her to listen to you carefully (although a good guide doesn't merely follow you around). Guiding is a skillful blend of directing and following, resulting in expert guidance based on close listening.

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Neither directing nor following alone is very effective when what is needed is behavior change on the part of the patient. Often health care providers lean too heavily on directing, even for complex lifestyle and behavioral issues (Rollnick, Miller, & Butler, 2008). We find that the middle ground of guiding is most effective in helping patients to change their behavior.

Motivational Interviewing

MI is a refined form of guiding. It is a particular way of having a conversation about change, one that is designed to strengthen the patient's *own* motivations and commitment to change. MI is a way of helping patients voice their own reasons for change. When you find that you are arguing for change and your patient is arguing against it, you've got it exactly backwards from an MI perspective.

There is a definite direction to MI—it's not just following. You know where you hope to go, the change goal that you wish to reach. In that way, MI is different from the medical position of *equipoise*, in which you are consciously seeking *not* to influence the choice that a patient makes. MI is practiced to help patients move in a particular direction that is in their best interest. Usually it is the direction in which the patient has asked for help, and in which at least a *part* of the patient sees the need for change. MI is not a way of tricking patients into doing what you want or of persuading them to do what they are unwilling to do. Rather, it is a way of harnessing their own natural motivations for health and change.

Why Take Time to Learn This?

We sometimes receive invitations to teach MI in a 1- or 2-hour period. Unfortunately, that really can't be done! You can learn a bit *about* MI by attending a lecture or reading about it, but developing skillfulness in using the technique takes time and practice. It's less like learning a simple medical procedure and more like learning to play golf or a musical instrument in that you can keep getting better at it throughout your career.

So, why would you want to take the time and effort required to learn this complex skill? Because you are reading this book, we presume you are interested in helping your patients make changes that will benefit their health. With that assumption as a background, we suggest three reasons why you might choose to make the investment.

First of all, MI has a solid evidence base confirming its *efficacy*, with well over 200 randomized clinical trials published across a wide range of health behavior change issues (*www.guilford.com/add/miller2/biblio.pdf*). The largest evidence base thus far relates to alcohol/drug use (Hettema, Steele, & Miller, 2005; Jensen et al., 2011; Lundahl & Burke, 2009), but meta-analyses have also reported efficacy with smoking cessation (Lai, Cahill, Qin, & Tang, 2010), weight reduction (Armstrong et al., 2011), and in managing cholesterol and blood pressure (Rubak, Sandbaek, Lauritzen, & Christensen, 2005). Average effect sizes (relative to no intervention) have been in the small to medium range, with wide variability across studies, providers, and sites within multisite trials (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010).

In diabetes care, MI has been effective in lowering A1C levels in adolescents who have type 1 diabetes (T1D). Teenagers who received a series of individual counseling sessions using MI had significantly lower hemoglobin A1c levels than the control group, a difference still present a year after the study ended (Channon et al., 2007). MI has also been used successfully to help women with type 2 diabetes (T2D), though in this study African American women did not respond as well to MI as other women in the treatment group did (West, DiLillo, Bursac, Gore, & Greene, 2007).

MI appears to work across cultures well. Practitioners are being trained in at least 47 languages at present, and a meta-analysis found that MI had twice the effect size when delivered to U.S. minority populations (primarily Hispanic and African American) as compared to white-majority samples (Hettema et al., 2005).

A second reason to use MI is anecdotal, and one for which we hope to see solid research in the future—namely, the impact on clinicians themselves. Across health care, the corrections system, and addiction-related and mental health care, providers who learn MI often tell us that it makes their practice more *enjoyable*. A common theme is the lifting of a heavy burden—one related to the feeling of futility or personal responsibility to

make patients change and to do it quickly. One of the quickest encouragements for their learning MI appears to be how readily patients respond even to their early approximations of MI.

Finally, MI is *learnable*. Here there is solid evidence from training studies, which have thus far found no relationship between years of education and the ability to learn MI (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). The skills are specifiable and can be reliably observed in practice. Once you know what to listen for, your patients can become your teachers because you receive immediate in-session feedback each and every time you practice MI. Some coaching and personal feedback can also improve skillfulness (Miller et al., 2004). Clinicians can learn how to influence the balance of change talk and sustain talk that their patients express, which in turn makes a difference in outcomes. The balance of patient change talk to sustain talk is clearly responsive to clinicians' MI skills (Glynn & Moyers, 2010; Moyers & Martin, 2006; Moyers, Miller, & Hendrickson, 2005; Vader, Walters, Prabhu, Houck, & Field, 2010).

Ultimately you decide how well this approach fits with your own practice style and in what ways it may benefit your patients. This book is designed to give you a clear introduction to and understanding of MI. Where you take it from there is up to you.

Key Points

- The effective management of diabetes requires a lot of behavior change for most patients.
- People tend to be ambivalent about change, with both pros and cons represented in their "internal committee."
- In an attempt to be helpful, health professionals often resort to the "righting reflex" and overly rely on a directing style.
- When someone advocates for change with a person who is ambivalent about it, a natural response is to defend the other side.
- MI is a learnable and evidence-based clinical style for helping patients to voice their own motivations for and ideas about change.
- MI is a refined form of guiding, which finds a middle road between directing and following.

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