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Feature Article

Motivational interviewing for older adults in primary care: A systematic review

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ABSTRACT

Chronic disease is now the leading cause of death and disability in United States. Many chronic illnesses experienced by older adults can be prevented or managed through behavior change, making patient counseling an essential component of disease prevention and management. Motivational Interviewing (MI), a type of conversational method, has been effective in eliciting health behavior changes in people in a variety of settings and may also be a useful tool to help older adults change. This review of the literature analyzes current research and describes potential biases of MI interventions that have been conducted in primary care settings with older adults. MI shows promise as a technique to elicit health behavior change among older adults. However, further study with this population is needed to evaluate efficacy of MI interventions in primary care settings.

Background

Advances in public health, such as improved sanitation, antibiotics, and vaccinations have contributed to a dramatic reduction in death and disability from infectious disease. As a result, people in the developed world are living longer. Longer life spans increase the likelihood of acquiring chronic illness, the leading cause of death and disability in the US.[1] While 80% of Americans have at least one chronic health condition, aging does not inevitably lead to poor health.[2] Many chronic illnesses experienced by older adults can be prevented or managed through behavior change, making patient counseling an essential component of disease prevention and management for health care providers.

In 1983, William Miller pioneered the use of Motivational Interviewing (MI), a communication method that employs client-centered counseling to elicit and strengthen motivation for behavior change.[3] Originally described as a communication approach for use in helping problem drinkers, in 2008, Rollnick, Miller, and Butler described an expansion of its use in addressing a wide array of health behavior changes needed to combat and manage chronic disease.[4] To date, more than 200 randomized control trials and 1000 publications have described its use in a variety of clinical settings.[5,6]

MI posits that persons considering behavior change experience ambivalence related to the pros and cons of change. MI seeks to help people resolve ambivalence by engaging them in a working relationship and focusing communication on change. The method seeks to evoke the client's own motivation for change, develop commitment to change, and formulate concrete plans for behavior change. MI is particularly useful for older adults because older adults bring with them symptoms, emotions, motives, and beliefs that are important to change.[7] Further, older adults value collaborative communication with health care providers[8] and may sustain behavior change more effectively following interventions that emphasize collaboration.[9] A central premise of MI is to encourage the use of "Change Talk" in which the patient explores reasons for change. Key communication skills used in MI include: 1) asking open-ended questions rather than instructing the patient on what they should do, 2) affirming, 3) reflecting, 4) summarizing, and 5) providing individualized information and advice with the patient's permission.[10] The MI practitioner focuses on the person's present interests and difficulties and tries to resolve the ambivalence by eliciting and selectively reinforcing "change talk" that will ultimately support behavior change.[10] Health care team members may find MI to be useful when discussing lifestyle changes, setting behavioral goals, discussing medication use and adherence, and developing plans of care in collaboration with patients. For MI to be effective, some degree of formal training in the spirit of MI and practice with techniques are essential for proficiency in the method. For some conditions, MI may be more effective when paired with other interventions (e.g., pairing MI with participation

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in a recovery program for substance abuse or using MI to improve participation in diabetes education).[4] In addition, because MI requires a significant amount of insight and communication ability, it may not be an appropriate strategy for older adults with cognitive impairments.

Several reviews have evaluated randomized controlled trials (RCTs) that explored the use of MI in primary care settings. VanBuskirk and Wetherell[11] identified 9 studies in which MI was more effective than other behavior change strategies in achieving a variety of outcomes in primary care patients. None of the studies reviewed by these authors included older adults, despite increasing evidence describing the importance of offering preventive health and risk reduction interventions to this rapidly increasing population.[12,13] Cummings and colleagues[14] reviewed 15 studies that reported on the use of MI interventions with older adults. However, only four of the reviewed studies had samples where the mean age of participants was 60 years or greater.

Objective

As understanding grows about the relationships between behavior change and health status improvement for older adults, it is important to determine if MI can be successful in helping this population achieve and sustain behavior change that will lead to improved health outcomes. The purpose of this paper is to systematically review research studies in which MI interventions were used to elicit health-related behavior change among older adults in primary care settings.

Review methods

We conducted a review of studies published before October 2013. Databases searched included ProQuest Dissertations and Theses, Medline, PsycInfo, and CINAHL®. The PICOS criteria (Participants/Problems, Intervention, Comparison/Control group, Outcomes, Study design) guided the search, retrieval, and review process.[15] Key words included Motivational Interviewing; health behavior change; and primary care, joined with "and" as a Boolean operator. Additional relevant research was identified using the ancestry method of retrieving sources cited in other publications. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines provided a framework for the review of the retrieved papers.[16]

Articles were selected for review if: 1) MI was described as all or part of the intervention, 2) the average participant age was 60 years or older, 3) they reported randomized control trials (RCTs) or pilot studies that included a comparison group, 4) they were published in English, and 5) they were conducted in a primary care setting.

We defined primary care using an adaptation of the American Association of Family Physicians definition: "Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings… performed and managed by a health care provider… collaborating with other health professionals."[17]

While authors often define older adults as those aged 65 years and older, increasingly, health screening and prevention guidelines suggest that individuals age 60 receive more recognition as the recipients of health promotion and disease prevention services.[12,13,18] Thus, we established 60 as the cut-off for the inclusion of publications related to health behavior change.

Papers were initially read and reviewed for content and to ensure that each met the established eligibility criteria. Data were abstracted and organized using a spreadsheet that included: 1) sample size/characteristics (i.e., age, gender) and targeted health behaviors, 2) type of MI intervention delivery, frequency/duration of the MI intervention, and intervener training, and 3) outcome/results. In order to evaluate validity of the findings, we assessed each study for the risk of bias. We paid particular attention to selection, performance (fidelity to protocol), attrition, detection (blinding), and reporting.

Results

The search yielded 42 papers, 36 of which were found in the initial electronic database search. An additional 6 studies were located using ancestry. After screening all abstracts, 2 duplicates and 26 articles that did not meet the inclusion criteria were rejected, leaving 8 articles for inclusion in this systematic review. Fig. 1 provides a summary of the retrieval flow and study results are summarized in Table 1.

Diet or diet and physical activity combined

Diet, physical activity, and weight control were the focus of the majority of the studies reviewed. Campbell and colleagues'[19] study evaluated the effectiveness of telephone-based MI in increasing the

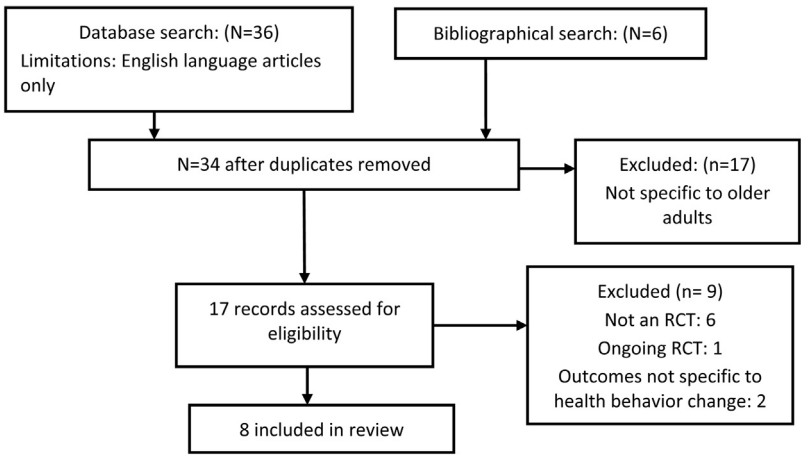

Fig. 1. Study review flow diagram.