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Learning Motivational Interviewing: A Pathway to Caring and Mindful Patient Encounters

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We designed our project to explore the experience of learning motivational interviewing (MI). The project impetus came from a desire to improve our skill in communicating with patients. We created a curriculum led by an MI specialist that provided didactic sessions, discussions and individual feedback. In evaluating our audio-taped MI encounters, we approached beginner proficiency. Also, we recognized the need for formal MI education and practice to fully develop the interventionist skills needed for clinical work and our next research project about preparing patients for transition to adult health care. Lastly, we realized that MI strategies reflect aspects of caring theory and mindfulness, important components of patient-centered care.
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AS CLINICIANS WHO provide pediatric rehabilitation services, we are passionate about promoting healthy lifestyles and recognize that communication skill is important in motivating patients. Our multidisciplinary team works hard to involve patients in planning care, sometimes with success and sometimes not. Motivational interviewing (MI) is a well developed counseling approach that is patient-centered and can inspire positive change (Rollnick, Miller, & Butler, 2008). Clinicians who successfully use the dynamic tools of MI convey genuine interest and gentle guidance. The defining characteristics of MI include open-ended questions, reflective listening, affirmation of patient strengths and clinician summaries of the patient viewpoint. These techniques give the patient a safe opportunity to explore personal values, goals and possible solutions for improving health. In adult and pediatric studies, there is evidence to support the use of MI to manage chronic health conditions (Jensen et al., 2011; Lundahl et al., 2013; Suarez & Mullins, 2008). As a team, we were intrigued and wanted to learn MI to improve our care-giving abilities, and so, our professional development project unfolded.

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Project Aim

In our project, we aimed to develop our skills in the art of motivational interviewing (MI). More specifically, we wanted to learn MI and implement this communication strategy in our Spinal Defects Clinic with children/adolescents/parents who need to perform daily clean intermittent catheterizations (CIC). These children, especially adolescents, are challenged with following a daily routine of this nature (Edwards, Borzyskowski, Cox, & Badcock, 2004).

Background and Significance

Interestingly, there is considerable empirical support for using MI in pediatric conditions like diabetes, obesity and addiction to bring about positive lifestyle changes that include learning new health-related procedures (Erickson, Gerstle, & Feldstein, 2005; Gayes & Steele, 2014; Jensen et al., 2011, Suarez & Mullins, 2008). Of note, in a PubMed, Ovid, CINAHL and PsycINFO search, we found no intervention studies about using MI in the spina bifida

population. In another search (PubMed, CINAHL, Ovid) about CIC and spina bifida, we found only descriptive studies that report parental/family stress, individual complexities and patient stigma with managing incontinence (Borzyskowski, Cox, Edwards, & Owen, 2004; Chick, Hunter, & Moore, 2013, Edwards et al., 2004; Fagerskiold & Mattsson, 2010; Fischer, Church, Lyons, & McPherson, 2015; Kanaheswari, Razak, Chandran, & Ong, 2011). We need more studies about empowering patients in doing intermittent catheterizations throughout the day as the procedure is a significant lifestyle change.

Clean intermittent catheterization (CIC) should be done every three to four hours, requires good handwashing and clean catheters and involves gently inserting a lubricated catheter into the bladder. When the bladder is emptied, the catheter is removed. We know that when CIC becomes a consistent practice, children with spina bifida can often experience less incontinence, achieve social continence, reduce odor and prevent renal dysfunction (Mourtzinos & Stoffel, 2010). Many of these children reach adulthood and lead fulfilling lives, especially when CIC is part of a daily routine. Those who struggle with this routine are good candidates for motivational interviewing as the conceptual components of MI are concrete, intuitive and easily applied in our conversations with patients about CIC.

Examples of MI Strategies

Motivational interviewing is a collaborative communication style in which the clinician separates from the traditional authoritarian medical model and attempts to gently elicit insight from the patient (Rollnick et al., 2008). First, one must express empathy by listening reflectively, accepting ambivalence and affirming strengths. The patient is viewed as capable of change despite the expression of reluctance. The clinician develops discrepancy, meaning the patient not the provider presents the arguments for change. One must listen for statements that reflect discrepancy and then encourage the patient to develop a concrete plan. Also, the clinician must roll with resistance and always obtains permission to explore health issues. Patients will appreciate a simple query. *Can we talk about some of the pros and cons with doing CIC?* At the same time, providers must emphasize the patient's freedom in choosing. Lecturing does not work with ambivalent patients. A kind, respectful approach in exploring ambivalence can be a powerful trigger for change. If patients have not been successful with CIC, the experience could be reframed as positive. *You have experience with CIC so you know what works and doesn't work for you*. Lastly, the clinician must support self-efficacy by encouraging choice and conveying a belief that the patient can change. *I sense that you are a very determined person*. The following MI strategies with exemplars reflect our project aim. OARS is the acronym for these strategies. Each letter of this acronym is illustrated in the examples that follow.

Open-ended questions: *How does cathing fit with your daily routine?*
Affirmations: *I'm very impressed with how well you do the procedure*.
Reflective listening: *It's embarrassing to leave the classroom to do cathing in the nurse's office.*
Summary statements: *It's important for you to be dry and stay healthy. On the other hand, cathing would be a big change in your life and may be hard to accomplish, especially four to five times a day. What else would you add?*

When clinicians respect patient autonomy, the provider/patient relationship is a collaborative partnership, not authoritarian and prescriptive. In "doing motivational interviewing", one develops a therapeutic connection that can be an authentic expression of caring.

Project Design and Structure

Our project team included two RNs, a nurse practitioner, social worker and physician. All team members were female and mid or late career clinicians who work in a Midwestern children's hospital in the Rehabilitation Medicine Clinics, which includes the Spinal Defects Clinic. We completed formal MI instruction before inviting participation from ambivalent subjects who were identified during Spinal Defects Clinic by the urologist/APRN as appropriate for CIC. We audio-taped five interviews with subjects from this clinic to critique our MI skill. Our subjects are described in Table 1. Also, we were encouraged by our MI trainer to practice the MI strategies with patients or parents in other settings. As part of the MI learning trajectory, we kept a reflective journal about our MI encounters. The project was an IRB approved plan for professional team development.

Our experience with learning MI began with a 4-hour workshop held during our yearly Rehabilitation Medicine Department retreat. One of our in-house child psychologists who is an MI trainer and researcher introduced the MI philosophy and strategies. The seminar content stimulated our interest and soon after we planned more formal training. Subsequently, our MI trainer led three, 3-hour, on-campus sessions over a two month period. The training included didactic instruction, discussion following MI videos, multiple MI practice sessions with each other and discussion of scenarios related to CIC. During the duration of this project, we met weekly over the lunch hour to role-play, discuss readings, view MI videos, set realistic goals for our next meeting and identify interview candidates. Monthly, our MI trainer met with us to review our audiotape-recorded role-play and live interviews. We were able to easily incorporate our meetings and training into our clinical work schedule.

Our MI trainer followed the MITI 3.1.1 interview coding scheme developed by Moyers, Martin, Manuel, Miller, and Ernst (2010). These researchers developed an explicit coding methodology for rating clinician interview skill (intervention fidelity): global spirit of MI and MI behavior counts (open-ended questions, reflections, etc.). Overall, we were

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