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Short communication

Need and desire among pharmacy practitioners for motivational interviewing to be incorporated into pharmacy curricula

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Abstract

Objective: To determine if new pharmacy practitioners express a need and/or desire for motivational interviewing (MI) to be incorporated into pharmacy school curricula.
Methods: An electronic survey was distributed to North Carolina pharmacists. Need was determined based on respondents' level of preparedness to counsel in traditional or MI styles at completion of pharmacy education. Desire was evaluated based on whether the respondent supported incorporation of MI into pharmacy education curricula and if the respondent stated MI is applicable in current practice.
Results: Less than 75% of respondents ($n = 257$) indicated they were well prepared to counsel using either traditional or MI styles. Furthermore, 94% of respondents supported incorporation of MI into curricula, and 85% stated it was applicable to current practice.
Conclusion: Among recent graduates, there is a need for improved patient counseling education. Based on the strong level of desire, schools should consider incorporation of MI. Pharmacy schools should assess when and how MI would best be incorporated into curricula.

Keywords: Patient counseling; Motivational interviewing; Pharmacy curriculum

Introduction

Definition of motivational interviewing

Motivational interviewing (MI) is a counseling technique that seeks to elicit the patient's own motivation for change in an effort to guide the patient to treatment adherence. Developed in 1983 for use in patients with substance abuse disorders, it has since evolved into a counseling style that can be used in any health care setting that involves direct patient interaction.[1] The "spirit" of MI is

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the necessary collaboration between practitioners and patients, the evocation of the patients' thoughts about behavior change, and the value of the patients' autonomy.[1] MI balances three styles of communication: following, directing, and guiding. The directing style of communication has become common in health care practice and, for the purposes of this study, will be referred to as traditional counseling. In the directing style, communication mainly flows in one direction—from the health care provider to the patient. In contrast, MI seeks to balance directing with following (active listening) and guiding (encouraging and motivating a patient to find their personal reason for change).[1] This is accomplished by four guiding principles: resist the righting reflex, understand the patient's motivation, listen to the patient, and empower the patient.[1] Overall, MI helps elicit patient change by seeking to overcome ambivalence and involve patients in the process of considering, committing to, and making changes.[1]

Efficacy, usefulness, and barriers to motivational interviewing

MI use by various patient-centered health care providers has been studied in multiple practice settings. There is a lack of data including pharmacists; however, the authors feel research among other providers can be extrapolated to pharmacy practice. Examples of these data were incorporated into one meta-analysis that evaluated 24 articles utilizing MI in diet and exercise counseling and nine articles in diabetes counseling. The results showed MI to be beneficial in specific issues such as weight loss, improved diet, and improved hemoglobin A_1C.[2] Another meta-analysis of 72 trials evaluating MI in various settings found effect sizes varied widely among the outcomes. Alone, and especially in conjunction with additional treatment approaches, MI was beneficial in improving addictive (alcohol, tobacco, and illicit drug) behaviors and health (exercise, diet, and treatment compliance) behaviors. These trials were conducted by a variety of professionals including physicians, nurses, dieticians, masters level counselors, and others, but the authors comment that effect sizes were smaller when MI techniques were manual-guided.[3] Pharmacists who provide counseling in similar areas would likely be able to apply MI techniques for improved outcomes, such as increased medication adherence and incorporation of therapeutic lifestyle changes.

In addition to community and ambulatory care settings, there is an expanding role for the use of MI in the hospital pharmacy setting. The Joint Commission (TJC) requires patient involvement in the treatment plan. The "Roadmap for Hospitals," a guiding document published by TJC, summarizes that a hospital will respect the patient's right to participate in decisions about his or her care, treatment, and service by incorporating the patient and family as members of the heath care team.[4] MI can be incorporated into TJC requirements as these guidelines reflect the "spirit" of MI.

Pharmacists may better understand the usefulness of MI when related to the more familiar framework of the transtheoretical model of behavior change. As patients shift between stages of pre-contemplation, contemplation, preparation, action, and maintenance, there may be times when a patient who is perceived to be "unmotivated" may actually be experiencing ambivalence.[5] Any patient can experience ambivalence as a natural human state when one considers positive and negative consequences of a given behavior.[6] For example, a patient may believe that monitoring blood glucose will provide useful information for insulin adjustment but at the same time be hesitant to monitor due to social stigma or other perceived barriers. This ambivalence may impact outcomes as patients make health care choices regarding lifestyle changes, medication adherence, and use of technology. Pharmacists may find MI techniques beneficial to build rapport and improve communication with a patient who shows resistance to a more traditional style of counseling in which the pharmacists is giving expert advice.[7]

Certain barriers could impact the implementation of MI. Söderlund et al. examined barriers faced by pharmacists seeking to incorporate MI in the community setting. The most common barriers included availability of an appropriate counseling environment and creation of sufficient time. Study participants recognized it was easier to utilize MI techniques with certain patients (e.g., diabetes and smoking cessation) while other conditions (e.g., sexually related concerns) were more uncomfortable to address. Additionally, pharmacists stated it was difficult to change their perspective of patients from passive participants to empowered decision makers.[8] However, to reach this point of incorporation, the initial barrier of training and practice must be addressed. Hettema et al. describe the use of a workshop to increase exposure to and confidence when using MI techniques. The study showed that two-day training workshop sessions increased participant confidence in using MI but offered only modest improvement in the use of MI and no statistically significant difference in patient response. However, additional training from expert coaches, specific feedback from practice tapes, and to a lesser degree, additional self-study improved proficiency.[3] This specific barrier can be addressed by incorporating MI into pharmacy curricula.

Rationale and objectives

Need for motivational interviewing in pharmacy education

The Accreditation Council for Pharmacy Education (ACPE) requires that schools include interviewing techniques, principles of behavior modification, strategies for handling difficult situations, problem-solving, and the understanding of pharmacy as a patient-centered profession in pharmacy education curricula. ACPE does not articulate a specific method in which schools must fulfill these requirements. Therefore, schools develop a patient communication