*Original Article*

# Patient and Caregiver Opinions of Motivational Interviewing Techniques In Role-Played Palliative Care Conversations: A Pilot Study

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## Abstract

**Context.** Although many have examined the role of motivational interviewing (MI) in diverse health care encounters, no one has explored whether patients and caregivers facing serious illnesses identify specific MI techniques as helpful.

**Objectives.** The aim of this pilot study was to describe how patients and caregivers perceived MI techniques in palliative care role-play encounters.

**Methods.** About 21 patients and caregivers participated in a role-play encounter where we asked the participant to act out being ambivalent or reluctant regarding the goals of care decision. The participant met with either an MI-trained physician or a physician who was not trained in MI (usual care). After the simulated encounter, we conducted cognitive interviews ("think-aloud" protocol) asking participants to identify "helpful" or "unhelpful" things physicians said. Participants also completed a perceived empathy instrument as a fidelity test of the MI training of the physician.

**Results.** Qualitative analyses revealed that participants independently identified the following helpful communication elements that are consistent with core MI techniques: reflection and validation of values, support of autonomy and flexibility, and open questions acting as catalysts for discussion. Participants rated the MI-trained physician slightly higher on the perceived empathy scale.

**Conclusion.** This pilot study represents the first exploration of patient and caregiver perceptions of helpful techniques in palliative care conversations. Use of MI techniques shows promise for improving palliative care discussions. J Pain Symptom Manage 2015;50:91–98. 

***Key Words***

*Motivational interviewing, palliative care, empathy, patient perceptions*

## Introduction

Patients with serious medical issues frequently make challenging decisions. Effective decision making requires high-quality communication between patients, their family caregivers, and health care providers, including responding to negative emotion, conveying prognosis, and delivering bad news.[1–3] However, even clinicians with extensive communication training, such as palliative care clinicians, still find themselves "stuck" in commonly experienced difficult conversation scenarios.[4] Some particularly challenging conversations involve patients or caregivers who feel ambivalent, both wanting and not wanting to do something or reluctant (e.g., do not want to discuss hospice).[5]

Motivational interviewing (MI) can be effective for resolving ambivalence and reluctance in challenging conversations in primary care (e.g., patient does not want to quit smoking although he knows it is bad for

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health).[6] MI also could potentially be applied to palliative care situations.[7] MI is a patient-centered and guiding approach that helps patients resolve ambivalence or reluctance about behavior change.[8] The MI approach includes: 1) reflecting back to patients what was heard; 2) praising patients for even small things; 3) allowing patients to set their own goals; 4) asking permission before giving advice; 5) accepting patient's motivation or lack thereof to change, rather than confronting or judging; and 6) working collaboratively while supporting patient autonomy.[8,9] Using MI principles, including expressing empathy, may motivate patients or caregivers to engage in challenging situations.[10]

Specific MI techniques for helping resolve ambivalence include juxtaposing behaviors and values or exploring "good" and "not so good" aspects of the choice ("What are some good things about continuing treatment? What are some not so good things about continuing treatment? With this information, what do you think is most in line with your goals?"). The MI techniques for handling reluctance include naming the reluctance ("I can see you do not want to talk about hospice right now") and querying extremes in which clinicians explore what would be the best possible outcome and the worst possible outcome ("What is the worst thing that might happen if we discuss hospice? What is the best thing that could happen if we discussed hospice?"). Use of MI techniques also enhances trust and builds rapport by respecting patient or caregiver autonomy rather than confronting, persuading, or judging.[11]

In this pilot study, we hypothesized that patients and caregivers in palliative care situations would independently identify MI techniques as helpful, particularly when they are feeling ambivalent or reluctant. To our knowledge, patient or caregiver in-depth perspectives on palliative care communication have not been evaluated. Therefore, we designed a pilot study using role-played palliative care encounters with physicians, one who was trained in MI and the other who was not, to explore patient and caregiver perspectives of the communication. We trained one physician in MI to increase the likelihood that specific MI techniques would be present in the encounters. We anticipated that patients and caregivers would identify behaviors that are consistent with MI as helpful. Participants assessed perceived empathy of both physicians as a fidelity check for the MI training.

## Methods

### Design

This pilot study involved role-played encounters between 21 patients and caregivers and a palliative care physician, one of whom received specific training in MI for this exploratory study. We chose patients and caregivers who had experienced serious illness to make the role play as realistic as possible. Participants were randomly assigned to one of four role play options to provide variety in the types of conversations and allow for use of different MI techniques: 1) ambivalent role with MI-trained physician, 2) reluctant role with MI-trained physician, 3) ambivalent role with non-MI trained physician, or 4) reluctant role with non-MI trained physician. This study was approved by the University of Colorado Multiple Institutional Review Board.

### Procedure

We identified patients and caregivers from seven internal medicine physicians' panels. Patients were eligible to participate if they were adults aged 18 years or older and had a serious illness with an expected life expectancy of two years or less. Similarly, caregiver participants were defined as people who served as a family caregiver of a loved one aged 18 years or older, who was diagnosed with a serious illness, and had an expected life expectancy of less than two years. Caregivers were specifically included because they often play a meaningful role in decision-making conversations with patients and health care providers. Eligible participants were able to speak and read English and to review an audio playback of their role-play encounter. Participants unable to provide consent were excluded.

We recruited potential participants by mailing them a letter signed by their physician asking them to enroll in a study to examine effective communication. We allowed participants one week to call to refuse and then called potential participants to ask them to participate. Study staff randomly assigned participants to a role play scenario (ambivalent vs. reluctant) and study physician (MI-trained vs. non-MI trained), using www.graphpad.com/quickcalcs/randomize2 before obtaining written consent and basic demographic information. Participants reviewed three palliative care scenarios involving decisions regarding completing advance directives, pursuing further chemotherapy, or electing hospice care (Table 1) and selected the scenario they personally felt they could best role play in their assigned role (ambivalent or reluctant). The designated study physician then entered the room, turned on the audio recorder, and started the role-play encounter. After the role play ended, the study physician left, and the study staff member asked the participant to complete a survey that assessed perceived empathy.

The staff member then conducted a cognitive interview with the participant. In this "think-aloud"