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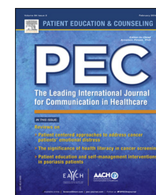

Communication study

Patient-provider concordance with behavioral change goals drives measures of motivational interviewing consistency

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ABSTRACT

Objective: Motivational Interviewing (MI) consistent talk by a counselor is thought to produce "change talk" in clients. However, it is possible that client resistance to behavior change can produce MI inconsistent counselor behavior.

Methods: We applied a coding scheme which identifies all of the behavioral counseling about a given issue during a visit ("episodes"), assesses patient concordance with the behavioral goal, and labels providers' counseling style as facilitative or directive, to a corpus of routine outpatient visits by people with HIV. Using a different data set of comparable encounters, we applied the concepts of episode and concordance, and coded using the Motivational Interviewing Treatment Integrity system.

Results: Patient concordance/discordance was not observed to change during any episode. Provider directiveness was strongly associated with patient discordance in the first study, and MI inconsistency was strongly associated with discordance in the second.

Conclusion: Observations that MI-consistent behavior by medical providers is associated with patient change talk or outcomes should be evaluated cautiously, as patient resistance may provoke MI-inconsistency.

Practice implications: Counseling episodes in routine medical visits are typically too brief for client talk to evolve toward change. Providers with limited training may have particular difficulty maintaining MI consistency with resistant clients.

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1. Introduction

Motivational Interviewing (MI) is an evidence based method of behavior change counseling, developed in the 1980s to increase the effectiveness of alcoholism and drug abuse treatment [1]. It has since been applied to many other health-related behaviors including issues commonly addressed in medical practice such as medication adherence, smoking, and diet and weight management [2]. Originally, MI was delivered by highly trained specialist counselors, but recently there has been interest in training general medical practitioners – physicians and nurses – to use MI techniques in routine practice [3].

MI is comprised of a relational and a technical component [4]. The relational component consists of empathy, evocation, and empowerment. Empathy refers to the keen interest of the practitioner in the patient's point of view, normalizes the experience of ambivalence about change, and is operationalized by complex reflective listening skills. Evocation refers to eliciting the patient's reasons for change, and preferred processes of change. Empowerment serves to support autonomy.

Based on the hypothesis that what patients say during consultations is the best predictor of subsequent behavior change, the technical component of MI refers to the identification, elicitation, and reinforcement of "change talk", patient utterances that indicate preparation for, and commitment to behavior change. Practitioner verbal behavior can elicit and reinforce patient change talk, countermand, or extinguish it. Patient change talk is often

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extinguished when the practitioner misses opportunities to reinforce it, or overuses direct persuasion, which tends to elicit commitment to the status quo. It can also be countermanded when practitioners undermine rapport by over-directing the consultation and limiting patient-perceived choice. There is considerable empirical support both for the connection between client change talk and subsequent behavior change [5], and between MI consistent practitioner behavior and client change talk [6].

Counselor fidelity to the technical component of MI is evaluated directly through widely used coding instruments, such as the Motivational Interviewing Treatment Integrity code (MITI) [7,8] and the Motivational Interviewing Skills Code (MISC) [9]. These label practitioner verbal behaviors, at the level of the speaker turn. Some are classified as MI consistent, such as asking permission before giving advice, affirming the client, emphasizing the client's control, and supporting the client with sympathetic statements. MI inconsistent behaviors are advising without permission, confronting, and directing the client—giving orders or instructions. MI practice also encourages the use of "reflections," in which the practitioner repeats back an interpretation of what the client has said, often with some elaboration or reframing in order to test hypotheses about the client's feelings or beliefs, reinforce desirable motivations or beliefs, or reframe undesirable motivations to encourage the client to reconsider. These practices are also coded.

There is an extensive evidence base for the effectiveness of MI in behavioral counseling by trained practitioners. However, evaluation of MI techniques in regular medical practice has been more limited. Some studies have found that training providers to use MI in routine medical practice can result in greater practitioner competence in the technique, [10,11] and other purportedly positive provider behaviors [12], or that providers feel more competent and comfortable counseling patients after training [13]. A few have linked MI consistent behavior by medical providers to outcomes such as reduced saturated fat intake [14], patients' self-reported confidence to improve their nutrition [15] and weight loss [16].

Leading experts argue that MI consistent behavior by the therapist induces change talk, which in turn predicts positive outcomes [1,4,17]. Indeed, it has been observed that MI consistent verbal behaviors by therapists are more likely to be immediately succeeded by client change talk than are MI inconsistent or other behaviors [6,18]. On the other hand, client resistance to change has been found to produce more confrontational, MI inconsistent behaviors by practitioners with varying degrees of prior MI training (specifically, 56.3% reported having an unspecified amount of previous MI training) [19].

Here we present empirical data addressing the relationship between patient concordance with provider behavioral change goals and measured MI consistency from two studies of the primary care of people with HIV. In the first study, the Physicians as Counselors coding system (PaCCS) was developed and tested, and provided preliminary support for the hypothesis that patient-provider concordance on behavior change was associated with greater MI consistency. In the second study, ECHO3 (Enhancing Communication for HIV Outcomes, the third in a series of related studies) we tested this hypothesis in a larger, independent sample, using coding more specific to MI consistency. We conducted these analyses because it is important to understand the extent to which MI consistency is a cause, or an effect, of patient change talk.

2. Methods

2.1. PaCCS study

We coded a corpus of transcribed routine outpatient encounters in HIV care, taken from two previous studies [20,21]. The material had already been coded using the Generalized Medical Interaction Analysis System, [22] which divides the dialogue into units based on Speech Act Theory [23,24], and labels each utterance according to the social act it embodies such as various forms of questioning, giving information, expressing desires or opinions, giving instructions, and others.

The Physicians as Counselors coding system (PaCCS) [25] was designed to be relatively easy to implement with clinical encounters. Because the providers in these data were not generally trained in MI or any other specific method of behavioral counseling, we did not try to assess fidelity to specific technical components of MI. In fact the providers rarely used techniques such as reflection, or asking permission to advise. Since the HIV specialists also generally served as the patients' primary care providers, many health related behaviors were discussed, including adherence to antiretrovirals and other medications, smoking, alcohol use, other drug use, safe sex, and diet and weight management.

A segment of text is not coded if the patient is reliably performing a positive health behavior, in other words we did not code prophylactic advice-giving or positive reinforcement. Counseling starts when it becomes clear that there is an issue with the patient's behavior that conflicts with standard medical advice, whether the patient brings it up spontaneously or the physician inquires about it.

We define an "episode" as all discussion of a given targeted behavior change within a single medical encounter, regardless of whether all of the discussion is contiguous. The system labels each episode with the targeted behavior, e.g. smoking. Then it assigns three additional levels of coding, called concordance, counseling style, and counseling technique.

In concordant interactions, the patient shows positive engagement with the behavior change goal. This sentiment is clear through expressive statements of the desire to change. Interactions are coded as discordant if the patient appears to be neutral, avoidant, or resistant to the targeted behavior change. If the patient's position is unclear, the interaction is coded as discordant. A patient may be concordant with regard to behavior change in one subject and discordant with regard to another. In principle a patient may switch from concordant to discordant or vice versa during the interaction.

The second level of coding indicates the overall approach taken by the provider in behavioral counseling. Interactions are classified as either directive or facilitative. In directive interactions, the provider does not seek patient input, but independently generates advice or instructions about how the patient should modify a behavior. In a facilitative approach, in contrast, the provider is responsive to patient input, such as expressed goals or problem solving strategies. (The provider may or may not actively elicit patient input.) There is shared decision making or problem solving in response to a patient's expressive need. Additional coding which describes specific strategies employed by the provider is not used in this analysis.

2.2. Intercoder reliability

To assess reliability, 5 cases were coded independently by 2 different coders. Twelve behavior change counseling episodes were identified within the 5 cases by both coders. Three behavior change counseling episodes were identified by one coder but not the other. Of these, 1 consisted of only 2 utterances (advice to stop smoking), and another of 8; only one (identified as a discussion of weight management by the single coder) was substantial, consisting of 24 utterances. The disagreement is whether this constituted behavioral counseling, or was purely informational. Of the twelve episodes identified by both coders, agreement on the included utterances was above 95% in 11, and 80% in one. Agreement on whether episodes were concordant or discordant,

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