



Motivational interviewing within the different stages of change: An analysis of practice nurse-patient consultations aimed at promoting a healthier lifestyle

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ABSTRACT

Combining the Stages of Change (SOC) model with Motivational Interviewing (MI) is seen as a helpful strategy for health care providers to guide patients in changing unhealthy lifestyle behaviour. SOC suggests that people are at different stages of motivational readiness for engaging in health behaviours and that intervention methods are most useful when tailored to a person's stage of change. However, it is unknown whether practice nurses (PNs) actually adapt their MI and more generic communication skills to a particular stage during real-life face-to-face consultations with their patients. The aim of this study was to explore whether and how PNs apply MI and general communication skills to the different SOC of patients, targeting behaviour change about smoking, alcohol use, dietary habits and/or physical activity.

Real-life consultations between nineteen Dutch PNs and 103 patients were recorded on video between June 2010 and March 2011. All consultations focused on a discussion of patients' lifestyle behaviour. The Behaviour Change Counselling Index (BECCI) was used to code PNs' MI skills. Generic communication skills were rated with the MAAS-global. Patients' SOC was assessed for each consultation by observing the communication between patient and PN regarding the patient's current lifestyle behaviour.

Multilevel analyses revealed that PNs adapt their MI skills to a patient's SOC to some extent. On average PNs apply MI skills more to patients in the preparation stage ($P < 0.05$) than during the other stages of change. PNs adjusted three MI skills and one generic communication skill to patients' SOC. This explorative study suggests that, at least to some extent, PNs intuitively assess the stage of patients' readiness to change and tailor their communication accordingly. However, differences between the stages were small. By teaching PNs to explicitly identify patients' SOC they could further enhance and adapt their MI and general communication skills to the individual.

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Introduction

Primary health care is seen as an appropriate setting for the prevention and management of a patient's lifestyle behaviour (Coups, Gaba, & Orleans, 2004; Nielen et al., 2010; WHO, 2002). In primary care, addressing lifestyle behaviour and referring to programmes promoting lifestyle can generally be carried out by a practice nurse (PN). Previous studies indeed show that PNs adequately monitor patients with chronic conditions, provide patients with lifestyle advice and guide them during smoking cessation and weight reduction (Laurant et al., 2009; Richards, Carley, Jenkins-Clarke, & Richards, 2000).

Most primary care providers rely on their (authoritative) professional role to convince people to change by providing information or advice about behaviour change, although the effectiveness of these methods are ambiguous (Britt, Hudson, & Blampied, 2004; Davis et al., 2011; Elder, Ayala, & Harris, 1999; Miller & Rollnick, 2004). Such a traditional persuasive approach does not do justice to the complex nature of changing lifestyle behaviour (i.e. smoking, alcohol use, dietary habits or physical inactivity). Health behaviour change requires effort, motivation and time from both patients and health care providers. At the same time, patients are often ambivalent about behaviour change (Britt et al., 2004; Miller, 1996) and have variable levels of motivation over the course of time (Lange & Tigges, 2005). A more promising approach to changing unhealthy behaviour is motivational interviewing (MI) (Bowen et al., 2002; Hardcastle, Taylor, Bailey, & Castle, 2008; Richards, Kattelman, &

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Ren, 2006). MI is a patient-centred directive approach to enhance intrinsic motivation to behavioural change by helping patients explore and resolve ambivalence between the desired behaviour and their actual behaviour (Martins & McNeil, 2009; Miller & Rollnick, 2002). It focuses on what patients can do to improve their own health, as opposed to health care providers telling them what to do.

Since patients have varying levels of motivation over time (Lange & Tigges, 2005), combining MI with the Stages Of Change (SOC) construct from Prochaska & DiClemente's Transtheoretical Model is seen as a possible potentially helpful strategy to help patients change their behaviour (Emmons & Rollnick, 2001; Lange & Tigges, 2005; Miller & Rollnick, 2004; Petrocelli, 2002). According to the SOC, individuals are at different stages of motivational readiness for engaging in health behaviours, and intervention methods (i.e. interpersonal communication) are most useful when they are tailored to a person's current stage of motivational readiness. The core organizing principle of the Transtheoretical Model is the SOC construct, which represents a temporal dimension and distinguishes five stages of change indicating individuals' predispositions to change: precontemplation (no intention to change behaviour within the next 6 months), contemplation (intention to change behaviour within the next 6 months, but does not act on intention to change behaviour), preparation (intention to change behaviour within 30 days), action (people changed from unhealthy to healthy behaviour within the past 6 months), and maintenance (maintenance of the behaviour change for more than 6 months) (Elder et al., 1999; Petrocelli, 2002; Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Redding, & Evers, 2002). Progression between the stages is not linear and patients may move forward and backward. Individuals in the various stages differ with respect to the stimuli and barriers they experience in the process of health behaviour change. In other words, the factors and processes hindering or facilitating behaviour change are assumed to differ in each specific stage of change. Hence, patients are assumed to benefit most if health care providers adapt their communication to the individual's SOC (Elder et al., 1999; Petrocelli, 2002; Ruggiero, 2000). However, there are studies that indicate that the Transtheoretical Model or SOC construct is not beneficial in changing behaviour (West, 2005).

Although the idea that communication should be tailored to individuals (stage of change) is widely acknowledged, it remains unknown whether PNs actually adapt *their* MI and/or more generic communication strategies to a particular SOC during real-life face-to-face consultations with their patients. The aim of the present study is to explore if and to what extent PNs apply MI techniques and general communication skills (including clinical competence) during the different SOC for patients, with emphasis on targeting behaviour change about smoking, alcohol use, dietary habits and/or physical activity.

We hypothesize that PNs are more likely to invite and encourage the patient to talk about behaviour change during a patient's precontemplation and contemplation stage, than during the other SOC. This is also true more for during the preparation stage than during the action and maintenance stage. This can be seen as what is described as 'consciousness raising' (Prochaska et al., 1992), even though theoretically patients in the precontemplation stage benefit most from 'consciousness raising' (Prochaska et al., 1992). In addition, we expect that PNs are more likely 'to ask questions to elicit how the patient thinks and feels about behaviour change' during the precontemplation and contemplation stage than during the other stages. This is reasonably in accordance with the principle of 'dramatic relief' (Prochaska et al., 1992). However, in theory, patients in the precontemplation stage benefit most from 'dramatic relief' (Prochaska et al., 1992). Furthermore, we expect that PNs are

more likely 'to acknowledge challenges about behaviour change that the patient faces' during the patient's preparation stage, or during the action and maintenance stage, rather than in the precontemplation or contemplation stage, since these are stages where the patient is ready to change or is already changing. Besides, we hypothesize that PNs and patients are more likely to exchange ideas about how the patient could change current behaviour during the preparation stage than during the SOC, since patients in the preparation stage show willingness to change behaviour. Finally, we expect that PNs' clinical competence, i.e. their ability to adhere to relevant practice guidelines, will be performed independent of patient's SOC. We had no preconceived ideas concerning the generic communication skills of PNs in relation to patient's SOC since there is no published literature on this topic.

Method

Participants and procedure

Nineteen Dutch PNs from eight general practices participated in this study and agreed to have approximately ten consecutive, routine consultations videotaped between June 2010 and March 2011. General practices were located throughout The Netherlands. All PNs from seven practices were approached by contacting the GPs from these practices who (except for one practice) had participated in an earlier study (Noordman, Verhaak, van Beljouw, & van Dulmen, 2010). GPs from one other practice (a health care centre) contacted us for inclusion of all of their PNs. On average PNs had 4.5 years of working experience (SD = 2.79). All nineteen PNs were trained in MI as part of their education, and thirteen of the PNs had undergone extra post-education training in MI (Noordman et al., 2012).

Consultations were video-taped with an unmanned camera located in the consulting room during one or two random days. Adult patients who were scheduled for an appointment with the PN were approached beforehand by a researcher in the waiting room ($n = 181$, excluding non-response 7.7%). All participating PNs and patients filled in an informed consent form before recording of the consultation. Participants could withdraw their consent at any time; no one did. Before the recording of the consultation, patients were asked to fill in a questionnaire about their sociodemographic characteristics (e.g. age, gender), the reason for their consultation and their current lifestyle behaviour (smoking, physical activity).

PNs completed a short questionnaire after each recorded consultation. This questionnaire contained information about patients' characteristics (e.g. age, gender) and perceived complaints and diseases. The study was carried out according to Dutch privacy regulations were approved by the Dutch Data Protection Authority. According to Dutch legislation, approval by a medical ethics committee was not required for this observational study.

Selection of patients and discussion of lifestyle behaviour

Patients were selected who indicated in the patient questionnaire that they smoked or reported a medium intensive physical activity level of less than 30 min a day, five days a week, according to Dutch guidelines (Kemper, Ooijendijk, & Stiggelbout, 2000; NNGB, 1998). A second selection criterion was that the lifestyle behaviour (smoking, physical activity, alcohol use or dietary behaviour) of the included patients was discussed during the video-recorded consultation. In total, video-recorded consultations of 149 patients were selected, of which 103 consultations were analysed. Forty-six consultations were not included because lifestyle behaviour was not discussed (even though patients smoked or

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