Brief motivational interviewing as a clinical strategy to promote asthma medication adherence

Belinda Borrelli, PhD, a Kristin A. Riekert, PhD, b Andrew Weinstein, MD, c and Lucille Rathier, PhD d
Providence, RI, Baltimore, Md, and Philadelphia, Pa

Patient-centered approaches are associated with better patient retention and treatment outcomes, without increased time and cost. Motivational interviewing (MI) is a patient-centered counseling approach that can be briefly integrated into patient encounters and is specifically designed to enhance motivation to change among patients not ready to change. Existing asthma management approaches (eg, education and self-management) increase resistance among patients not ready or willing to follow medical recommendations. MI helps patients resolve their ambivalence about behavior change and builds their intrinsic motivation before providing education. Although MI overlaps with patient-centered communication, it additionally includes some concrete motivational strategies that can be briefly and easily implemented in medical settings (eg, setting an agenda, assessing motivation and confidence for change, helping the patient weigh the costs and benefits of change, and providing medical advice and health feedback). Reflective listening is used to help patients clarify their ambivalence and diffuse resistance. MI has been shown to be efficacious across a wide variety of health behavior change areas. This article will describe the method and spirit of MI as applied to asthma management by reviewing the principles of MI, brief MI strategies to motivate medication adherence, the evidence base for MI, and the costs and benefits of building MI into clinical practice. (J Allergy Clin Immunol 2007;120:1023-30.)

Key words: Motivational interviewing, adherence, medication adherence, brief interventions, health behavior change, asthma management

Successful asthma management requires an array of patient behaviors. National asthma guidelines (National Asthma Education and Prevention Program) suggest that individuals with persistent asthma take 1 or more daily controller medications, use rescue medication as needed for symptoms, monitor lung function with peak flow monitors, and avoid asthma triggers. Adherence rates for inhaled corticosteroids (ICSs) range from 44% to 72%. Only 8% to 13% of patients taking ICSs continue to fill their prescriptions 1 year after the initial prescription. Nonadherence is associated with increased asthma symptoms, frequent emergency department visits, hospitalizations, and need for oral steroids. Given the number of patients seen for asthma each year (13.6 million visits in 2004), the medical visit is a prime opportunity to promote adherence.

Increasing asthma knowledge through education yields little improvement in patient adherence or asthma outcomes. Interventions that encourage patients to monitor symptoms or peak flow have shown significant but small effects on asthma morbidity. Self-management approaches, including identifying barriers to adherence, self-monitoring medication use, goal setting, and problem solving, result in fewer urgent care visits, short-term improvements in adherence, higher asthma management self-efficacy, improved quality of life, reduced asthma symptoms, and less β-agonist use. Unfortunately, the majority of self-management studies involve more than 5.5 hours of patient contact.

An important limitation of both educational and self-management approaches is that they are predicated on the assumption that patients are motivated to accept treatment recommendations. These approaches might be effective for those who are ready to change but less so for those who are not.
are not ready.21,22 Schmaling et al,23 for example, found that asthma education resulted in increased knowledge but decreased motivation to use medication. There is a need for innovative approaches to promote motivation for medication adherence that (1) build on previously validated interventions, (2) are easily integrated into standard clinical care, and (3) target both those who are ready and those who are not ready to change.

The goal of this article is to describe motivational interviewing (MI), a patient-centered approach specifically designed to enhance motivation to change among patients not ready to change.21 A brief version of MI, described in the current article, was developed for use by health care providers (HCPs) and structured for both hospital bedside and outpatient settings.24 MI is “patient-centered” in that the HCP tries to understand the patient’s expectations, beliefs, and concerns regarding their health and treatment recommendations, thereby achieving an understanding of the patient and not just his or her illness.25 Patient-centered communication skills have become a standard part of medical curricula and are required as a specific competency (eg, the American Board of Internal Medicine). MI overlaps with patient-centered approaches but additionally includes some concrete motivational strategies that can briefly and easily be implemented in practitioners’ offices24 and is based on 25 years of social-psychological research on attitude change.26 This article will describe the method and spirit of MI as applied to asthma management, review the evidence base for MI, and discuss building MI into clinical practice.

MI: BASIC PRINCIPLES

MI involves 2 key aims: (1) building patients’ intrinsic motivation to adopt health recommendations and (2) resolving patients’ ambivalence about behavior change (eg, adherence).21 In MI intrinsic motivation is strengthened by discussing how change is consistent with the patient’s own values and goals.26 For example, if a patient loves to play basketball, the HCP asks how taking his or her asthma medication can help him or her play better. Intrinsic motivation is also increased by having the patient play an active role in the consultation. For example, recommendations are presented as a menu of options, and the patient’s concerns and beliefs about these options are explored (eg, concerns about ICSs). The HCP becomes a consultant, rather than an educator, in the process of choosing among the options. Increasing intrinsic motivation through greater patient involvement enhances the likelihood of both initial change and sustained change.27-30

A second important focus of MI is to help patients resolve their ambivalence.21 Ambivalence (perceiving both the pros and cons of changing and not changing) is conceptualized in MI as a normal part of the process of change. Studies have shown that educating and confronting an ambivalent person about change can have a paradoxical effect (eg, the ambivalent person argues more fervently for not changing).31-34 In one study the number of alcoholic drinks consumed per week was predicted by the level of HCP confrontation: the more the HCP confronted, the more the patient drank.34 Instead of confronting patients about the need for change, the MI HCP asks questions that elicit patients’ “change talk” (positive statements about change). Research has shown that when people speak in defense of a new perspective, even one that is opposite to their prior views, their attitudes and behavior shift in the direction of the new perspective.26,35 Thus the more patients hear themselves argue in favor of medication adherence, the more committed they become to adherence. Verbal commitment is associated with smoking cessation,36 decreased opiate and cocaine use,37 and increased medication adherence in pediatric settings.38,39

In MI change is viewed as a process rather than a discrete event. This idea was borne out of Prochaska and DiClemente’s stage-of-change model,22 in which people are theorized to go through a series of distinct stages before changing their behavior, ranging from not thinking about change at all to contemplating change to making some initial changes. Problem solving before sufficiently building motivation for change often leads to patient resistance (“I’ve tried keeping the medicine by my toothbrush, and it doesn’t work”). These statements are often reflective of an underlying motivational problem rather than a poor self-management strategy. Educational approaches are therefore an inefficient use of clinical time because unmotivated patients are less likely to initiate and maintain treatment.21-23,40

PATIENT-PRACTITIONER COMMUNICATION STRATEGIES: FOUNDATION OF MI

An important goal of MI is to establish a comfortable and noncoercive atmosphere so that patients feel free to discuss their feelings about the recommended treatment. This is particularly relevant for asthma medication, about which patients might falsely self-report adherence.3 Creating a nonjudgmental atmosphere enhances the likelihood of accurate self-report.30 Four communication components engender MI spirit: open-ended questions, affirmations, reflective listening, and summary statements (OARS). OARS has been shown to increase patient collaboration and satisfaction, treatment adherence, and patient-physician working alliance.31,32,41 Underlying OARS is empathy, or the HCP’s ability to understand the patient’s thoughts, feelings, and struggles from their point of view. Empathy is a strong predictor of treatment outcome.42

Open-ended questions cannot be answered with a yes or no. They produce less biased data because they allow patients to “tell their story.” Open-ended questions elicit important information that otherwise might not be asked. Closed-ended questions often damage rapport, decrease empathic connections, and paradoxically end up taking more time.43,44
Affirmations are statements of appreciation, which are important for building and maintaining rapport. Efforts to make changes are acknowledged, no matter how large or small (eg, “I am impressed by your maintaining a weekly schedule during the allergy injection build-up phase”).

Reflective listening involves taking a guess at what the patient means and reflecting it back, restating their thoughts or feelings in a slightly different way (Table I). Reflective listening helps to ensure understanding of the patient’s perspective, emphasizes his or her positive statements about change, and diffuses resistance. Resistance occurs most often when patients experience a perceived loss of freedom or choice. Reflective responses move the interaction away from a power struggle and toward change.

Summaries are longer than reflections and used to transition to another topic, highlight both sides of a patient’s ambivalence, or provide a recap at strategic points to ensure continued understanding (eg, “You have several reasons for wanting to take your asthma medication consistently; you say that your mom will stop nagging you about it and you will be able to play basketball more consistently. On the other hand, you say they are a hassle to take, and that they taste bad. Is that about right?”).

**BRIEF STRATEGIES FOR ENHANCING MOTIVATION FOR CHANGE**

**Beginning the consultation**

Setting an agenda. Koning et al47 found that one third of patients with asthma or chronic obstructive pulmonary disease desired greater participation in decision making about their treatment. Patients with asthma who report active participation in treatment decisions are more adherent.48 However, patients might be hesitant to voice their agendas without being prompted.49 MI provides a framework to actively solicit patients’ agendas. The HCP provides a menu of options for discussion and lets the patient decide where to start the conversation (eg, “Would you like to talk about taking your medication, monitoring asthma symptoms, or avoiding asthma triggers? What are you most concerned about?”). Having patients take initial control of the consultation helps them be more active and invested.24 This approach has shown high acceptability among primary care practitioners.24 Although collaborative agenda setting might increase consultation time in the short term, patient satisfaction and health outcomes show improvements over the long term.25

Discussing a typical day. A single open-ended question inquiring about the patient’s typical day allows the HCP to assess the patient’s social context and adherence in a nonjudgmental framework.52,53 Instead of asking, “How many times did you take your medication this week?,” which can lead to face-saving answers, the HCP can ask, “What is a typical day like for you, from start to finish, and, if you like, tell me about where taking your medication fits into your day.” This technique has been used successfully in medical populations and is easily conducted during a physical examination.

**Assessing motivation and confidence for change.** Both motivation and confidence for change have been found to be strong predictors of asthma treatment adherence.14,39,55 Assessment of motivation and confidence levels helps clinicians calibrate their approach to patients. For example, the HCP can ask, “How motivated are you to take your medication? Rate your motivation on a scale of 1-10, where ‘1′ is not at all motivated and ‘10′ is very motivated.” Confidence in the patient’s ability to adhere can also be rated. Studies have shown that patients, even those who are older and medically ill, do not have difficulty with this form of numeric assessment.

Using midconsultation strategies to enhance motivation for change

Using the lower-higher exercise. After motivation is assessed as outlined above, the HCP asks: “Why not a lower number?” This nonjudgmental approach helps to elicit positive statements about change, which have been shown to be associated with better treatment outcomes.37,38 After the patient provides several reasons, the HCP asks, “What would it take for you to get to a 9 or a 10?” This approach helps to identify barriers and facilitators of adherence. The same exercise can also be done with confidence levels.

Exploring the costs and benefits of change. Exploring the costs and benefits of change helps patients to (1) see both sides of their ambivalence simultaneously, (2) realize that the HCP is interested in both sides of their ambivalence and not only the “prochange” side, and (3) articulate and think more deeply about their reasons for adherence and nonadherence. Exploration of ambivalence about change has been successfully used across a wide variety of health behaviors.54,58 In asthma, studies that included a discussion of the pros and cons of adherence have been effective in improving adherence and health outcomes.15-17 More benefits and fewer perceived barriers are associated with better asthma self-management.7,39,59 In MI the HCP might start with the “not so good things” about taking medication to convey a nonjudgmental posture. The HCP can then ask, “What about the other side; what are some ‘good’ things about taking your medication?”

The HCP encourages detailed answers. For example, in response to the “good things about taking medication,” if the patient says “improved asthma,” the HCP asks him or her to clarify what that means functionally (eg, reduced symptoms or better able to perform activities). After gathering this information, the HCP provides a summary, an empathic statement, and a query about next steps: “On the one hand, you feel that taking your medication limits your freedom. On the other hand, you say that when you don’t take your medication, you are not free to do the things that you want to do, like play tennis. This is a tough position to be in.”

Providing medical advice and feedback. In MI health information is shared in a manner that increases the
TABLE I. Types of reflections

<table>
<thead>
<tr>
<th>Type of Reflection</th>
<th>Patient</th>
<th>HCP</th>
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<tbody>
<tr>
<td>1. Repeating</td>
<td>“I don’t want to take my medication.”</td>
<td>“You don’t want to take your medication.”</td>
</tr>
<tr>
<td></td>
<td>“I want to take my medication, but I have trouble fitting it into my day.”</td>
<td>“Taking your medication is important to you.”</td>
</tr>
<tr>
<td>2. Rephrasing</td>
<td>“You’ve probably never had to deal with anything like this.”</td>
<td>“It’s hard to imagine how I could possibly understand.”</td>
</tr>
<tr>
<td></td>
<td>“I’ve tried to take my medication consistently, but I just can’t seem to pull it off.”</td>
<td>“You are persistent, even in the face of discouragement. Controlling your asthma is really important to you.”</td>
</tr>
<tr>
<td>3. Empathic</td>
<td>“I know that not taking medication is bad for my asthma.”</td>
<td>“You’re worried about your asthma getting worse.”</td>
</tr>
<tr>
<td>Reflection</td>
<td>“My mom is totally exaggerating my symptoms. My asthma isn’t that bad.”</td>
<td>“There’s no reason to be concerned about your asthma.” (said without sarcasm)</td>
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<tr>
<td>4. Reframing</td>
<td>“Taking medications just takes away my freedom. It’s such a hassle.”</td>
<td>“On the one hand, you find that medication takes away your freedom. On the other hand, you said that your asthma symptoms limit your freedom by preventing you from doing things you enjoy. What do you make of this?”</td>
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In MI patients’ perspectives on their condition are elicited (eg, “What connection, if any, do you see between your taking your medication and your asthma?”). The HCP then asks permission to provide education (eg, “Would you like to know more information about how medication can help your asthma?”) and then provides the information (“What usually happens to some of my patients who take their medication…”). The person’s interpretation of the information is elicited because it is the patient’s interpretation of the information and not the information itself that determines adherence (eg, “I wonder if we could talk briefly about whether or not this may apply to you. What do you make of this information?”). Feedback can be given about test results, health care use, medication use and symptoms, or activity limitations.

**Advising the patient to change.** In MI, advice is given after a relationship has been established and the patient’s perspective on the situation has been sufficiently explored. Giving advice has 5 components, creating the acronym RAISE: (1) relationship with the patient; (2) advice to change; (3) “I” statements; (4) support of patient autonomy; and (5) empathy. For example, the HCP can say, “As your doctor, I (‘I statement’) think the best thing you can do for your asthma right now is to take your medication (‘advice’). I am not going to pressure you to do that; the decision to take your medication is completely up to you (‘support autonomy’). I know that these decisions can sometimes be difficult (‘empathy’).”

**Asking evocative questions.** There are several key questions HCPs can ask to evoke optimistic statements about adherence from patients: (1) “If you were to take your medication consistently, what might be the best results you can imagine?” (2) “What worries you most about your asthma?” (3) “How does asthma stop you from doing the things you want to do?”

**Ending the consultation**

The MI consultation ends with a summary and a query about what the patient would like to do next, if anything,
about managing his or her asthma. Attainable goals are negotiated if the patient is sufficiently motivated.

THE EFFECTIVENESS OF MI AS A PATIENT-CENTERED METHOD

MI overlaps with patient-centered medicine in that both approaches involve patient acceptance, collaboration, open-ended questions, and listening skills. MI uses patient-centered communication but also includes a set of strategies to help move patients toward change. Patient-centered approaches improve health outcomes for a variety of conditions, such as asthma, obesity, smoking cessation, and blood pressure. In asthma management, MI has been used as an intervention itself. A meta-analysis found that MI in a prelude to treatment (eg, motivating treatment entry) or as an intervention during routine medical care, although they might not be expecting it. In one study by Borrelli et al., patients receiving Visiting Nurse Association service who were randomized to receive nurse-delivered MI for smoking cessation were twice as likely to be continuously quit at a 12-month follow-up than those who received a standard educational approach. These effects were obtained despite almost 75% of the participants not being motivated to quit before treatment.

There is evidence for the effectiveness of MI as either a prelude to treatment (eg, motivating treatment entry) or as an intervention itself. A meta-analysis found that MI interventions result in small effect sizes for smoking cessation, medication adherence, and exercise. In medical and public health settings, MI has been used as an opportunistic intervention in which patients receive behavior change counseling during routine medical care. MI was originally described by Miller in 1983 to address problem drinkers and has since been applied to a variety of settings (primary care and hospital), and health behaviors, such as smoking cessation, dietary change, medication adherence, exercise, HIV risk reduction, drug use, gambling, eating disorders, sleep apnea, hypertension, and obesity. In asthma management, MI has been used as an intervention itself. A meta-analysis found that MI in a prelude to treatment (eg, motivating treatment entry) or as an intervention during routine medical care, although they might not be expecting it. In one study by Borrelli et al., patients receiving Visiting Nurse Association service who were randomized to receive nurse-delivered MI for smoking cessation were twice as likely to be continuously quit at a 12-month follow-up than those who received a standard educational approach. These effects were obtained despite almost 75% of the participants not being motivated to quit before treatment.

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BUILDING MI INTO CLINICAL PRACTICE

Although HCPs might be concerned about the time it takes to integrate MI into a busy clinical practice, studies have shown minimal time differences (typically no more than 2 minutes) between delivery of patient-centered counseling and delivery of standard approaches. One study of primary care physicians found that MI took an average of 9.69 minutes. The small amount of extra counseling time might be well spent, given that patient-centered approaches are associated with better adherence, better patient retention and satisfaction, greater physician satisfaction, lower malpractice, more accurate diagnosis, and better clinical outcomes than usual care. HCPs need not apply the entire arsenal of MI techniques during a single visit but rather chose the strategies that fit best with their own style and with patient readiness to change. CPT Evaluation and Management codes allow HCPs to be reimbursed for time spent counseling patients. Practices can also be reimbursed by having nurse practitioners or physician assistants provide patient-centered counseling.

The Accreditation Council of Graduate Medical Education mandated that directors of residency programs provide communication skills training for their residents and fellows. Trainees must be proficient at (1) demonstrating caring and respectful behaviors, (2) performing counseling and education, and (3) interpersonal communication skills. The MI skills reviewed above fit well with the training requests of the Accreditation Council of Graduate Medical Education. Practitioner-patient communication training to improve adherence have been provided at state, regional, and national meetings. Two health plans (AmeriChoice-Pennsylvania and Blue Cross Blue Shield-Delaware) now provide an adherence/communication training CME course for primary care physicians treating asthmatic patients (Weinstein A; CME course available on request). A series of half-day training periods over time combined with self-study (readings and viewing training videos) and follow-up training booster sessions are recommended for HCPs.

CONCLUSION

Patient-centered approaches improve the HCP’s performance, patient satisfaction, and health outcomes without an increased burden of time and cost. MI is a
patient-centered approach that is effective for promotion of health behavior across a wide variety of areas. MI involves fostering practitioner-patient communication and using brief strategies to help patients resolve their ambivalence about change and build intrinsic motivation for change. MI strategies have been modified such that HCPs can readily incorporate them into regular clinical care.

Although the literature is suggestive of MI as an effective strategy to enhance treatment adherence, further research is needed specifically examining the efficacy of MI in promoting asthma management. In 2007, there were 117 National Institutes of Health–funded trials on MI, 2 of which were on asthma management, one with low-income adults and the other with inner-city teens. Demonstrating to HCPs that patient-centered counseling serves their needs by reducing daily frustrations of nonadherent patients, decreasing adverse events, and improving the quality of care with minimal drain on time could motivate HCPs to learn and use these skills.

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