Consultations about changing behaviour

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Persuading patients to change behaviour that is damaging their health can be difficult. Changing the style of consultation could improve the experience for doctors and patients.

Health threatening behaviours are the commonest cause of premature illness and death in the developed world, affecting the sustainability of our health services and society.1 Almost every healthcare worker interacting with almost every patient has an important opportunity to change health behaviour. Examples include a general practitioner talking to a patient about smoking or exercise, a health visitor engaging a mother about her child’s diet, an accident and emergency house officer talking to an injured patient about alcohol, a renal nurse discussing fluid intake, and a dental hygienist discussing flossing. These consultations can be difficult to navigate, however, and practitioners often make a cursory attempt to satisfy external guidelines or end up avoiding the subject altogether. Here, we consider how the flexible use of a guiding style could make health promotion more satisfying and effective.

Skilfulness makes a difference

The challenges of changing health behaviour have parallels in everyday life. For example, the more we raise the stakes in telling a child to do something, the more likely conflict will follow. “Please get into the bath, now!” is often followed by, “But I am not dirty!” In the more polite confines of the consulting room, weariness is a common reaction. Doctors feel pressure to do more to prevent the effects of health compromising behaviours on their patients. Yet, doctors say they are not social engineers, cannot dictate the lives of their patients, and were trained primarily for diagnosing and treating medical conditions not monitoring and modifying their patients’ behaviour. When they raise health behaviour, clinicians usually default to a directing style of interacting with their patients.

It is not difficult to distinguish discussions that go well from those that go badly. When the discussion goes well, the patient is actively engaged in talking about the why and the how of change and seems to accept responsibility for change. When the discussion goes badly, the patient is passive, overtly resistant, or gives the impression of superficially agreeing with the practitioner. These reactions are measurable, predict outcome,2 and are influenced by the behaviour of the practitioner; confrontational interviewing, for example, predicts high levels of patient resistance.3 Therefore, practitioners might have greater potential to raise or lower patient resistance than many assume. If this is true, skilful consultation about behaviour change, like the skillful and compassionate breaking of bad news, is worthy of every effort to give patients the best quality of care possible.

The process of changing behaviour

Just telling people they are at risk of developing a disease is rarely sufficient to change behaviour.4 People change if they come to believe that it is both of value and achievable.5 Maintaining change is not easy, and successful change often requires multiple attempts.6 Decisions about change can be finely balanced and linked to other behaviours, as with the smoker who gets irritable and puts on weight each time she quits. Information about risk is but one of several influences on this process. We can help patients weigh up the value of change and set realistic targets, but ultimately the patient must decide whether to change and how.7

This rather obvious conclusion probably accounts for the enthusiasm with which motivational interviewing has been adapted from psychotherapy into healthcare settings.8–12 Since patients often feel ambivalent about change, they are sensitive to well intentioned efforts to persuade them one way or the other. Resistance and denial are common reactions, but these can be overcome, and outcomes improved, if the practitioner elicits the case for change from the patient rather than imposes it.

Directing or guiding?

So, how might everyday healthcare practice be improved? It is useful to contrast at least two styles of consulting about behaviour change. When practitioners use a directing style, most of the consultation is taken up with informing patients about what the practitioner thinks they should do and why they should do it. When practitioners use a guiding style, they step aside from persuasion and instead encourage patients to explore their motivations and aspirations. The guiding style is more suited to consultations about changing behaviour because it harnesses the internal
motivations of the patient. This was the starting point
of motivational interviewing,9 which can be viewed as a
refined form of a guiding style.

Core skills

Asking, informing, and listening can be thought of as
core tools or skills used by practitioners in different
combinations and in the service of either directing or
guiding. Asking involves the use of questions. Paying
careful attention to choice of words, timing, tone of
voice, and the ambiguities and contradictions often
elicited in replies will engage patients more actively.
Informing involves providing information, advice,
feedback, or a demonstration. Focusing attention on
clarity, evidence, purpose, and congruence with
patients’ needs is likely to achieve efficient use of
time and reduce the likelihood of resistance. Listening
involves hearing what patients say and ensuring that
their meaning is understood. Responding appropri-
ately, sometimes by conveying understanding through
empathic or reflective listening, engages patients
constructively. The box shows the use of these three
core skills in the service of either directing or guiding.

Directing and behaviour change

In the directing style, informing is usually the
dominant mode. This is appropriate in many
circumstances—for example, when a patient has acute
appendicitis. However, to be effective in changing
health behaviour this style requires a particularly well
timed and personally relevant quality. More often, the
directing style manifests in a rigid routine in which, for
example, the first question to a smoker, “How much do
you smoke?” is followed by a series of closed questions
before the delivery of advice to quit. Informing then
becomes telling patients what they already know (or
have considered, tried, and rejected) and presenting
them with a single, apparently simple solution.
Resistance is a common reaction, and this dysfunc-
tional interaction can leave practitioners blaming the
patient for lacking motivation or being in denial.

Perceived lack of time is a common explanation for
the almost reflex use of a directing style when trying to
change behaviour. Contractual obligations to discuss
certain subjects may lead to a raw, number crunching
approach that loses sight of individual needs. Similarly,
guidelines may also unwittingly reinforce an oversim-
plified approach by encouraging practitioners to
advise patients about lifestyle change in an unhelpful
manner.

Guiding and behaviour change

The three core skills are also used in the guiding style,
but here asking often involves eliciting from patients
why or how they might change and listening is used to
convey understanding of their experiences and to
encourage further exploration. Even the use of
informing is different. Informing is combined with ask-
ing to encourage choice and promote autonomy
rather than to tell the patient what to do (see box).
Challenges for the practitioner include being
restrained, conveying the conviction that solutions lie
within the patient, and handing over responsibility
about decisions to the patient while retaining control
over the time and overall direction of the consultation.13

The style being used can be reflected in small
things like the phrasing of a question, the offering of an
invitation to consider change, or the seating arrange-
ment. Everyday life provides other examples. Parents
commonly use both styles. Directing seems essential
and appropriate in some situations but quickly gener-
ates resistance if clumsy or wrongly timed. To avoid
resistance, parents and teachers use scaffolding or
guided participation, adjusting the level of support
according to the needs of the individual. This occurs
consistently across cultures and predicts later success
for the learner.14 15

Everyday practice

Shifting from a directing to a guiding style requires
doctors to change their attitude about who is responsi-
ble for solving the problem and how the momentum
and the direction of the discussion are controlled. One
practitioner described it thus: “It’s a shift from ‘Do this,
do that’ to ‘Nudge, listen, summarise; nudge, listen,
summarise.’ The ability to switch between the skilful
use of these styles, even within the same consultation, is
a marker of good practice.

Giving advice is often viewed as the delivery of
expertise within a directing style,16 and characterises
much of what is known as brief intervention in
addiction and elsewhere.17 18 However, by integrating
skilful informing with listening and asking, a guiding
style could be used to deliver brief interventions. This
approach seems to tune with wider developments—for
example, the recent white paper Choosing Health, which
encourages the move from “advice from on high to
support from next door.”19

Patients themselves are probably the best teachers
when it comes to learning how and when to use the
Summary points

Patients’ behaviour contributes considerably to variation in disease outcomes and mortality

Consultations about changing behaviour are important, common, and provide special challenges

Clinicians typically use the three core skills of listening, asking, and informing

Change is more likely if patients are helped to make decisions for themselves rather than being told what to do

Use of a guiding style, which is a simplified form of motivational interviewing, may facilitate such decisions.

directing or guiding styles. For example, if a patient shows resistance in response to directing it might be a signal for the practitioner to shift style. Conversely, impatience or other evidence of lack of progress with a guiding style may lead the practitioner to switch to directing.

The guiding style can also be used to change practitioner behaviour, avoiding the didactic approach assumed in evidence based guidelines and incentivised targets.20 21 The goal is to enable practitioners to adjust their routine approach to talking about behaviour change and engage the patient more in decision making.22 Despite the subtlety of processes, it seems possible to measure skillfulness,23 24 to identify improvements associated with training,25 26 and to identify ways of maintaining changes in practitioner behaviour.27 While motivational interviewing itself might take time to learn, the guiding style on which it is based is well within the reach of busy healthcare practitioners.

Moving forward

Effective brief interventions in routine clinical care have enormous potential to improve public health. Research into consultations that aim to change behaviour is therefore likely to be worth while, and the box on bmj.com provides a list of sample questions. We already know that adaptations of motivational interviewing are generally more effective in changing single targets.20 21 The practice of autonomy: patients, doctors, and medical decisions. New York: Oxford University Press, 1998.


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