A manual of motivational enhancement therapy for DM

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Foreword

This manual describes using motivational enhancement therapy for people with diabetes. We use this intervention in conjunction with a workbook, given to patients. In the first session we use the Accuchek programme developed by Garry Welch at the Joslin centre for diabetes. This generates a feedback form which is given in addition to feedback of the baseline HbA_{1c} level.

The first section of the manual describes general motivational techniques. In order to use this optimally it is important the therapist has been trained in motivational interviewing (MI) techniques and also been able to translate these skills successfully into clinical practice with this patient group. This requires an iterative cycle of practice taping sessions and then examination of the tapes, with feedback from self or a supervisor and practice once again. Furthermore on going supervision (ideally using taped sessions) is required to ensure that these skills are successfully implemented in practice. The practitioner should have read the standard texts on MI (Miller, WR and Rollnick, S, 1991;Miller WR and Rollnick S, 2002 and also Rollnick book on health behaviour change) and have studied the training tapes and transcripts both for general motivational interviewing and those developed for this project. This first section of this manual describes the general approach.

The second section gives more specific advice on how to incorporate these skills into this patient group.

Chapter 1

In order to optimise their health people with dm have to follow a regime which involves balancing their insulin administration with their general lifestyle factors such as diet, exercise using a system of monitoring their blood sugar. This requires implementation of a portfolio of behaviours. Some people find these more difficult to incorporate into their lifestyle than do others. In this manual we describe the use of motivational interviewing which is a style of interaction which has been found to be able help people change behaviours that impair their health.

The development of motivational interviewing

Motivational interviewing was 'discovered' when Bill Miller, a psychologist from the USA, sat with colleagues from Norway and described what sort of therapeutic approach worked for people with alcohol problems. The process of discovery may have been like the technique itself. A gradual process of listening, reflecting to check understanding and clarification. Once the form was crystallised it was then subjected to a detailed academic analysis. Questions such as what, how, when, why and for whom have been studied. The approach has been fitted with various theoretical models relating to interpersonal processes and behaviour change. Details of the technique were detailed in a textbook co-written with Steve Rollnick, a South African psychologist working in Wales.

The academic underpinnings of motivational interviewing

The academic history of this approach stemmed from the work that Bill Miller and his colleagues were doing in New Mexico. They had been actively involved in developing cost effective treatments for people with alcohol problems. They observed that the therapeutic style had a major effect on outcome. They noticed that resistance to treatment was not a fixed variable, attributable to the patient, but was a product of the interaction between therapist and patient. This observation ran contrary to the model held at that time which was that resistance arose from aspects of the patient's personality. The style of therapy for alcohol abuse based on this model involved the therapist confronting the client to break the resistance.

The iterative process of analysis of scientifically based treatments by the New Mexico group revealed how therapists influenced motivation to change (for review see Miller 1995). For example, therapists differed markedly in their retention rates and patient outcomes differ substantially depending upon the therapist to whom they are randomly assigned. In part this is explained by therapist's appraisals. Thus therapist's expectancies about the ability of a patient to change influenced treatment adherence and outcome. But it was also influences by therapists behaviours. A high level of therapist empathy is associated with more favourable patient outcomes. If therapists changed their style between a confrontational and a client-centred approach, the client's resistance increased or fell. The patient's resistance behaviours are in turn predictive of failure to change. Simple actions by the therapist such as a follow-up note or phone call can double the probability that a person will return for further counselling after an initial or missed session. Miller concluded that some therapists find that a motivational style of interviewing is something that comes more naturally to them but that it is possible to train all therapists to adopt a motivational style

Miller developed a short intervention 'the drinkers check up' which operationalised some of the factors found to be useful to increase motivation and to optimise the outcome from short interventions. Motivational feedback and was compared with standard

confrontation. The outcome, in terms of drinking one year later, was worse in the group of patients who were given their feedback in a confrontational manner (Miller et al 1993). They went on to show that if a motivational feedback of the drinker's check-up was given as an initial intervention prior to entry into an inpatient clinic the patients had a better outcome. The therapists involved in the later stage of treatment noted that their patients had participated more fully in treatment and appeared to be more motivated (Brown & Miller, 1993; Bien et al. 1993).

Motivational feedback was then extended into motivational enhancement therapy by including some of the principles of the psychology of change. In particular some of principles outlined in the transtheoretical model of change such as the importance of ambivalence and the use of the concept of a decisional balance were included in this intervention as were strategies used to improve self efficacy. This aimed to overcome resistance to change by using an empathic, softly, softly approach. Motivational enhancement therapy was one of the treatment arms in a large randomised controlled trial of treatment for alcoholism (Miller et al 1992, Project MATCH). It was found to be the most cost effective form of treatment in that it led to the same outcome as cognitive behavioral therapy or an approach based on the 12-step philosophy with fewer sessions (4 compared to 12 in the other limbs). It was particularly effective for people who were hostile.

Resistance in diabetes mellitus

Resistance to treatment arises if the patient and therapist are working at different stages of change. The majority of patients with poorly controlled diabetes mellitus are not ready to move into action to improve self care when they first present.

The resistance may not always be easy to recognise. Patients may avoid expressing their irritation, anger or rebellion to you directly. However their resistance is obvious when they come back the next week with their sugar levels unchanged

Resistance caused by working on mismatched stages of change

The patient's disregard for the risk caused by poorly controlled diabetes may make the therapist anxious. It is important to contain this anxiety even though you may be sorely tempted to wag your finger at your patient and confront him or him/her with the facts to make him/her see reason. Unsolicited confrontation and advice without any attempt to see the patient's perspective or his/him/her stage of change merely leads to resistance. You cannot badger people into action. Rather you need to help them come to the conclusion that they want to make changes themselves.

When you meet resistance in diabetes mellitus (albeit passive) will feel anxious that you are not doing your job properly. You are aware that your patient is not playing the doctor-patient, counsellor-client game by the agreed rules. Your offer to provide help and advice is being rejected. You may be tempted to bully the patient and shake him/him/her into sense. Or you may feel rejected and want to shrug your shoulders and walk away.

Interpersonal resistance

Not only is resistance a product of different agendas with different stages of change but also you may find yourself playing a role in which you are in opposition to your patient, forced to take control, be a bully struggling to assert power. This extreme polarisation of power and control may be one of your patients' maladaptive relationship patterns.

What is motivational interviewing?

MI is a directive, client centred counselling style that aims to help patients explore and resolve their ambivalence about behaviour change. It combines elements of style (warmth and empathy) with technique (e.g. focused reflective listening and the development of discrepancy). A core tenet of the technique is that the patient's motivation to change is enhanced if there is a gentle process of negotiation in which the patient, not the practitioner, articulates the benefits and costs involved. A strong principle of this approach is that conflict is unhelpful and that a collaborative relationship between therapist and patient in which they tackle the problem together is essential. The four central principles of motivational interviewing are shown in table 1.

Table 1

1. Express empathy by using reflective listening to convey understanding of the clients point of view and underlying drives
2. Develop a discrepancy between the clients most deeply held values and their current behaviour.
3. Sidestep resistance by responding with empathy and understanding rather than confrontation
4. Support self-efficacy by building confidence that change is possible.

Rollnick & Miller (1995) were able to define specific and trainable therapist behaviours that they felt led to a better therapeutic alliance and better outcome. These skills are summarised in Table 2 and Figure 1.

Table 2 **The skills of a good motivational therapist**

1. Understand the other person's frame of reference
2. Filter the patient's thoughts so that pro change statements are amplified and extended and given attention and statements that reflect the status quo are dampened down.
3. Elicit pro change statements from the client: such as expressions of problem recognition. The acronym DARN, desire, ability, reason and need to change
4. Match processes used in theory to stage of change; Do not jump ahead of the client and rush into action
5. Express acceptance and affirmation
6. Affirm the client's freedom of choice and self-direction.

The first four items explore the reasons that sustain the behaviour and aim to help the client shift the decisional balance of pros and cons into the direction of change. The last two items in the list cover the interpersonal aspects of the relationship. The therapist provides warmth, and optimism and takes a subordinate, non-powerful position, which emphasises the client's autonomy and right to choose whether to avail him/her self of the therapist's knowledge and skills.

The fable about the sun and the wind is an apt metaphor about the spirit of MI.

'The sun and the wind were having a dispute as to who was the most powerful. They saw a man walking along and they challenged each other about which of them would be most successful at getting the man to remove his coat. The wind started first and blew

up a huge gale, the coat flapped but the man only closed all his buttons and tightened up his belt. The sun tried next and shone brightly making the man sweat. He proceeded to take off his coat'.

Therapists need to model themselves on the sun and show warmth and respect rather than energetic fixing of the health problem. A motivational therapists has to be able to suppress any propensity they might have to show the 'Righting Reflex' i.e. to help solve problems and set things right (this is not easy because health professionals are drawn into the field because they want to actively help others). Therapists have to be flexible and be able to have an appropriate balance between acceptance and drive for change.

Motivational interviewing helps change patterns of behaviour that have become habitual. It works in small doses to produce a large effect. It seems to work by reducing clients' behaviours that interfere with therapy. Client attributes regarded as markers of a poor prognosis e.g. anger, low motivation are less serious obstacles with Motivational Interviewing.

Motivational Principles

The principles are outlined in the book 'Motivational Interviewing' by Miller & Rollnick (1991). The training is usually quite short as the principles are easy. However it takes a great deal of practice and supervision to enact and maintain the skills. There are 5 basic motivational principles most of which describe the interpersonal relationship and underline the generic principals of warmth, optimism avoiding domination:

1. Express empathy.
2. Develop discrepancy.
3. Avoid argumentation.
4. Roll with resistance.
5. Support self-efficacy.

Express empathy

The relationship with your patient should communicate respect. Although at times your patient may call upon you for information and guidance part you will need to be a supportive companion and will not want to force change. This will involve you trying to obtain a good working alliance with your patient in which you have an agreement on goals and tasks and have a good bond. The emphasis is on the patients decision to change or not, although you should provide a subtle undertow in the direction of change. You need to come to an agreement on what aspect of their relationship with their health that you are going to help them improve. In some people with a very long history the goals may need to be limited. In order to help with the process of change you need to know what your patient would be losing by paying more attention to their diabetes care. You need to show that you are interested in your patient's values and beliefs and feelings and how these contribute to diabetes mellitus self-care.

Develop discrepancy

The drive to change can be fuelled when the client recognises a discrepancy between where they are and where they want to be. A focus on the decisional balance of the pros and cons of change can produce movement towards action. Your aim is to enhance and focus your patient's attention onto discrepancies in the world now by helping him/her

become aware of the consequences of their current behaviour. You will also need to overcome the 'permission giving' strategies he/she may use to avoid caring for his/her health and diabetes mellitus i.e. it is too hard to expect me to think of diabetes self care when i want to belong and be 'one of the lads' or I worked hard to control my diabetes mellitus when I was young as the doctors implied I could get over it. I was duped by doctors then and I am not going to be fooled like that again. Research has shown that conflict or discrepancies between core values or self-concepts creates discomfort and a force for change. However this needs to done gently, ideally by the patient him/herself. Too much tension will only lead to a retreat. You want to evoke from you patient the reasons for change.

Avoid argumentation

Handled poorly ambivalence and discrepancy lead to defensive coping strategies such as stubborn negativism. Your client will merely write you off as not being understanding. Your task is to let the client voice the adverse effects of not paying attention to their health/diabetes. Gradually you will want him/her to devalue the positive aspects this avoidance brings. If you are joining in with arguments it is a sign that you have slipped from your motivational approach. Acknowledge that you have made a mistake. Your motivational interviewing stake probably was that you were jumping to far ahead into action or that you have fallen into a dysfunctional reciprocal role and assumed the mantle of power and domination.

Roll with resistance

Resistance will emerge time and time again. Don't try to fight it down, rather try to explore in more detail the underlying ambivalence by reflective listening. The goal is to try to gently shift the patient's perceptions whilst going with the flow of resistance. Invite new ways of thinking about the problem, by helping your client highlight the problems and the solutions. This may require coaching in order to free up a restricted cognitive style.

It is important to bear the following points in mind when you meet with resistance. It is not an intrinsic part of part of pathology to be countered by 'macho' tactics. It will fluctuate over time. If you fight it directly resistance may increase. You should use resistance as a signal for you to change strategy. See yourself as a David facing the Goliath of avoidance strategies and develop strategies to duck and weave rather than bulldoze ahead.

Beware of resistance developing because of maladaptive interactions. Stop yourself if you hear yourself 'you should', 'you must'. These are signs that you are becoming critical, judgmental or too powerful. If anything, turn criticism on yourself. Suggest that you may have made a mi stake. 'Sorry, I must have misjudged the situation. Let's retrace out steps a bit'. Take a step down position freely, apologise and admit that you were wrong. Praise whenever possible. Remember in order to attempt to break avoidance patterns you need to be the opposite of a critical authority figure or even an authority figure who knows best. You should see yourself as a guide who has access to half the pieces of a jigsaw puzzles which, when completed, has the map, which shows the route to recovery. The sufferer has the other half of the pieces and you must work together to succeed.

Self efficacy

Even if someone is persuaded that they have a serious problem they will not move

towards change unless they think there is a reasonable hope of success. It is difficult to want to change if you do not have confidence that you can do it. Try to foster an environment that nurtures optimism. It helps if you yourself can believe in the patient's ability to change. Do not gloss over the fact that for some avoidance of dwelling on health issues becomes a way of life. A therapist's expectation has a great impact on outcome.

Whenever possible highlight environmental or prognostic factors that engender hope. For example, if they have come because of pressure from the family reflect on the fact that having a warm supportive family can be very helpful. If you do not provide any hope or optimism then a 'discrepancy crisis' may lead to defensive coping (rationalisation or denial). This is a natural and understandable protective process. If one has little hope that things can change, there is little reason to face the problem. Once the time is right and you have a glimpse at their weak areas use problem solving strategies and skills training to increase their sense of mastery.

Reflective listening

Reflective listening is an essential skill in mi. It is the foundation upon which all other skills are built and is a safe fall back whenever you are stuck. When done well it looks deceptively easy but it is a demanding skill. You have to suppress all your natural conversational skills such as joining in, adding your bit etc. As a member of the helping profession you have to suppress your instinct to take charge, to give advice and to succumb to the righting reflex i.e. put right what you see as wrong.

Your goal is to understand what your patient is saying and why she/he is saying it. A degree of coaching is allowable 'Some of my patients tell me...'. Once your patient knows that you are someone they can trust and who knows something about the illness then they will be more willing to join in. It sometimes is more helpful not to get distracted by trying to do complex reflective listening which may seem like complex technical jargon but to try at first to summarise or précis what the patient has been trying to say.

In high level or complex reflective listening you need to use your empathic skills to see things from you patients perspective also try to use the opportunity to destabilise things and shift the balance or status quo. You can do this in several ways, one is to try to name the emotion that they might be experiencing. What are they are trying to express? A good listening response will put to the test your hypothesis about what might be going on. You may have several alternative hypotheses that you could offer them. (For example when they say to you,' I haven't looked at the workbook'. You have not had a minute for yourself. It is impossible for you to set aside 5 minutes for yourself.

Avoid interrogations because the questioner is then perceived to be in a more dominant position. For example, if someone is telling you that they haven't made friends since they want to college do not be tempted to say, 'How did that make you feel?' Use your empathic skills to reflect 'It must have been very lonely for you at college'. Miller teaches that it is best practice to reflect with a statement without any hint of a question, i.e. a raised end of sentence. This may seem presumptuous and strange at first. In some forms of counselling you may have been taught the refrain 'How did that make you feel?' or some other none verbal communication which may make them feel that they are being put on the spot, at risk of being criticised or humiliated for not giving the correct reply.

The best word to help you get started with reflection is ‘you’. For example use the following stems at first:

So you feel...

It sounds like you...

You're wondering if...

You....

Good motivational interviewing is characterised by

1. more open to closed questions
2. more reflection than questions
3. more complex than simple reflection

Try to avoid asking more than three questions in a row as this leads to reflex answers and doesn't allow the issues to be discussed in depth. Avoid using responses, which block the flow of discussion. Examples of these are; ordering, threatening, and giving advice or solutions, persuading with logic, moralising, criticising, shaming, interpreting, reassuring or distracting. You will notice that all of these arise from a position of domination.

Motivational interviewing is very similar to client centred counselling but it differs in that you are trying to put a spin on your reflections so as to point your client into the direction of change. You want to help them discover the negative aspects of their behaviour and come up with self-motivating statements. To do this you will try to elicit from them explore the positive aspects of avoiding thinking about their health, and also the negative aspects of change. This draws resistance out from your patient making the covert subplot overt.

Often therapists feel inadequate because by just paraphrasing and summarising what the patient is saying it is as if they are not ‘really doing anything’. This feeling arises because as members of the helping professions we are locked into a belief that we need to actively help and problem solve. It does not come easy to step back from that role into one in which we can facilitate the patient finding his/her own solutions. Whenever we have run workshops for people in the helping professions and we get them to practice reflective listening in pairs we find that the person who was listened to found the experience very helpful whereas the listeners felt unsure of themselves and somewhat impotent.

Advanced reflective listening

This modification can be added once you are confident on your skills of reflection. In order to develop this skill you need to be thinking quickly and be sure about whim/here you want to be going. Do not worry if there are pauses before you speak. You will probably need this. Not only do you have to try to understand what they are saying and the emotional content behind this but you also will be filtering the process. You want to amplify statements that will promote change and dampen down those that maintain the status quo.

The theory, which underlies this approach, is the self-perception theory (Bem, 1967). Bem proposed that people learn what they believe in the same way that others do: by hearing themselves talk. When people publicly take a position their commitment to that position increases. The more a person argues for that position the more committed she

is to it.

Focused reflections

Try to get your patient to add to statements that lead to change that you want to amplify. One way of doing this is to deliberately undershoot the strength of the emotion. You will find that your patient will be inclined to go on and cap it. One the other hand if you want to dampen down a statement do the opposite, give a high strength emotional word. This will encourage your patient to back down.

The following is a list of adjectives of various strengths. If you want to promote a self-motivating statement go for a weak adjective, in contrast if you want to turn resistance around then use a strong adjective. For instance, see example as follows:

STRONG	sadness	anger
	despondent	enraged
	joyless	incensed
	depressed	furious
	blue	mad
	downhearted	angry
	low	cross
	down	irked
	unhappy	bothered
	a little low	irritated
WEAK	a little down	miffed

If your patient is ambivalent, then use double-sided reflections. A double sided reflection has the two opposing statements linked by an ‘and’. This seems slightly odd at first. Your instinct is to want to put in a contrasting conjunction such as ‘but’. However an ‘and’ allows the interaction to remain neutral with no hint of criticism or astonishment. You do not want your patient to perceive that you are foisting a discrepancy on them. It can seem quite risky to be neutral.

‘You are terrified of the effects that poorly controlled diabetes will have on your eyes and paying attention to your diabetes mellitus is boring and depressing’.

Guidelines for MI

Table 3

Do's

1. Let patients present argument for change.
2. Start with the patients (not the therapists) concerns.
3. Focus on eliciting patients concerns.
4. Emphasise personal choice and responsibility for deciding future behaviour. Negotiate goals and strategies.
5. Explore and reflect patient's perceptions.
6. Use emphatic reflection selectively.
7. Reflect feelings, concerns and self-motivational statements.
8. Reflect by paraphrasing and summarising.
9. Reflect with a statement starting with 'you' as the subject.
10. Summarise periodically.
11. Make a short summary of sessions at beginning and end of each session.
12. Offer advice and feedback whim/here appropriate.
13. Use positive restructuring of the patient's statements to improve self-esteem and efficacy.

Dont's

1. Argue, lecture or persuade with logic.
2. Assume an authoritarian or expert role.
3. Give expert advice at the beginning.
4. Order, direct, warn or threaten.
5. Do most of the talking.
6. Get into debates or struggles over diagnostic labelling.
7. Make moral statements, criticise, preach or judge.
8. Ask questions to which patients give short answers.
9. Respond to a patient's response to an open-ended question with another question.
10. Ask a series of (three) questions in a row.
11. Tell the patient that she has a problem.
12. Prescribe solutions or a certain course of action.

Clients who have made previous attempts at better diabetes control but who have subsequently lapsed may be demoralised and dispirited. This saps away any confidence in their ability to change especially if they have a tendency towards black and white thinking. Educate your clients into the predictions from cycle of change. The concept of

motivation to change will ebb and flow back and forth from wanting to change to being uninterested in change. It is incorrect to assume that because they were once in action and have subsequently entered pre-contemplation that this means that they are a failure or that they have made a mistake. Draw the analogy between audit and quality control, which regards mistakes as invaluable as you, can learn more from them 'Every mistake is a treasure'. Somehow this phrase sticks in my mind! It may help if you point out that science advances by making a hypothesis and either proving or disproving it. You can learn equally from both. Some of the hypotheses that are untrue have helped our understanding more than any that are true. Similarly going into a phase of action that has not led into maintenance can be a great earning resource.

Another analogy you can use is that of feedback control, for example in order to set a missile's path there is slight deviation to either side but this gets corrected. If a deviation to one side is regarded as unacceptable then this may mean that a less than optimal path is chosen. It is only by taking a risk that you can advance. The important thing is to review afterwards where things went wrong and form a new hypothesis. Success is built on learning from failures.

Motivational enhancement therapy

Motivational enhancement therapy has been derived from integrating the psychology of change, in particular, the trans-theoretical model of Prochaska & DiClemente (1982) with the skills of motivational interviewing. It was adapted for use both in alcohol and drug abuse (Project Match 1993;1997; Miller et al. 1992; Miller 1995).

Motivational enhancement therapy is a systematic approach for evoking change. The treatment strategy does not attempt to guide and train the client, step by step, through recovery but uses motivational strategies to mobilise the clients own change resources. MET addresses where the client is on the cycle of change and assists the person to move through the stages towards successful sustained change. The stages of precontemplation, contemplation and determination are most critical for motivational enhancement therapy. Indeed if the client is in action then skills training using techniques such as cognitive behavioural treatment maybe more appropriate. However it is common for readiness to change to shift back and forth and so you may need to shift from action based strategies back to more reflection. The processes appropriate for pre-action stages are self-reflection with a focus on factors such as importance and confidence. The goal of therapy is to change the decisional balance so that the benefits of change outweigh the difficulties and costs of changing and to bolster beliefs that the steps involved in change can be undertaken. MET can be divided into two phases (1) Building the commitment to change (2) Strengthening the commitment to change. In this intervention we are using some of these tools developed for motivational enhancement in the workbook.

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Four sessions of MET for diabetes

Background

The majority of patients with poorly controlled diabetes mellitus recruited into this study will be in the stage of contemplation about whether they want to focus more attention on their health when they are first seen. The screening process will have picked up some who are in the precontemplation stage; however those that have agreed to participate in the study will probably have some time when they are contemplating change. Of course these stages are not fixed. People frequently oscillate between these early phases. The aim of this four session intervention is to examine whether it is possible to help people move into action and also to maintain any changes that they make in the management of their diabetes mellitus in the long term i.e. over the following year. For the most part this intervention will be done for individuals but in some cases the therapist and patient may decide that it is useful to include significant others in the patients life.

It is not easy if you are a professional with specific expertise in diabetes mellitus, to change roles from giving advice, a usual practice for diabetic nurse, into the more reflective model of motivational interviewing. Your expertise is invaluable to optimally fulfil the role of a motivational interviewing therapist. By engaging with this therapy you will be learning extra skills so that you will be dual expert both in diabetes and in psychology and behaviour change. This expertise forms the background context which will help you fully comprehend what your patient is trying to tell you and what it might mean and what are the implications for chance. A keystone of therapeutic change in many psychotherapy modalities is empathy. What is meant by this is your ability to understand and make an effort to grasp the clients perspective. Beware of cultural, age, and gender differences that may interfere with good understanding and communication. You need to step into the other person shoes and be culturally empathetic and not let white, middle class, female, professional (or whatever) values intrude into the therapeutic process. It is easy to over look how culturally embedded your values are. Of course within motivational interviewing you should **not** be giving advice (unless it is with permission) or setting goals but how you understand and reflect (key aspects of MI) depends on what your 'mirror' is made of. For example, you may think that the best place to exercise is in a gym but to others this behaviour is alien, elitist and expensive. A good question if you feel lost about understanding your patient's way of life and you sense that you may be stuck in an impasse, bereft of ideas is to ask what their friends and neighbours say and do. If this question draws a blank you may want to elicit a curiosity about this.

These patients are often very knowledgeable about diabetes mellitus so you do not need you to lecture them (this runs counter to motivational interviewing principles anyway). Beware if you find yourself stepping into this role! Ask yourself this question, does the client really not know or are they enticing me into a game of logic perhaps to assert power or to distract you from emotional issues which may be more difficult for them to stay with.

Remember that the stance and spirit of motivational interviewing is to accept the individual's autonomy and right to chose what they do with their life. In medicine, we can be seduced into thinking that we are the experts with all the right answers. The spirit of motivational interviewing runs counter to these embedded values and is much more at home with the concept of 'expert patients'. Think over about how many times in your lifetime of medicine there has been a *volteface* about aetiology or strategies for

management (e.g. not so long ago a high fat diet was recommended for diabetes mellitus). So bend over backwards to not to be or appear to be judgemental. You do not want to give your patient the impression that you are pushing them down one path and solution. Part of you may want to get behind your patient and to get them to score ten out of ten on all areas health related areas such as improving exercise, stopping smoking etc. However they have to choose for themselves. Balance the need for acceptance of ill health with the need for change. The serenity prayer used in AA offers a very good mission statement in the management of diabetes mellitus. It is helpful if both you and your patient follow this approach.

God give me the serenity to accept things which cannot be changed;
Give me courage to change things which must be changed;
And the wisdom to distinguish one from the other.

An important new concept in the management of chronic disease is the idea of having 'expert patients'. It started with patients with arthritis but has moved onto other areas including diabetes mellitus. Motivational interviewing sits easily with this approach. A good strategy if you find yourself are falling into the advice giving, paternalist/authoritarian mode is to turn it around by asking your patient what they would say if they were an 'expert patient' and someone asked them the same question or what do they think an expert patient would suggest. Being asked for advice is sometimes a trap it can become a dance for power and may lead to a long conversations ending with 'yes but' . Another similar strategy to dodge being drawn into this trap is to ask what their family members would say. Of course giving advice with permission is an acceptable part of motivational interviewing practice, but beware of overstepping this line. In this specific description of this approach we have put into bold the items that are important.

Introduction

When introducing the study avoid the use of negatively connoted words for competent such as 'random' or 'trial'. These have different meanings and resonances in the lay context. Also avoid using the term 'motivational interviewing', again it has a non technical connotation such as high pressure sales strategies. Whenever possible in motivational interviewing avoid any type of labelling. If you want to describe what the 4 session motivational interviewing, intervention is say something like this:

'These four sessions are an opportunity to have a conversation about your diabetes mellitus self management. Nobody but you can decide about your priorities with this and whether you want to talk about or work on any of these areas. These sessions are not about me telling you what to do at all. It is entirely in your hands. I am a diabetic nurse but my role in this project is different to the role of any diabetic nurse that you have met before. In the first sessions we will use a computer programme from America to help you decide what may be the main focus on which you would like to work but through out these 4 sessions you set the pace and scenes '.

Remind your patient throughout these sessions that it is entirely up to them what they do. **This emphasis on the patient's autonomy is one of 3 key strategies that are consistent with the spirit of MI.**

All participants in the study have made some sort of sacrifice to enrol in the study. It takes up their time, resources and energy. Acknowledge this in the first phase of the study and give them positive feedback about it. **This affirmation is one of 4 key MI adherent behaviours, consistent with the spirit of MI.**

Therapist: ‘I am impressed that you have gone to the effort to come and join the project. It shows that you have an interest and curiosity about knowing more about yourself and diabetes. But over and above this it is a marker that you have an interest in helping others with this problem who may come after you. By adding to the body of knowledge about diabetes you will be contributing to shaping treatments and services in the future. Filling in the questions, having the tapes made will all go towards the detailed analysis. This is a complex and high quality study commissioned by the NHS and all the information gathered from it will be disseminated into NHS and form the basis good practice guidelines that are developed as part of NICE.’

This introduction sets the scene for the intervention in which you are collaborative partners working to increase knowledge. **This offer of support and collaboration is one of 4 key MI adherent behaviours, consistent with the spirit of Motivational Interviewing.**

This turns around the reason for coming for treatment from being bad with their diabetes mellitus control to being good for helping the NHS.

Avoid adopting the traditional/medical model in which you are cast as an advocate for change as this may force your patient into a stance of maximum resistance. Instead of advocating change your goal is to ensure that you patient has the opportunity to articulate the needs, reason and desire for better diabetes mellitus self care and to generate ideas and strategies as to how they could put that in place. This is not an excuse for you to sit back and do nothing. Rather you have to use all your cunning and keep your wits nimble to guide your patient onto the pathway for change without taking over and taking on an expert, parent type role. You will not be able to follow a standard pro forma but need to be prepared to deviate and detour as the opportunity demands. One consistent attitude and behaviour from you will be to remain empathic and respectful. Your job is to coach your patient into taking on the role of being their own expert patient by shaping and reinforcing the helpful behaviours and attitudes they show and by ignoring and not paying attention to the not so good attitudes and behaviours they might show. **This evocation of pro change behaviours is one of 3 key behaviours, consistent with the spirit of MI.**

Your main tools are to encourage, highlight and affirm behaviours that you want to see in your patient and to ignore and not give attention and reinforcement to the not so good behaviours. This approach echoes what good parents, teachers and coaches do.

Part of your work is to establish how ready and able your patient is to change and adopt more adaptive diabetes mellitus self care strategies. One way to do this is to develop discrepancy about their current sub optimal diabetes mellitus self care and to help them reflect on how this impinges on their life and health. It is important and helpful to be able to set this against the positive benefits they get from avoiding optimising their diabetes mellitus self care. Your aim is to elicit and facilitate your patient articulating the ideas, beliefs and intentions about diabetes mellitus self care. We are all influenced by hearing ourselves voice opinions. You want your patient to voice intentions about attending to their diabetes self care. However you need to gain his/her trust and interest before you get to this and you can do this by listening carefully to the reasons that she/he has for not wanting to change.

Phase 1: the Accuchek

The aim of this first phase is to examine how diabetes affects your patient’s life. We do this in the first instance by using the computerised Accuchek interview developed by

Garry Welch at the Joslin centre as part of a motivational interviewing strategy. This instrument asks about several domains of life that are impacted upon by diabetes mellitus. Here is a way you can set the scene for this to take place.

Therapist: 'One of the firm and consistent findings in medicine is that people find it helpful if they can have personalised feedback about how their illness affects them and have the opportunity to reflect on what this means. We will be doing this in these 4 sessions. The Accuchek is a tool which you can use as a first step to give you feedback. It was developed for use in diabetes clinics in America. We use it with you HbA_{1C} measurement which, as you know, is a summary of your blood glucose. The Accuchek takes a broader view than this and has a more holistic approach of you as a person with diabetes mellitus. We do the Accuchek in the first session. We will follow this with a more individualised analysis in the following 3 sessions. Does that sound Ok? Do you want me to explain it in any more detail or do you have questions? '

Accuchek

We have found that using a motivational interviewing and feedback styles works well with the Accuchek. You can offer to use the computer or let your patient do it.

Therapist: 'The computer asks some questions. At the end it can generate a written summary, I can give you this when I have access to a printer, next session. It is usually helpful if we can discuss some of the answers a little. Are you happy to run the key board or would you like me to do it?

The therapist asks additional open questions or gives reflections around each item to get further details and clarification. Sometimes it is necessary to clarify what some of the questions mean. If there is a positive response to an acutest item, before you ask them to grade how severe it is, ask them to tell you more about it. Get them to give you more examples. This helps to build a picture of the patient's life and a formulation of their relationship with diabetes. Although this takes time it usually means that the therapist can form an opinion about what some of the scores later in the interview will be. This means that we use the Accuchek more like a semi-structured interview. Whenever possible it is a good idea for you to have a stab at the grading rather than ask your patient to do it grading their thoughts etc.(it is a strange and unusual procedure for them) but then let them adjust it as necessary. Later in the interview you can go through some things quickly because you already have enough information on which to base your judgment i.e. you do not have to be meticulous in waiting to hear what the patient to every point but you can summarise what he has already told you and check that your judgement is correct.

Therapist: 'I guess from what you have told me about the unwanted effects that diabetes mellitus in everyday that we may want to give you a 3 on this. For example, you told me that your girl friend notices when your blood sugar is low because you become crankier. (This highlights the negative aspects of suboptimal diabetic control). This is a complex reflection which highlights and evokes change in thoughts.

Therapist: 'It must be unpleasant for you to realise that you appear to others to be in a bad mood, crabby & irritable when it is out of your control in this way. You are the sort of person who is sensitive to other people's feelings and their reactions to you.' Reflect and emphasise the underlying emotion and

meaning of this statement, complex reflection. In the second part you use the opportunity to help the patient build up a positive image of themselves, **(affirmation)**

'So I would think you would merit a score of 3 on this item diabetes has an impact on my life. What do you think about this?'

Many people find managing hypoglycaemia very difficult. The lack of control that occurs is very shameful and embarrassing. It is worth trying to go into this a little as talking openly about it can remove some of the shame and stigma.

Therapist: 'It is a common thing to feel embarrassed about what happens during a hypo some people fear that they might lose physical control of their body for example wet themselves, others worry that they might sound stupid or mad or be sexually inappropriate or aggressive. Do you have any worries like that?'

Others worry about the reaction of others to their hypoglycaemic episodes.

Patient: 'I think my wife thinks I bring on the hypos myself'.

Therapist: 'Your wife sounds concerned about your health'.

Complex reflection, this reframes his wife's concern into care and concern about him

Patient: Yes she is pretty frightened about it all, especially the operation on my foot.

There is a section of difficulty working with professionals on managing diabetes. Sometimes it can be helpful to give permission or show that you 'allow' a discussion on this topic.

Therapist: 'It sounds as if it is hard having all those different doctors involved in your management. You said you go and meet with a doctor at the clinic and they change things but then don't follow through because it is a different doctor next time. Thus you have to provide the continuity but you fear that you do not have all the resources you need for this'. **(Reflection)**

Some people are reluctant to consider that they have problems. They use avoidant strategies both when filling out the Accuchek and when describing their everyday life with diabetes. They try to minimise any problems.

Patient: 'Yes I am determined to not let it get to me. Yes, I go in the clinic and they go on about my blood sugar but I walk away and not let myself get upset.' This is maladaptive behaviour in relation to his diabetes

The therapist will need at some time to get underneath this avoidance in order to elicit the problems that they have.

Therapist: 'Can you tell me more about how you are able to put things that might worry other people to the back of your mind- you mentioned how you did this with blood glucose. Do you do it with other things in life?' **(Open question).**

Let the patient talk a little. You may follow on this conversation with:

Therapist: 'It sounds as if you have found it a useful strategy for coping'

Therapist: 'From what you have told me it works well for you are there any occasions when it does not work so well, that it has got you in trouble'

Here you are trying to raise some ambivalence about avoidance-evocation about behaviour which is linked to suboptimal control . You have let him tell you the good side of this strategy and you now know where the resistance lies, now find out the bad side of this strategy with the following open question.

Therapist: 'Can you please tell me more about when it has not worked as well for you' etc

Elaborate on this as much as possible, get specific examples, reflect on these. You then may want to give a double sided reflection such as the following.

Therapist: 'So for some aspects of life you have found that it is best to ignore problems and for other things sweeping it under the carpet, laughing it off may not be as appropriate'

Use reflection and open questioning to get as complete a picture as possible about their behaviour in relationship to monitoring blood sugar as this is the **main target behaviour** in this study.

Patient: I hate doing my blood sugar every time I do it I feel horrid.

Therapist: Can you tell me some more about that please?

Patient: Well it feels as if I am doing an exam and that I am being judged. So often I do it and it is wrong.

Therapist: It sounds as if you are the sort of person that does not like to make mistakes. That often goes with being a perfectionist. Is that how people would describe you?

You might follow this conversation by examining whether and if she is a perfectionist in other areas of life. This could lead into a conversation about some of the helpful and not so helpful aspects of perfectionism.

Patient: I've got no confidence in managing my sugar. I am so confused.

Therapist: It is hard when you get so many mixed messages about how to control your blood sugar. At times you get treated like a child and told not to eat cake. At other times you are expected to manage your diabetes mellitus completely out of the normal context such as when you were on the hospital ward. You must feel a bit like the story of clever Hans possibly doing the right thing but at the wrong time. It's often impossible to micro manage diabetes mellitus control.

Patient: Yes the normal rules don't always apply. I thought because in hospital I wasn't doing any exercise therefore I had no (or less) need for insulin. So that's what I did but then my sugars were high then the diabetic consultant came by and seemed to explode because my diabetes mellitus was badly controlled.

Therapist: I can see why you get to lose confidence. It is hard to mind read what is necessary for your insulin and glucose needs of your body all the time. It seems unfair to expect you to be able to think of what is happening inside your body for example, with tissue repair and stress hormones. You were

not given any help and information to understand that the demand for insulin and glucose might be higher because of that **(complex refection).**

Patient: Yes sometimes I feel like giving up.

Therapist: It gets dispiriting trying to second guess your physiology all the time **(complex refection).**

Your role as a therapist is to act a little as detective in order to understand why your patient has problems with their sugar control. You need to be alert to any area of possible difficulties and to note and reflect on it. You will need to zoom in on areas which are coloured by negative emotions. Men in particular seem to find it more difficult to open up about their emotional reactions and impact of diabetes and seem to prefer to focus on cognitive aspects for example by engaging the therapists in prolonged discussions about the minutia of the regime.

Be very alert for non verbal markers of emotion. Look for little signs of sadness around the eyes which may briefly fill with tears. They may flush with embarrassment or show a slight frown. Catch the times that people look away or have a pause in the conversational flow. Watch also for abrupt changes in topic and tone when there may be a knight's move in the direction of the flow of conversation as they move away from a hot topic. Body posture can also give some clues to emotional reactions. Emotions are important as they are the fuel that can motivate change. Any change has to come from the head and the heart if it is to be long lasting. You therefore need to find the emotion and use this energy to move towards change.

You may worry that discussing some of the emotional issues in your patients life might be straying from your agenda which is to bring about good control of the diabetes. There are several reasons for doing this. Stress and negative emotions are critically important in the control of diabetes. Stress leads to the release of noradrenaline, adrenal and cortisol which act to counter insulin and sugar control. Also negative emotions lead to a loss of energy and drive and thus difficulty implementing all the extra tasks that good diabetes control entails. Therefore coping with stress is a key aspect of good diabetes mellitus control. In some cases the level of emotional distress is so high and complex that specialist skills are required.

Here is a reflection that was used with one patient who noted that the interactions with her husband were very stressful.

Therapist: 'It must be hard to have so much stress relating to your husband. It sounds as if the mixed feelings that you have about this are difficult to manage. Part of you finds some of his attitudes and values so at odds with your own that you would want no more to do with him but another part knows that as the father of your children it will be important for him to have some role in your life.' **(double sided i.e. complex reflection)**

Therapist: 'How do you try to resolve that balance and stop the hassles involved getting to you? '

This **elicits** talk about how the person is able to cope and manage stress which is important to then give them the energy to then focus on caring for their diabetes.

It may be difficult for you as a therapist to hear about the negative aspects of their life. Often people with diabetes have closer contact with deaths and morbidity in their everyday experience. They may know of people who have coped badly with their diabetes. When you start doing mi you may be worried about focussing on these

negative areas. You may wonder whether it is as if you are 'rubbing their noses in it' and doing them a disservice in talking about it. However acknowledging the grief and sadness and showing empathy is helpful and follows the spirit of motivational interviewing.

In such a case where a depressed mood is very dominant you will aim to focus on target behaviours that will reduce the low mood, which in turn will give your patient more energy to get better diabetes mellitus control. Thus you might be want to elicit ideas about how they can improve their mood (You will be looking to see if you can shape and model talk about positive coping strategies for low mood e.g. pleasant activity scheduling, exercise, social support etc).

Therapist: 'It sounds horrible to have that nameless dread hanging over you. It must be terribly frightening and sad when you think about those people you have known that have died'.

Therapist: 'When your mood is low it is impossible to have the energy and resilience needed for good diabetes mellitus control. What strategies do you have to improve your mood to build up more energy?

When someone is depressed and full of gloom help them to find some positives about themselves and give feedback that can improve their self efficacy.

Therapist: 'I am impressed that despite feeling so bad that you have made the effort to come here today and have the courage to understand things more' **(collaboration and affirmation)**

or

Therapist: 'Despite feeling so bad there is a small part of you that thinks that you can be helped and has the courage and curiosity to go for this'. **(Complex reflection and affirmation)**

In some cases people are able to be articulate about their emotional problems. In other cases it is important to attend to the non verbal expression of emotions such as the case of Susan who burst into tears immediately on coming into the session

Therapist: It seems so upsetting to enter the room and see me and to think that you've got to concentrate on the diabetes. **(Therapist reflects on the underlying meaning of Susan's distress at coming to discus her diabetes).**

Susan: I feel overwhelmed by my diabetes. I can't work and also control my diabetes.

Therapist: 'It must be so frustrating that you can't get your diabetes under better control now you are at work. It looks as if the expectations and goals that have been set were wrong. I was misled to let you continue with the expectation that you had the energy to do both'.

Susan: *More tears*

Therapist: 'I think we as the medical team may have set you an impossible task. It is impossible to get reasonable control of diabetes if you are extremely highly aroused. High levels of arousal and stress release adrenalin which would just constantly antagonise the insulin and make the control more brittle. From what you have told me you have arousal levels that are off the roof. You avoid going to sleep, because then you get flashbacks in

images and memories of the past trauma you experienced. I think giving you help to manage the symptoms of this past trauma might be an important first step maybe before we go for control of your diabetes mellitus. What do you think about that?' **(Complex refection and affirmation)**

Reflection not questions

One of the important cornerstones of motivational interviewing is to use the skill of reflective listening. The essence of this is to listen carefully to what is said and to reflect it back slightly modified or reformed. If it is possible name the explicit or implicit emotion behind 'hot' statements and to capture some of the meaning and implications about what your patient is saying. You may be able to over or understate their comment in order to evoke thoughts of change. Alternatively you may only reinforce that aspect of their talk that leads to change. Metaphors are a useful way of capturing what it is they are trying to say. **These latter strategies are complex reflections. A high ratio of complex to simple reflections is a marker of competent motivational interviewing**.

An important part of motivational interviewing is to develop high levels of empathy in which the therapist conveys a spirit of collaboration and acceptance. Reflections are an important way to build this sort of relationship. Try as much as possible not to use questions but to use reflecting statements. **A high ratio of reflections to questions is a marker of competent motivational interviewing**.

Avoid phrases such as, 'How did that make you feel?' Many people with poor treatment adherence block off and avoid thinking about how they feel both somatically and emotionally and so you are asking them to do an impossible task. Use your own experience and ability to talk about emotions to make a hypothesis of what it is like for them.

'It sounds as if you are saying that….

'It is as if ……

'I am not sure but you seem to be saying

These sorts of stems allow for the degree of uncertainty but do not ask questions. You may worry that giving a reflection rather that a question does not show respect. However a functional analysis of many transcripts has found that reflection and not questions are more motivational.

Dealing with resistance

Resistant behaviours within treatment such as arguing, interrupting, denying a problem, side tracking are associated with a poor outcome. The extent to which these behaviours persist depends to a large extent on you. You need to develop strategies to deflect or sidestep resistance rather than getting embroiled in a battle, arguing back or confronting. Many therapy sessions with people who do not want to change cause therapists to fall into this trap for about 10-15% of a session. However even a small dip into the confrontation/resistance trap can have adverse effects on the outcome of your intervention. **Any confrontation, direction and giving advice without getting permission is defined as a non MI adherent behaviour**.

E.g.

'Checking your blood sugar before and two hours after each meal is best to begin with'

(which is not motivational interviewing compatible).

If you meet with resistance either give a simple reflection or try to shift the focus with a complex reflection by using mplification. Another strategy is to use a double-sided reflection in which you balance the reflection of the lack of concern with a previously voiced statement of concern. Never meet resistance head on. Another way to handle resistance is to help your patient perceive things in a new light. For example, statements from friends and family can be reframed to show concern and warmth rather than criticism or hostility. Problems are re-looked at a positive or optimistic light

A good response if you hear any counter change comments (resistance) is to use double sided reflection and say something like:

Therapist: 'Part of you does not want to be deprived of food. There is another part that is less sure how reasonable a position that is and wants to care for your diabetes and your health and well being'

This is a simple form of double sided reflection which does not require you to scrabble around trying to think of some pro change statements they have said before (although these work well too). Work on the assumption that even if they have not been explicit about it they will be ambivalent about some of their unhealthy behaviours otherwise they would not be there with you. So always talk as if there is a part of them however small that wants to have a better relationship with their diabetes.

Affirmation increasing self efficacy

No matter how motivated someone might be to change unless they believe that they have the capability to change they will not embark upon the process. Often people with diabetes mellitus have low self esteem. Being labelled as someone with a chronic illness decreases their sense of self worth. It is helpful if the therapist can use any possible opportunity to put a positive spin on what their patient self discloses and what this means about them as a person. The Accuchek focuses on painful aspects of diabetes and so warmth within the session counterbalances this especially if it is reinforced by strategies to increase their self esteem. Try not just to use simple adjectives such as 'good' and 'well done', 'how good you are being' which sound patronising rather think about the deeper meaning. Also do not use terms like 'good control of diabetes, being good with your diabetes or being bad with your diabetes' etc. These all have an implicit moral model and it is putting you in the powerful, expert, God like position. The downside of that is that it leads to the emotions of shame and humiliation when people are not able to come up to scratch. Give more empathetic responses throughout all phases of the intervention.

In the first phase of the intervention you can give reinforcement for them joining the study with self-efficacy affirmations such as the following.

1. 'You are obviously the sort of person who is curious and wants to understand more, that is why you are here today'.
2. 'You are the sort of person who has an interest in making sure that your experience can be used to help others that is why you are here today'.
3. 'You are the sort of person who has given time to help reflect both on yourself and to help the broader diabetes mellitus community'.

Later in the intervention when discussing some of the difficulties of blood glucose control or giving feedback the following phrases might be helpful.

‘It’s tough and confusing to have to take on the role of a pancreas’

‘It sounds like you are getting your head around what it is like to be a pancreas’.

‘I think you have shown great courage in being open to consider the difficulties you are having’

‘You obviously have a very loving family and that will be a source of great strength to you.’

Patient: ‘It’s OK I can live with the diabetes no problem. It’s the complications I don’t like’

Therapist: ‘You have been able to find solutions and resources to enable you to live with your diabetes (start with a positive spin) however what you have to cope with evolves over your life course. This means that you have to find more resources and adjust again which can be difficult. I wonder if we reflect back on how you adjusted and coped in the past we can learn what works for you.’ (This end with the idea that there is hope and that they are the sort of person who can cope and adjust) It also evokes with pro change and pro coping strategies.

Rather than using words such as good and bad perhaps you can comment on them being curious, reflective, courageous, or resilient. It is worth sitting down and thinking about what is involved in their day to day life and think of adjectives that describe the sort person they have to be. People with diabetes mellitus have to cope with a large amount of hassle and difficulty in their life. They survive by mastering a variety of skills and resources in order to cope with a life threatening situation.

The following examples illustrate the sort of reflection that can be relevant.

‘You sound like:

1. the sort of person who does not like to be thought of as grumpy
2. the sort of person that people can give feedback to
3. the sort of person that reflects on what people say to him’.

It may be useful to make an assessment of self-efficacy in relation to change by using questions such as:

‘What makes you think if you decide to improve your diabetes self care you could do it?’

‘What do you think would work for you if you decided to improve your diabetes self care?’

‘Have you known any one else who has good diabetes self care? Would it be possible for you be able to follow in their footsteps?’ What do they do?

When and if they have taken steps to put some goal into place again try to say more than good or well done. The following stems may give you ideas.

1. I am really impressed that you managed to …
2. It must have taken a lot of effort to ……
3. It must have been really scary….
4. I am curious as to how you were able.. please tell me
5. Tell me more about…

6. I think it is amazing that you have been able to develop calm acceptance …. Etc etc
7. It is not easy to be mindful of your diabetes mellitus, how exactly did you ……'.

Feedback

Once the Accuchek is finished a summary is generated. Feedback of this summary can be done at the end of the first session and can also be repeated at the beginning of the next session. In addition to the Accuchek summary at this time also feedback about their HbA_{1C} **(the reason and target outcome they were recruited into the study).**

Therapist: 'One of the reasons that you were chosen to be in the trial was that your blood glucose lit up an amber/red on our system. We need to add this to the Accuchek summary when you decide what you would like to work on in these sessions'

Therapist: Your HbA_{1C} at 12 was in the red. What this means is that that your average blood sugar runs at 18. Of course an average covers a lot. It may be that you are swinging between hypos and highs. Sometimes may of the highs are at night when you do not measure your sugar. It can be confusing.

The advantage of this last feedback comment is that it gives people an outlet to save face. It does not sound so confrontational.

The Accuchek does not cover all areas that cause concern for people with diabetes mellitus. For example one man commented that the domain of sexual function was not mentioned. He said that as it is difficult to talk about it should be specifically mentioned. We have a simple diagram in the workbook which contains the domains of the Accuchek and additional areas that our patients have talked about and blanks so that people can fill in on areas that are important for them

Therapist: 'We realise that the Accuchek does not focus on all the areas that are relevant for everybody so we have made a flower diagram which illustrates the common domains. Sex roles and function, motherhood and potency are common problem areas that the Accuchek does not ask about. There are also blank spaces for you to fill in topics that might be relevant to you.'

Patient: 'It's not easy to know what to do as a mother. I don't want him to have to care for me so I have not told him about the diabetes. I let him play downstairs in the morning until I get up. I have a feeling of threat hanging over my head. I could be unconscious in bed all morning and nobody would know.'

Therapist: 'That sounds terrifying it must be difficult to be a parent and to know when, what and how it is appropriate to tell your child about your diabetes mellitus. (**complex reflection)** How much should you let him know and how much should be kept secret?' **(open question)**

Initial conceptualisation

At the end of the first assessment it is helpful to orally summarise what has been discussed in the session. Giving feedback is a useful technique to overcome the resistance to improving self-care in diabetes mellitus but it has to be carefully judged.

The summarising statements after your patient have said something is an example of the micro process of feedback. Macro levels of feedback are also useful. During the assessment procedure, it is helpful to recap on problems that have been discussed.

Therapist: 'So, to summarise, your family have been concerned about your health. You have become more irritable with your family'. **(A volley of simple reflections). There is no need to make very long summaries another marker of competent MI is the ratio of client to therapist talk time.**

It is helpful to acknowledge that they probably are ambivalent about coming for sessions with a focus on diabetes self care and have mixed feelings about it. Questions, which may help open up about these issues are :

Therapist: 'You may have been in two minds about paying more attention to your diabetes self management. What are the things you fear you may lose or will be problems for you if you pay more attention to your diabetes mellitus self management?' **(This question evokes a discussion around the key factors in the decisional balance about change).**

'We often find that people who come for help with diabetes mellitus self management have mixed feelings about it. Have you experienced anything like that?'

'What do you think will happen if you don't give diabetes mellitus self management your best shot?

'Why do you think you might want to make a change in you diabetes mellitus self care?'

The next stage is to introduce the workbook. It is good practice to set outline the tasks within the workbook in advance so that they can have time to reflect on and think about the issues involved. However this has to be done within the MI spirit. You do not want to demand that they do these tasks but rather indicate that they can be something that can help them be more curious, mindful and reflective.

Therapist: 'We have had a conversation today guided by the computerised programme. The next stage of the protocol in the following sessions to have more open ended conversations based on your thoughts on various topics in this work book.

Therapist: 'The workbook sketches out a few ideas which may be a helpful focus for our work together. Some people like to stick to the framework of the workbook. Others prefer to be less constrained and write letters in a notebook or draw sketches. Having mixed feelings or being in two (or more) minds about diabetes mellitus self care is confusing. The working space of the brain cannot cope with contradictory and complex information and so it can be helpful to use writing and paper as a tool. The evidence suggests that it is helpful to play with these tools, but of course it may not work for you.

Therapist: 'We have found that people find it beneficial if they can reflect on their diabetes out of the one to one context. These are topic guides that can help that process'.

Therapist: 'Does that sound OK. You are welcome to take it off into any direction that suits you. Is there any thing you would like to ask me about that?'

Encourage your patient to write spontaneously and intuitively. The accounts should be subjective and may contain irrational thoughts. Make it clear that you are not interested in matters of style, spelling, grammar, sentences etc. Indeed indicate that you would be pleased if the written work is somewhat incoherent. If it is somewhat confused it will be a more accurate reflection of the mixed feelings that are most common. A polished idealised letter may be a form of defence. No spelling mistakes may mean that their compensatory strategies such as perfectionism are coming to the fore. The aim of the worksheets is to raise their curiosity and to make space and opportunity to reflect and think. They do not need to do exactly what the book or workbook recommends. Leave an element of choice.

It is best practice to encourage your patient to do the written exercises at home. However the task is not done you could offer time within the session to write a few notes. The therapists have been very creative in helping the patient with the written task not making it an added burden, e.g.

1. Going out to make a cup of tea to share whilst the patient does it.
2. Letting the patient talk and then writing down a summary which is shared, etc.

Session 2

There are several opening gambits that you can use for this session. One would be to ask about what had been recalled or reflected on from the last session, or what they had talked to their partner about afterwards. You can then turn to the summary from the Accuchek and ask whether that accurately reflected their thoughts about their quality of life. It is also a good idea to check whether the task that they highlighted on the Accutest is one that they still considered that they wanted to change. It is worth emphasising that the process is in their hands and that it is entirely up to them what, where and how they want to use the time and opportunity.

You may want to offer the flower diagram as an illustration of other options of goals that they might want to work on. Once a target for change has been identified you may want to establish where your patient is on his/her pathway to change. A simple way to do this is to use readiness rulers on Work sheet 1 and ask what score they would give themselves. This closed question elicits a large amount of change talk and is a useful way to keep the content of the session in the spirit of motivational interviewing.

This readiness ruler is a useful starting point to obtain useful information about what strategies might be needed to facilitate change. Questions that are useful when using these rulers are something like:

Therapist: ‘You have not given yourself 0 so there is part of you that is aware of wanting …… Can you tell me more about that’ etc.

This is quite a good starter as it opens the arena to your patient to make pro change, motivational statements. In turn this can open the way for you to make statements that affirm or support their pro change efforts. You can praise them for their achievements so far. The more you give them the opportunity to talk about this the better.

Here are some further questions that might be of use to explore willingness to change **(remember however not to ask several questions in a row and keep the flow going longer by using reflections):**

1. 'It is interesting that you have given yourself x. Why have you given yourself that rather than 1 or 10?'
2. 'What would have to happen for you to move from x to 10?'
3. 'What would you need from me to help you move from x to 10?'
4. 'Have you ever been at 1? What helped you to move from 1 to x?'
5. 'What would you need from your family or friends to help you move from x to 10?'
6. If you had a friend who gave themselves that score what sort of advice would you give them to help them to move towards 10?
7. What are the good things about x behaviour? What are some of the less good things about x behaviour?
8. What concerns do you have about x behaviour?
9. If you were to change what would it be like?

Wanting to change is only part of the equation; the other part is how much they feel that they are able and confident that they could change. Follow a similar process with these additional rulers.

Here are some questions that can be used to explore their ability to change

1. What would make you more confident about making these changes?
2. Why have you given yourself x score for confidence?
3. How could you go up higher so that your score goes from x to y?
4. How can I or anybody else help you succeed?
5. Is there anything that you have found from previous attempts reduces your ability to change?
6. Is there anything that you found helpful in any previous attempts to change?
7. What have you learned from the way things went wrong last time you tried?
8. If you decided to change what might your options be? Do you know of any ways that have worked for other people?
9. What are the practical things you would need to do to achieve this goal? Are they achievable?
10. Is there anything you can think of that would make you feel more confident?

You might want to adapt these rulers and examine how much the family, close others and doctors want them to change.

Here are some questions that can be used in this scenario.

1. 'Who exactly is driving the move to change?'
2. 'How do they do indicate that they want change'
3. 'Would those who are driving change want to come to meet with you so that you

can work together'?

It can be helpful to give these simple pen and paper task at regular intervals over the 4 sessions and to plot the changes in these over time. Also it may be of interest to use these rulers with different behaviours (sub-goals of the final target behaviour) that they may want to work on.

Typical day question

There are several types of questions that can move therapy on if it appears to be getting stuck and which may help build up the alliance and increase empathy. One is to ask about a typical day (you might want to specify a work or weekend day).

'I wonder whether you can walk me through a typical working day with your diabetes mellitus self-management (eg blood test, insulin, meals –what, activity, relationships) and how your diabetes impacts of this. How does this compare with a typical weekend day? This will give you more information about their life situation.

At the end of the second session introduce the self reflection task (please avoid the use of the word homework it is too judgemental and also in order to stay within the spirit of motivational interviewing it is important not to be directive). This is to set the task to write freely for 10 minutes on these 2 topics 'What it is like to live with diabetes mellitus?' 'What it is like to live with diabetes mellitus in my family?' Explain that the Accuchek approach gives a very structured approach to diabetes mellitus management and only considers certain domains of life, but you are aware that it is much more complex than that and that how any individual interacts and develops a relationship with the illness is unique and complex. Give them some free space to write down whatever comes to their mind on these topics. There is no wrong or right answer this is an opportunity for them to freely express themselves and be playful. It might be helpful; to spend some time planning how they will implement this. Get them to tell you how, where and when they will do this. Ideally they should plan to be in a private space and uninterrupted doing these tasks.

Going over Worksheet 2

Spend some time with Worksheet 2, 'What it is like to live with diabetes mellitus'. This task usually which usually focuses on the negative aspects of living with diabetes mellitus. It is in this area that your patient is the expert and you are the amateur. You need to use a large measure of reflective listening to understand the meaning of diabetes mellitus and how it fits with wider aspects and values of living. Worksheet 2 will give you information that is essential to your formulation.

The probes for this area if your patient has chosen not to work alone are:

In what way has your diabetes mellitus self care affected your physical health?

In what way has your diabetes mellitus self care affected your psychological health?

In what way has your diabetes mellitus self care affected your family life?

In what way has your diabetes mellitus self care affected your social life?

In what way has your diabetes mellitus self care affected your romantic life?

In what way has your diabetes mellitus self care affected your education and career?

In what way has your diabetes mellitus self care affected your spiritual life?

Has your diabetes mellitus self care interfered with your financial security or got you in trouble with the law?

(Remember to intersperse these questions with reflections). You need more reflections than questions to qualify for competent in motivational interviewing.

Overall do you have concerns about any aspect of your diabetes self care that had not been covered earlier?

If there are difficulties in getting the task done explore the reasons for this and then offer to give time in the session or say you will write down what comes to mind and then reflect on this later. You may want to give a few prompts and cues which may normalise their experiences and ask about particular problem areas such as the following:

1. Psychological Health: Low mood, irritability.
2. Social Life: Disinterest. Difficult to join in with groups.
3. Romantic Life: Disinterest. No libido, impotence.
4. Family: Anger, anxiety, and frustration.
5. Career: Poor concentration, stigma.

The part of the exercise 'What it is like to live with diabetes mellitus in my family' may give some insight into the social aspects that facilitate avoidance of effective self management

At the end of this session you can offer the self reflective task for the next session which can be to write an account of, 'What life would be like without having to care about diabetes mellitus in your life (for self and family)'. Often people find this task difficult and they might prefer to just to the alternative letter which is to spend some time discussing their ideal self. Discuss how to they would be able to implement this task during their week.

Your aim during your sessions is to build up a discrepancy between giving themselves optimal diabetes self care and their overall values and goals. Alternative questions that can build up such a dissonance about undertaking diabetes self care may be the following

'What do you anticipate the difficulties would be if you started the habit of monitoring your glucose regularly?'

'What problems might arise if you increased your exercise each day'?

By raising the issue of obstacles and road blocks to better diabetes self care you can the ask them to generate solutions to these problems.

'How would you be able to create the time and space to do …….on a habitual level.'

We have noticed that in some of these letters about diabetes that many patients notice that a spiritual element sustains them and gives them an energy and resource. For example, many people note the fact that they would have died without insulin and so they are able to reframe their life to think that every day following their diabetes is a gift. You can use this as a lead to elicit some positive statements and to reframe their experience. The following are examples:

1. ‘What we find people tell us is that living with diabetes mellitus makes people think on a deeper/ more spiritual/ less superficial level and think about the things that have a deeper meaning. Do you think like that at times?’
2. ‘Being close to death which is what happens with acute diabetes mellitus is can put life in perspective’. Has that happened to you?

You would then follow on with reflective listening which would build upon this and reframe their experience of self management of diabetes mellitus as a gift and blessing rather than a curse or chore. This is often a good time to get people to think about the values that are important in their life. There is an additional work sheet that is available that lists various values. It can be a good motivational exercise to ask people to rank their top 4 or 5 values that are relevant to them and then to follow on by asking. How do the values that you have ranked high play themselves out in your everyday life? Does subopti diabetes mellitus self-management interfere with your living with those values?

Other things you can comment on positively is the need for them to have developed good coping skills.

1. ‘Having to have your brain take over from your pancreas certainly gives it a lot of exercise you have to be creative and resourceful.’
2. Living with diabetes mellitus means that you get good practice at multi tasking.
3. ‘Living with diabetes mellitus means that you have to learn how to guide others to be helpful to you if you can. You have experience of how reactions between people can be helpful or not so helpful. (Doctors and nurses can be the worst!)’
4. Living with diabetes means that you have to be able to step above getting caught in the moment and develop an overview, the long shot view of life.

Session 4: Worksheet 3.

The account of what life would be like without diabetes mellitus in your life (for self and family) allows people to reflect on what are the positive aspects they might get out of avoiding having a focus on the management of their diabetes. It is helpful to elicit both what might be positive about neglecting their diabetes self care and also what might be negative about changing and putting more effort into diabetes self care. These are the elements of resistance, the enemies of change. Once you have identified your enemies then you can think of ways of making them less powerful. Thus once areas of resistance appear try to explore them in detail with reflective listening as this these will help to build up the discrepancy and the balance of pros and cons which relate to looking after their diabetes care. The aim will be to make these positive aspects in relation to avoidance or whatever process is going on less relevant or to discount it in some ways. Your aim is to juggle with these mixed feelings and to shift the balance so that the any positive aspects of having a greater focus on health will outweigh the negative.

These written tasks often can help clarify the positives and negatives of the diabetes self care. We find that these tasks can sharpen the focus on the negative aspects of their current behaviour. It can be helpful to be able to examine some of their core values and beliefs. This can then open up the opportunity to explore and reflect the discrepancy between their current behaviour and their optimal functioning .The person with diabetes response to this exercise may help you understand what skills they will need to develop

and what steps they will need to take to give him/her confidence about undertaking change.

Session 4. Commitment to change

Your goal at the end of the four sessions will be to have the person with diabetes mellitus to be able to make a commitment to making some change in relationship with their self-management of their diabetes for the long term. It is important not to rush into this task prematurely. We often find that people may make many changes after the first session. If they have made changes earlier you might want to suggest that they look at the page detailing commitment to change. This is a template for eliciting change talk about how they can move into maintenance. It is a good idea to frame the move into change behaviour as an experiment rather than to prematurely focus on it as if it will be the permanent way.

'It's great that you have moved into checking your blood sugar more regularly. We can use this as an experiment to explore what are the good and less good aspects of this and to reflect more widely around it'

Sometimes even after 4 sessions it will not have been possible to guide your patient into an action stage about having a greater focus on their diabetes self management. In such a case it is best to leave the idea open and something the person may want to think about later. Remind them (and yourself) that it is entirely up to them if and when they want to focus more on diabetes mellitus self management.

Goal setting – targets for behaviour change

Goal setting is a cognitive behavioural therapy technique that can be used once people are in action when they really want to consolidate their changes. In motivational interviewing you will not be pushing for this but your overall agenda would be to encourage your patient to develop idea about doing this for themselves. Do not try to push or direct your patient into any kind of action too soon. Do not transfer from your CBT skills the habit of setting a goal of some behaviour change at the end of each session. **Directing the patient or giving advice without permission is a strategy that runs counter to motivational interviewing.** Such statements counteract any pro change statements you might have been able to elicit in the session. Obviously if your patient has set their own goals (We have found that this often happens after the first session) and has demonstrated that they are in action then you will want to be positive and reinforce that behaviour as much as possible. However it is wise to frame it as an experiment and to use motivational strategies, reflection, elicit, advise with permission etc to explore it more.

'It is impressive that you have been able to explore the idea of optimising diabetes self care by putting some changes into practice**. (Affirmation which is a motivational interviewing adherent behaviour).** This gives us lots more information about what this will mean for you. What have you noticed so far?

(This will elicit more ideas about what change into improved diabetes care will mean).

Knowledge about what works best with goal setting and implementation is useful to have as a background context. These will be interim target behaviours that you might want to help them focus down on (**Remember do not give direct advice unless you asked permission first as this runs counter to motivational interviewing.)**

For example, the best way to manage a lifestyle change is to introduce small steps into everyday activity. With exercise there are simple non expensive ways to include more exercise into life e.g. walking once round the block before and after going to pub, getting off a bus a stop earlier, always using steps not lift, gardening, dancing etc. Do not just have a blinkered idea about going to the gym as the one and only way to add in exercise. Another idea to have in the back of your mind is that they might be able to get a reduced rate at some leisure centres with a doctor's letter. It is something they could explore.

If and when you hear any core value or goal which means living more healthily and optimising diabetes mellitus self care go for it and elaborate on it as much as you can. This is something that they will want to change for and you can come back to it later when working to plan for change.

The following statement illustrates how the therapist aims to shape the form of the conversation to include goal setting as a possible later agenda.

Patient: 'I am not worried about myself I have a fatalistic attitude. If it's my time to go that's it. But my daughter is 2 and I would like to see her married'.

Therapist: 'So you want to be able to give your daughter away into safe hands?

Reflect on his positive goal **(Complex reflection as it is emphasising change in one direction. Here the therapist ignores his statement which dismisses the importance of caring for his health and focuses on a goal and value that is important to him. This makes it a complex reflection as it enlarges upon his statement and changes the direction of the talk. It encourages him to talk more about pro change and self-care topics.)**

Therapist: 'You have seen enough of life/reflected enough on life to realise that one's offspring require parenting/fathering for a long time. The research evidence would support you on that.' Positive affirmation supporting the importance of this goal for health for him

Therapist: 'I guess the odds are that she would marry by 30. So it sounds as if an important goal for you is to be as healthy as possible for the next 28 years. How do you think you could do that? Would there be any things you could do to optimise the chances of you reaching this goal?'

(This reflection and open question is aimed at eliciting pro change statements from him). This sequence gives a great deal of time and attention to values reacting to change.

Another common way of reacting to setting goals for blood glucose monitoring is for patients to go to extremes.

Patient: 'If I start testing my blood then I get compulsive, retesting, it all the time. It becomes too much I can't keep it up then I stop it. It's all or none for me.

Therapist: 'It sounds as if you are person who goes very much to extremes…..It is as if you either try to be very good like the girl with the curl but then you end up being naughty and horrid!! ……Does this intermittent type perfectionism affect other aspects of life?

This is a complex reflection as it introduces a metaphor which highlights her maladaptive pattern of behaviour. This could be explored further by reflective listening and then building up discrepancy between the advantages and

disadvantages of this type of behaviour.

Patient: 'Yes I do it will my study at Uni. I do not do much during term time and then I retreat and isolate myself for exams and stay up all night revising.'

Therapist: 'It sounds as if going to extremes i.e. pulling out all the stops at exam time and working like a slave and then at other times during term letting of steam has worked pretty well for you academically so far and now you are less certain whether this pattern would translate into your general working life as a doctor when you have to perform to a 'good enough' level more consistently'. (**complex double sided reflection)**

The following example is another example in which goal setting is planned

Patient: 'I think if I decide to check my blood sugar I will gradually increase the number of times I do it each day. I cannot imagine myself starting off by doing it perfectly.'

Therapist: 'That is a evidence based approach you are thinking about. In behaviour change we are told that people need to set themselves small, but achievable goals. It is important to be sure that the goal is not too big and that you can successfully accomplish it. Nothing is more motivating than success or as anti motivational and dispiriting as failure. Therefore the secret of successful behaviour change is to set yourself the correct sized goals, too big and you fail, too small and you may dismiss and neglect your achievement. Try to emulate Goldilocks and get it just right!, but it may like her, need trial and error' **(Affirmation with attention given to goal setting)**

Patient: I do want to remain well to see my daughter gets married. However thinking of the next 20 years testing my sugar every day seems like purgatory

Therapist: 'Is it OK if I make a suggestion? Did you watch or hear about the film, 'Touching the void'. A climber with a broken leg, hunger, thirst and exhaustion was able to keep going by setting himself simple goals. He set himself targets to reach on the glacier in 20 minute time periods. It is a good idea to break up a large task into smaller bite sized pieces. (**Advice with permission)**

Therapist: Would it be OK if I gave suggestions. Some people find it a good idea to give yourself planned holiday from doing some of your tasks such as monitoring your blood glucose. Plan for a holiday one or more days a week. If you take a planned break it is easier to get back into it than if your gradually lapse which saps away at your self confidence. (**Advice with permission)**

Making dietary change

It can be difficult for people to translate healthy eating into other cultures. Nutritional knowledge such as what is the glycaemic index of various food items is very complex. (Many dieticians have to look it up from a web site). It is not appropriate to push pasta on a West Indian who wants to eat yams. Empathise with such a man.

Therapist: It must be very difficult and confusing to know what to do about your diet. Probably so much of the information is written for diabetes mellitus about European diets. You must be uncertain how this translates to West Indian food. For example, are yams, plantain and bread fruit good because they are fruit and vegetables or bad because they have carbohydrate. Have you been able to get the information that you want about this from the dieticians attached to the unit?

Highlight their use of behaviour change strategies

If your patient tells you that they are doing things that you recognise to be part of CBT or other behaviour change advice, make sure you emphasise what they are doing. This is an affirmation of change behaviour. Stop the conversational flow to congratulate them that they have discovered what psychology text books teach as a strategy for behaviour change. Name what the technique is and encourage them to use it more. For example, patients often state that living with diabetes makes them more aware of their health and the need to adopt a healthy lifestyle. If you hear this from your patient congratulate them on the use of 'reframing'.

Patient: 'Having my diabetes has made me more health conscious. My daughter said to me I am so glad you are my mummy because you think about a healthy diet and going to the gym, not like my aunts who are fat and lazy'.

Therapist: 'It is impressive that you are able to see the full half of the glass when you talk about your diabetes. Your common sense has led you to use a strategy that is taught as part of CBT. As you may know one of he essential elements of CBT is to modify thoughts with the aim of enhancing emotional well being. You have just illustrated one of these approaches which is called reframing. You have worked to shape your thoughts about diabetes to focus on the positive rather than negative (glass half full rather than half empty). This will serve to keep your mood high, buffer you from hassles and give you the energy to take the necessary steps to implement the behaviours that are necessary for good diabetes control'.

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