Motivational interviewing for midwives: creating ‘enabling’ conversations with women

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Effective communication skills are critical to the role of the midwife and identified by women as one of the most important attributes of a ‘good midwife’ (Nicholls & Webb 2006, Carolan 2011). Women particularly value midwives who are good listeners, able to put them at ease, and empathetic. However, midwives report that having ‘enabling conversations’ with women about behavioural issues such as obesity, smoking, and substance use is often difficult (Randall 2009, Schmied et al 2011).

Introduction

Antenatal care is an opportune time to address lifestyle choices and behaviours that negatively affect health; evidence suggests women are motivated during pregnancy to make positive changes that are likely to benefit their baby (Herzig et al 2006). Although midwives accept that they have an important role to play in health promotion, evidence suggests that they lack confidence, resources, time, experience and ability, and hold a belief that their messages do not ultimately change the woman’s behaviour (Randall 2009, Schmied et al 2011).

Midwives are well aware that building a trusting relationship is central to providing effective care, and evidence suggests that the majority of women want a ‘special relationship’ with the midwife, based on friendship and advocacy (Fraser 1999). It is therefore no surprise to learn that midwives are often unwilling to risk this relationship by raising issues that may be perceived as critical of a woman’s lifestyle choices (Randall 2009, Schmied et al 2011). However, if behaviours that are potentially damaging to the woman’s health or her pregnancy are not broached by the midwife, the woman receives the message that such behaviours do not affect her or her baby (Furness et al 2011).

In this article we explain how the principles of Motivational Interviewing (MI) can be used to open up ‘difficult’ conversations with women, using examples from practice. Our own experience of introducing midwives to MI in New South Wales, Australia has been enlightening and inspiring in terms of achieving change in a variety of settings, and we are enthusiastic about promoting this form of communication for midwifery practice.

Simply delivering a message does not guarantee that it will be received or acted upon. Furber (2000), suggests that a ‘traditional’ approach to health education based on information and advice is largely ineffective, with reported success rates of only 5–10% (Bien et al 1993), as knowledge alone rarely leads to change. Suggestions have been made in the literature that midwives would benefit from additional training in communication skills, such as MI, to fulfill their health promotion role (Everett-Murphy et al 2011, Biro et al 2013). Over the past decade MI has received particular interest as a brief intervention that is particularly helpful in supporting decision making and overcoming resistance to behavioural change.

What is Motivational Interviewing?

Communication styles are said to fall into three broad groups: directing (or advising), guiding or following (Rollnick et al 2008). MI is a form of communication that uses a guiding style to create a conversation about the possibility of change, sometimes known as ‘change talk’. Rollnick et al (2008) describe MI as a collaborative, person-centred way of strengthening motivation for change that is not based on advice-giving or scare tactics, and is not confrontational, forceful, guilt-ridden, or authoritarian.
MI was originally developed for addiction counselling in the 1980s and is increasingly used by a variety of health professionals to encourage many aspects of behaviour change such as:

- enhancing change with eating disorders (Dunn et al 2006)
- promoting the continuation of breastfeeding (Taveras et al 2004)
- assisting with smoking cessation (Karatay et al 2010)
- supporting increased physical activity (Bennett et al 2008)
- encouraging cardiovascular health (Thompson et al 2011).

In Australia, motivational interviewing is also receiving interest as a potential strategy for family support workers to engage more effectively with families who have complex multiple needs (Iannos & Antcliff 2013).

A meta-analysis of 119 studies where MI was used as the intervention for a range of behaviours, demonstrated that 75% of participants overall gained improvement with MI, and these were durable gains of up to one year follow up (Lundahl et al 2010). MI was also associated with positive gains for participants in measures of general well-being, such as lower stress and depression levels. Importantly, although the analysis demonstrated that for some behaviours, other or additional forms of counselling or intervention were more successful, there was no evidence that MI did any harm to the study participants, and for the majority it was helpful or very helpful.

Using Motivational Interviewing in midwifery practice

Whilst there is a body of evidence demonstrating the successful use of MI by general practitioners, psychologists, practice nurses and medical students, there are only a very small number of published studies where MI was specifically delivered by midwives. The majority of these involve midwives using MI for smoking cessation (Tappin et al 2005), and a small minority for reducing alcohol consumption (Wilson et al 2012).

This lack of evidence for MI in midwifery practice is surprising as MI is a good ‘fit’ with the partnership philosophy of midwifery, where the woman is the expert of her own needs, and the midwife acts as a guide and a resource. In terms of the diversity of midwifery practice there are also practical advantages to this form of communication; MI can take the form of a brief intervention and be used in one-to-one consultations, in groups, face-to-face or by telephone. Small-scale evaluation of MI training for midwives has been positive. One study where midwives were trained in MI to help pregnant women quit smoking in pregnancy reported that MI training gave the midwives more ‘hands-on tools’ for their daily work (Hassel & von Rahden 2007).

Developing workshops for Motivational Interviewing

Our first contact with MI occurred in 2010, when we were involved in the introduction of ‘group-based’ antenatal care for obese women in Sydney, Australia. This model of care aimed to help women limit their gestational weight gain in order to improve perinatal health outcomes (Davis et al 2012). An exploration of the literature led to the choice of MI as a communication tool to enable the midwives involved in the service to broach the subject of weight and weight gain more easily with women.

A systematic review of studies related to training for MI skills (Madson et al 2009) demonstrated that the most common (and popular) format was a workshop where short didactic sessions were followed by experiential activities, and trainees’ skills could be assessed during role play. The review also noted the importance of coaching and the availability of feedback in MI training programmes.

A workshop was subsequently developed to introduce midwives to MI prior to the implementation of the weight management model of care. The workshop was structured in line with that described as beneficial in the MI literature. The workshop was led by a nurse psychologist, trained in and currently practising MI. Each midwife received a total of eight hours of training over two days, a month apart. The purpose of having a month between sessions provided time for the midwives to gain some practical experience prior to the second session when feedback was provided, and alternative strategies discussed.

During the workshop, short theoretical sessions were followed by opportunities for the midwives to practise their skills. This involved experiential exercises such as role play or group discussion, and modelling activities such as observing others in real time or on a video. Peer or instructor feedback was provided after each segment of the workshop, and personal goal-setting was initiated as a plan for action between workshops.

Using Motivational Interviewing to promote change

The following section describes in simple terms the basic principles and conversational flow of the MI approach. Practical examples of how the technique can be used by midwives in their everyday practice are provided.
The basic principles of Motivational Interviewing

Change can be uncomfortable initially, and often requires sustained effort and support from friends and family. Moving a woman towards change is the goal. Four basic principles underpin successful MI (Iannos & Antcliff 2013). These basic principles are 'Rolling with resistance', 'Expressing empathy', 'Developing discrepancy' and 'Supporting self-sufficiency'.

Rolling with resistance

Rolling with resistance is sometimes termed 'going with the flow'. Arguing or lecturing the woman on what the midwife believes is right, sometimes referred to as the 'righting reflex' (Iannos & Antcliff 2013), should be avoided at all costs. Arguing inevitably results in increasing resistance to change. When this occurs the woman will respond 'yes but'. In this situation the conversation can easily end in deadlock with both parties feeling the other is not listening. The important thing is to maintain the relationship with the woman, with the possibility to re-visit the conversation in the future. For example:

Woman: 'Yes but I don’t really smoke that much now, some days it is only one or two.'

Midwife: 'It's great that you have been able to reduce your smoking to one or two a day.'

Expressing empathy

Expressing empathy assists in the building of a relationship with the woman. This conveys to the woman that the midwife can see her point of view, understands her, and most importantly that she is respected. Showing empathy does not, however, mean that both parties agree — differences in opinion may be held whilst demonstrating understanding and respect:

Woman: 'All my family is overweight. My husband doesn’t like salad or healthy food.'

Midwife: 'Yes it can be hard when your family and partner want to eat other types of food.'

Developing discrepancy

The motivation to make a change (or make a difficult decision) comes about when a person identifies a discrepancy between where they are now and where they want to be. Helping the woman to identify inconsistencies can result in self-realisation that can either motivate change or assist decision making.

The midwife may need to assist the woman to find this discrepancy (or inconsistency) in order to support her motivation to change, or to assist in her decision making. For example:

Midwife: ‘Being active during labour seems really important to you, but you are thinking about an epidural. How much do you know about epidurals?’

Supporting self-sufficiency

Sometimes the woman is unwilling to make a change because she lacks confidence, rather than believing the issue is unimportant. For example, a woman may believe losing weight would be important to her health but lacks confidence to be successful.

Supporting self-sufficiency, or self-confidence, is essential. The midwife can do this in two ways, by asking the woman to identify occasions where she has previously been successful, and by re-enforcing her achievements. For example:

Midwife: ‘You have done so well in reducing your smoking to five a day. When we met last time you mentioned that you had managed to quit in the past, what helped you then?’

The conversational flow

Rollnick et al (2010) describe the conversational flow of MI as asking how the person feels, listening to the response, informing (briefly!) by providing relevant information, asking how the person feels about the information, listening to the response and so on until both parties have found common ground.

Using active listening skills

The skills required for MI are not new for midwives; many midwives will be familiar with 'reflective' or 'active' listening skills. Active listening means making a conscious effort to hear not only the words but to understand the message. Active listening firstly enables the midwife to ascertain the woman’s readiness for change and lays the groundwork for building and maintaining the relationship. When active listening is combined with the basic principles of MI, the conversation between the midwife and the woman becomes an opportunity to explore the pros and cons.
of change. The following sections describe some of these opportunities.

**Open-ended questions**

Open-ended questions are a useful way to broach the topic with a woman and can also help to explore the benefits of change versus status quo, or one decision over another. They can also be valuable in assessing a woman’s knowledge and confidence — essential elements for motivation. Examples of how open-ended questions can be used can be found in Boxes 1 and 2.

**Clarification**

In order to really understand the woman’s meaning or to reiterate an important point she has made, the midwife may need to use questions to clarify the issue. It can also be helpful to the woman to hear her own words repeated back to her. Examples of clarifying questions can be found in Box 2.

**Summarising**

Summarising essentially ‘packages’ the discussion and hands it back to the woman. Summarising is a very useful active listening skill that can be used in situations where time is short, and can act as an opportunity to seek permission to document the conversation. It can be used:

- to begin or end an interview
- when transitioning to a new topic
- to provide clarity in lengthy and complex issues or statements.

**Encouragers**

Encouraging the woman to put into words how she feels can help to identify why a decision is difficult. Verbal and non-verbal cues are useful tools which encourage communication. Examples of verbal and non-verbal encouragers can be found in Box 3.

Maintaining a silence is perhaps the most powerful encourager. However, this can be hard to do as it is natural to want to fill those ‘awkward silences’. Asking a difficult or challenging question can feel quite uncomfortable but the woman often needs time to think through her response, particularly if the midwife has uncovered a challenging reality.

Having fully explored the issue, the woman may be ready to commit to making some changes. The next stage is setting some goals for change.

**Goal-setting**

The midwife can invite the woman to set some goals (they must be the woman’s and not the midwife’s!)

Midwife: ‘Can you think of any ways in which you could change...?’
Goal-setting is an important strategy in MI; even one small successful change is a step forward and has the potential to increase the woman’s confidence. Equally, failing to meet goals can be damaging to the woman’s self confidence so it is critical to encourage goals that are specific, achievable and realistic. Asking the woman how her ideas feel will help; if the goal feels too hard, encourage a simpler first step.

**Evaluating the workshop**

The evaluation of our workshop has been undertaken by a pre and post-questionnaire to investigate the confidence of midwives to discuss weight and weight gain with women during pregnancy. Based on the success of the first workshop we were awarded an additional practice development grant from the NSW Nursing and Midwifery Office, when we were able to offer workshops to midwives from all over the state of NSW. The same format (eight hours training in two phases over one month) was continued.

In total 72 midwives attended workshops during 2010/2011. Overall, 67 matched questionnaires were received. It should be noted that the questionnaires formed part of a general evaluation of the workshops and were not validated instruments. The results therefore must be treated with some caution.

In terms of pre and post-training confidence, there was a considerable increase in midwives’ confidence over the two workshops in both broaching the subject and talking to women about weight and weight gain (Figure 1). We acknowledge that it is common for there to be a marked increase in confidence following a skills workshop that may not persist in the longer term, but our results are in line with similar increases in confidence, knowledge and intention to use MI in practice, noted in the majority of studies that introduced MI training in the systematic review by Madson *et al* (2009).

Satisfaction with the workshops was high and in response to the question ‘What was the most helpful aspect of the workshop?’, midwives consistently identified the development of a variety of ‘tools’ to use in their communication with women. Modelling activities such as hearing phrases on the video, or through watching live demonstrations in the workshop, were particularly useful, suggesting that learning from each other (vicarious learning) was the most helpful feature. This finding has informed the design of further workshops.

**Promoting the potential of Motivational Interviewing for midwifery practice**

Since 2011 we have expanded the focus of our workshops to include a wide variety of topics that are relevant to
midwifery practice, including decision making around vaginal birth after caesarean section, pain relief and induction of labour. We have coordinated workshops in other Australian states and territories to multidisciplinary audiences including GPs, dietitians, Aboriginal health workers, student midwives and midwives working across the midwifery continuum.

Having realised the importance of modelling activities in the development of MI skills, we were presented with the opportunity in 2011 to develop our own DVD resource ‘Talking about Change’, featuring some of the midwives who took part in our original training. The DVD models key MI skills and techniques and provides midwives with the opportunity to share some of their success stories. The DVD is now widely available throughout the Sydney metropolitan area in hospital libraries.

In our experience clinicians have reported that following workshops they felt more able and confident to approach difficult conversations with women. Further structured research needs to be undertaken using validated objective tools to investigate the effectiveness of this style of communication undertaken by midwives and to assess the impact of using this technique with women.

Conclusion

Effective communication skills are considered to be the hallmark of a ‘good’ midwife. In the workshops we did not intend to turn midwives into clinical psychologists but we wanted to assist them to create ‘enabling conversations’ with women. Midwives are relationship-builders and experienced in individual consultations with women; however, they often need help in starting these critical conversations. MI has the potential to increase midwives’ confidence in having enabling conversations with women that allow them to explore their desire for change and find their own solutions.

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References


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