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Motivational Interviewing across cultures:Training notes

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In this brief paper, we aim to present our experiences of training clinicians from all disciplines in the changing context of healthcare. From a standpoint that seeks commonalities in clinical practice across the globe, we share the experience of using a particular activity in different settings, and share our own tips on how small changes in the presentation of training materials can lead to better parity for participants in the continuing professional development training room.

Changes in global healthcare

The provision of healthcare is changing. In the last 30 years, patients and their communities have become (or have had the potential to become) more informed about conditions and treatment possibilities, and practitioners have had more timely access to the latest science about medications and approaches to behaviour change. Alongside this, improved economic progress in lower-income countries (LICs) has increased life expectancy and in part brought about a shift in the disease burden: communicable disease outbreaks now coexist with chronic diseases and diseases of 'affluence' such as diabetes and hypertension (Global Burden of Disease Study 2013 Collaborators, 2015).

Across the globe, we are all living longer, and so have the potential to spend more years of life with chronic conditions. Many of these conditions are down to the lifestyle choices that we make on a daily basis; in general we know that we shouldn't smoke, drink too much, choose healthier food and be more physically active, but other priorities (motivational, economic and family) are constant barriers to achieving optimum health. In this context, healthcare practitioners across disciplines are being asked to address behaviour change with patients and embrace more psychological techniques as part of regular clinical practice.

Commonalities in practitioner experience

Despite the differences in healthcare funding systems, practitioners across contexts and cultures often have a shared set of experiences. In the past 4 years, one of the authors (FM) has collected responses during continuing professional development training sessions delivered across continents to healthcare practitioners. One opening activity involves a discussion where participants indicate what they would consider 'good practice' in their own settings, and follow this up with a discussion of the barriers to this good practice, again in the context of their own clinical environments. Responses generated across over 50 groups of multi-disciplinary health professionals spanning North America, Europe, Africa and Asia, have been remarkably similar (see Table 1).

Table 1
Top Five Features and Barriers to Good Practice

Features of Good Practice	Barriers to Good Practice
1. Listening skills	1. Time for each patient too short
2. Knowledge of practice area (and own limitations)	2. Resources limited
3. Respect for patient and patient's experience	3. Variable ability to refer to appropriate support services
4. Acknowledgment of patient's role in management of condition	4. Difficulty in communicating with patients from a different linguistic background
5. Ethical Conduct	5. Limited time for training and supervision of new techniques

From this (albeit potentially skewed) sample of participants in training sessions, the following insights can be drawn. 1. Practitioners are busy: in Singapore, psychiatrists reported seeing more than 60 patients per day, a situation also not uncommon for general practitioners in Nigeria. 2. Language matters: a language barrier was present in all continents, and only one group (in South Korea) did not list this as a major barrier to effective care. From urban centres with a large influx of nationalities of practitioners and patients (UK, USA, Singapore, Hong Kong), to communities where there are multiple national languages and local dialects (Singapore and Nigeria), practitioners are increasingly interacting with multiple cultures on a daily basis.

Motivational interviewing

Motivational interviewing is a type of person-centred counselling that has a broad international evidence-base across health risk or health promoting behaviours (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Lundahl, et al., 2013; Martins & McNeil, 2009). With this body of research literature, MI appears in national guidelines in multiple contexts, and many healthcare organisations include training in MI as a key area of professional development for front-line medical and social care staff. Interest and demand for MI training courses is intensifying along with growing numbers of MI trainers across the world who have joined professional networks such as the Motivational Interviewing Network of Trainers (MINT). The role of the MI trainer is often more than the facilitation of a learning process, with many trainers asked to give follow-up skill-focused supervision for clinicians, and sometimes institutional support in the integration of MI into existing services and routine care.

One key area where motivational interviewing training can be particularly helpful is in giving practitioners the time and space to re-engage with their respective professions and re-define the scope of their 'helping' role in relation to their patients. In an age that is increasingly driven by targets, cost-cutting measures and an overwhelming barrage of politically-driven protocols and care pathways, combined with frequent reports in the media of poor standards of care and failures in communication, motivational interviewing can be an effective way to deepen skills in expressing empathy and building rapport with the patient while responding to the cost-effectiveness agenda.

Conducting training against this backdrop can sometimes be a minefield for trainers – who are often brought in as a managerial response to a perceived shortcoming in either staff

performance or patient outcomes. However, with supportive working environments that allow professional development, even a two-day training in motivational interviewing can urge clinicians/practitioners to think more deeply about engaging with patients, and to have brief but meaningful conversations that reflect good practice yet do not require additional time or resources.

Activities, Culture and Language

Miller and Rollnick's core texts (2001; 2013) have been translated into multiple languages, and there is a strong tradition within the MI community of sharing practice and experience at regular professional and scientific meetings, held both internationally (usually in English) and regionally in local languages. At the core of motivational interviewing are four processes: Engage, Focus, Evoke and Plan, around which typical two-day 'introduction to motivational interviewing' trainings may be framed. Within this, specific skills such as using reflective listening strategies are practiced, with most trainers encouraging a practice-based training environment for participants to develop and hone their skills. While linguistic differences in the formation of particular parts of speech such as questions (de Ruiter, 2012) could affect some parts of the training, to date, we have observed that reflections appear to function in the same way across linguistic groups and trainees respond to the core material in similar ways across continents.

An example of the similarity in reactions of trainees to their training materials is a favourite exercise among some trainers that has the core purpose of developing (in trainees) empathic reflections in response to a single sentence stimulus. This is an activity that has been used across different cultures and indeed languages, to a similar effect. The trainer asks for one or two volunteers to give the group a single sentence of something that they are worried about at present (for the activity process, see table 2). This is typically framed as something they are comfortable to discuss in public, yet something that is a genuine concern. Over the years, the worries that have been presented in my trainings have been varied but have generally fallen into the following categories: concerns about health systems, workloads and patient care, work-life

Table 2
Reflection Activity Process

1. Trainer requests volunteer with a current concern
2. Volunteer writes the first sentence of their concern at the top of a piece of paper
3. Volunteer leaves the training room to continue their 'story' in note form
4. Participants form reflective statements based on their own experience, to try to express empathy with the participant
5. Trainer facilitates group work with suggestions for 'underselling' reflections, encouraging participants to think about situations where they have had similar concerns
6. Volunteer returns
7. Participants read out reflections (volunteer asked to just nod or shake their head, without expanding)
8. Volunteer speaks about their reaction to the reflections– if they were right or wrong, and then expands on their original concern.

Source: Motivational Interviewing Network of Trainers

balance, or broader political issues that trainees are facing in their own countries.

What is most significant, rather than the individual concerns, is how trainees respond to the activity. It has been a true source of the 'a-ha' moment that can be so rewarding during training, and is a good example of reminding clinicians that the delivery of the message is as important as the message itself, and also how a subtle reflective statement can do much to build rapport and express empathy. This activity also can be a great source of unexpected learning moments, with a trainer able to respond to questions about nuances in language, and how framing each reflection in different ways affects the response from the volunteer once they are back in the room. Additionally, there is the valuable personal reaction from the volunteer. Their reactions to statements that are accurate, i.e. in line with their experience can often be a smile and deep repeated nodding of the head (remember that during this part of the activity, the volunteer is encouraged to avoid verbal responses). Furthermore, where a response may not quite reach the mark it becomes evident that the volunteer/speaker is keen to add further information to correct the inaccuracies of the reflection. Taking this back to the clinical context, it is a powerful demonstration that as clinicians, we do not need to be absolutely accurate, but that in trying to understand a patient, we should aim to open the door for them to share their world and how best to work together.

In addition to the success of the activity in different cultures, this is an activity that has been conducted in different languages and seems to work in the same way within each linguistic group. Some areas of language are different across cultures, for example, in how different linguistic groups form questions - however, reflective statements have, across the authors' training settings at least, been consistent.

Cross-cultural adaptations of material

In an ideal training universe, each training course would have the resources to commission a specific, tailored set of accompanying materials that reflects the cultures, context and clinical issues of the participants. MI trainers make frequent adaptations, and negotiate content within the flow of the workshop in response to trainee feedback. Trainers are arguably even more

I am worried that I am working too much… ☹

1. You are worried that you have too little time with your family
2. It sounds like you are under a lot of pressure at the moment
3. Perhaps you don't have much leisure time
4. Feels like you are not enjoying your job so much at the moment
5. You would like to have a bit more breathing space

Figure 1. Example of reflections activity in Chinese-language context with translation

flexible where there may not be many target-language resources available (the majority of professionally-produced training video clips are in English and Spanish language versions). Experienced trainers borrow techniques from the discipline of second language acquisition where these challenges have been well established, and where new teachers are taught to adapt 'authentic materials' for training purposes (Gilmore, 2007). In the MI training room, these authentic materials may involve the trainer modelling motivational interviewing in live demonstrations with a real or simulated patient, who may be a co-trainer or participant. Beyond specific activities embedded in the training situation, trainers model and emphasise collaboration and autonomy with participants, just as a clinician would be encouraged to collaborate with their patient/client.

Although the options to access training materials in languages other than English may be limited, live demonstrations, continuous modelling, and experiential learning through activities, can have a powerful impact on understanding and building competence around MI. A range of MI training activities can work across cultures and contexts with no changes to procedures or content yet adaptations in the materials can improve engagement with the audience/trainees and hence learning environment.

These adaptations of materials broadly fall into two categories, linguistic or visual. In settings where slides are used, there may also be a combination of these two categories. In health communication, we know the importance of face validity with a group; for audiences in Singapore, training materials that contain images of patients should include representations of the racial and ethnic diversity of the target population of trainees. Similarly, when addressing Nigerian clinicians, it may not be appropriate to have images of patients who are ethnically Chinese or Malay as this can weaken the core message of the training.

Linguistic changes can involve a subtle change of the context and phrasing to make statement more relevant to different settings. In training I commonly use the patient's statement 'I don't even know why you're here. We are doing fine. It's not as if you understand what life is like for me anyway'. This kind of sentiment is reported frequently by trainees and clinicians in practice, so has become part of a slide used to encourage discussion of the different reactions by clinicians to this kind of discord from a patient (discord in MI refers to interpersonal tension in the interaction and serves as a red flag for the need to re-engage). However, the initial prompt slide could look quite different according to the audience. Linguistic adaptations are presented in table 3.

Many tips for good training apply as much to cultures within the trainer's home setting, such as the organisational culture within a hospital or institution as they do to less familiar settings. In setting up an activity for any group, it is important to consider how to encourage participation. In addition to careful consideration of the wording of various exercises and activities, and the design of slides (Undrill & McMaster, 2012), activities can be subtly structured to meet cultural norms and expectations, particularly in how participants may expect particular traditions at the start or end of their training day (Mead, 2003). However, in general, there are a few principles that we find particularly helpful in cross-cultural training, which will be familiar to anyone working in adult education or language acquisition: engagement, humility and respect are important with any group; small group activities build confidence when tackling new material; and materials that reflect the participants' clinical settings add to the validity of the training.

Of course, spending time in the culture and

Table 3
Cross cultural linguistic adaptations to slide content

UK	Singapore	Nigeria	USA
'I don't even know why you are here – it isn't as if you know what life is like for me anyway'	*'Bringing up three children on my salary isn't easy and my family are back in Malaysia.'*	*'Bringing up ten children isn't easy and we also look after my brother's children too. How can you understand!'*	*' I don't even know why I am here, it isn't as if you know what life is like for me anyway'*
Original sample statement from a home visit setting from a health visitor in the UK.	To reflect typical family size of 3 children, and also that there is migration so that families with children do not always have the older generation nearby to assist with childcare and financial support.	To reflect larger family size in parts of Nigeria, and also the cultural norm for community help to families in need	Change of location – in the US healthcare system, most child visits are done in a clinic rather than in the home by community nurses.

context in which you are training is the best way of understanding the training group, at the very least allowing additional time upon arrival to gauge some measures of culture. Both authors, in their international work, have developed habits of walking around, reading the local newspapers, and seeking the current trends on social media. With just a little time immersed in the environment there can be invaluable insights into preparing materials that are appropriate and useful to the target population of clinician training participants.

Conclusion

It is rare to find clinicians who are not genuinely compassionate, or who do not have the underlying intention of caring for their patients. However it is extremely common in almost all locations to find clinicians who feel busy, overworked, undervalued and increasingly pressured to deliver in terms of number of patients seen and in improving patient outcomes. Many clinicians feel burned-out, and acknowledge that their clinical practice may suffer as a result. Motivational interviewing is a style of communication that can, with careful preparation of training material, be synergistic with trends and priorities in the caring professions across different cultures. The appreciation that patients have for the effort and concern demonstrated by practitioners to see the world through their eyes can deepen rapport, and lead to better clinical outcomes (Del Canale et al., 2012; Kelley, Kraft-Todd, Schapira, Kossowsky, & Riess, 2014). Even in the context of the routine brief consultation, a couple of minutes of engagement can save practitioners time in allowing them to build a better basis for working on the presenting issue(s).

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