

CATALYST FOR CHANGE

Motivational interviewing can help parents to help their kids

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A collaborative approach with pediatric patients and their parents that incorporates motivational interviewing can facilitate successful behavioral change. This first part of a 2-part series discusses the process of motivational interviewing, how to conduct a motivational interview, and how to address change with patients. Part 2 will address strategies for implementing change in patients who are ready to take action.



Pediatric healthcare practitioners are often faced with patients and their parents who have difficulty accepting or following through with medical advice on issues such as diet and exercise¹ or vaccine administration.² These and other health issues can be difficult to address and manage for patients, parents, and clinicians. Patients may feel overwhelmed by their problem, and parents may be stressed in general by all their responsibilities. Patients and parents may fear the prospect of confronting the problem and failing. Clinicians are challenged by the demands of a busy practice and by parent expectations. Furthermore, clinicians may be unsure or unaware of how to administer advice in such a way that patients will accept it and comply with it.

Many clinicians adhere to a traditional, authorita-

tive “professional as the expert” model of dispensing medical advice and may resort to nonproductive approaches such as coercion and scare tactics to effect patient change. A directive approach may be appropriate for handling specific, acute problems, such as fever or vomiting, but a more collaborative approach is often required when facilitating patient behavior changes. Through the use of motivational interviewing, clinicians can foster a collaborative relationship with patients and their parents and serve as catalysts for promoting behavioral change.³

Factors that influence thinking and behavior

Before motivational interviewing can effectively be put into practice, it is necessary to understand the

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different variables that influence how people think, and then, how they behave.

Default to zero

When confronted with opportunities for change, people are often inclined to maintain the status quo and “default to zero” by doing nothing or as little as possible. *Status quo bias* appears to be a natural phenomenon often exploited by marketers, such as when magazines offer limited-time free subscrip-

tions but require active cancellation to stop the service from continuing.⁴

Illogical thinking

People often do not think logically, even though clinicians may do their best to present logical and statistically sound arguments for change. For many people, *correlation* is equivalent to *causality* so that, in their view, a recently administered inactivated influenza vaccine may have caused their child to get the flu. People may also assign relevance to what may be a coincidence. For example, a parent who becomes aware of several autistic children in the community may conclude that vaccines or an environmental toxin must be the culprit because they were all recently vaccinated or all live in a similar environment.

Other types of illogical thinking include the *infallibility* bias, which is common among adolescents (“It won’t happen to me. Unlike *other* people, I can



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handle excessive drinking without consequences”), and the *ego bias* (“It won’t be difficult for *me* to change. Unlike *other* people, when I decide to stop overeating, it will be easy for me”).

Media, family, and peers

Patients are swayed by celebrities, commercials, and the opinions of family, friends, and members of online social networks. Sociologists refer to these types of influential effects as *availability*.⁴

People want to feel connected to, be accepted by, and behave similarly to others in their social network. For example, studies

show that the average obese person is more likely to have friends and friends of friends who are also obese. The average nonobese person has a similar network of nonobese friends.⁵

Social networking literature also refers to the “contagion of ideas” that, like a virus, spreads between people in a specific social network and exerts a strong influence on behavior and in creating social norms. Eating in fast

food restaurants with friends may become the social norm for overweight teens. Parents who are reluctant to vaccinate their children may link with friends or online social networks that ascribe to similar thinking that influences their behavior.

Windows of opportunity

Patients who have been refractory to change may suddenly shift their behavior when confronted with a personal crisis. A family member may develop type 2 diabetes mellitus, which precipitates a change in family eating habits, or a parent may know a family whose unvaccinated child has developed pertussis, which leads the mother to rethink her position on vaccination for her own children. These crises may *open the window* for change, and the clinician should be prepared to assist families when these moments arise.

Points Taken

> People are more likely to change a behavior if they view the alternative behavior as being positive.

> Motivational interviewing can facilitate positive behavioral changes.

Motivation influences change

Motivation is the driver of behavioral change. People are more likely to change a behavior if they view the alternative behavior as *positive*. Positive alternatives may include those behaviors that enhance pleasure, health, or self-esteem or reduce discomfort. A patient who loses weight may find that he or she “feels better” (pleasure), “has more energy” (health), “looks better” (self-esteem), or experiences “less teasing” (reduced discomfort). The alternative behavior should also be perceived as *meaningful* to the patient and congruent with core personal values (eg, “I want to be healthier”). Behavior that is meaningful may occur within a *broader context*. For example, a teenager may decide to lose weight before the upcoming prom or give up marijuana in order to join the armed forces. In addition, people are more likely to embrace a behavioral change that enhances *social connection* by creating a sense of closeness to and acceptance by others.

It is important to note that unhealthy behaviors can offer compelling countermotivation to patients. Alcohol may be viewed as pleasurable, drugs may reduce the discomfort of depression, and risk-taking behaviors may lead to social acceptance. In order to be effective facilitators of change, clinicians need to understand how motivational factors can anchor patients to healthy as well as unhealthy behaviors.

Motivational interviewing

Motivational interviewing has been successful in facilitating positive behavioral changes in the areas of substance abuse, smoking cessation, and weight loss.⁶ The motivational interviewing model views the clinician-patient relationship as a partnership. By engaging in a process of asking, listening, and informing, the clinician seeks to help patients address their ambivalence about change and to generate their own reasons—for motivations—for changing their behaviors. The clinician also explores the patient’s readiness for change and ultimately assists the patient to discover ways to implement and maintain healthier choices.

Ask and listen

The motivational interviewing process begins by asking open-ended questions related to the behavior

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in question, such as, “Can you tell me about . . . ?” “How do you feel about . . . ?” or “What do you think about . . . ?” For example, “Can you tell me about what your child is eating?” for the parent of an overweight child; “How do you feel about vaccines?” for the parent reluctant to vaccinate her child; and “What do you think about smoking?” for the teen stuck on cigarettes.

The next step is to listen. Active listening is the process of absorbing and reflecting back or summarizing in a nonjudgmental manner what the patient is saying and feeling. For example, a parent may say, “I am really scared about vaccines. I heard they cause autism.” The clinician may then respond by restating what was said: “It sounds like you are very worried that vaccines can harm your child.”

Determine the stage of change

Changing behavior can be viewed as a dynamic process of movement through the stages of change, which include precontemplation, contemplation, preparation, action, and maintenance.⁷ The clinician can try to gauge the patient’s stage of change by asking “Is this a problem for you?” or “Have you considered . . . ?” For example, when working with an overweight child, the clinician can ask the patient or parent, “Is this a problem for you?” or “Have you considered changing your diet or your child’s diet?” For the parent who seems reluctant to initiate vaccines, the clinician can ask, “Have you considered getting your child vaccinated?” In the case of the teenager who is smoking, the clinician can ask, “Is smoking a problem for you?” or “Have you considered stopping?”

How the clinician proceeds will then be determined by whether the direct or inferred response from the patient is “no” (precontemplation), “maybe” (contemplation), or “yes” (preparation/action). Clinicians can use motivational interviewing to focus discussion for the patient in the “no” precontemplation stage (Figure 1) and the “maybe” contemplation stage (Figure 2). The clinician’s goal is to gently nudge the patient from one stage of change to the next, bearing in mind that it may take time for this to be achieved.

Precontemplation stage: Plant seeds of change

The task of the practitioner for patients in the “no” precontemplation stage is to plant seeds of change by raising the patient’s level of *awareness* and to assess *readiness* for change (Figure 1). Patients in this stage often deny, minimize, or make excuses for their current behavior. An overweight teenager may claim that he is only a little bit overweight or that he does not have time to exercise or watch what he eats. A parent may state that her child does not need vaccines because he does not attend daycare and therefore is not at great risk for illness. The teenager who smokes may claim that she can stop at any time. The clinician can assist the patient by helping to create heightened awareness of the behavior in question through the use of probing questions that allow the patient to think aloud about the behavior.

Points Taken

➤ Plant “seeds of change” by raising the patient’s level of awareness and assess readiness for change.

Explore the pros and cons of the current behavior

The clinician can begin by exploring how the patient views his current behavior: “What is keep-

➤ The clinician can explore how the patient views his or her current behavior.

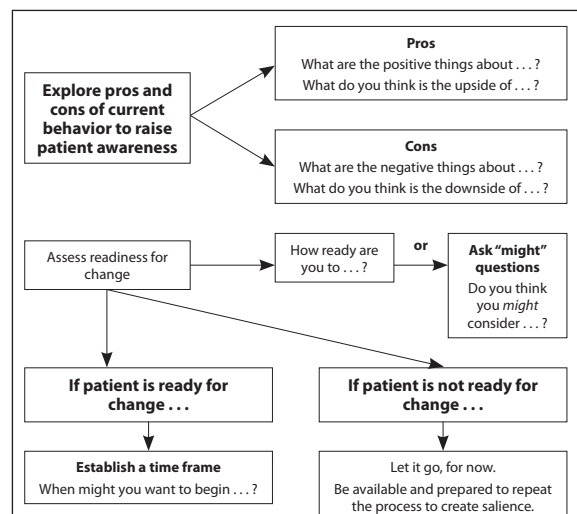


FIGURE 1

Motivational interviewing for the precontemplation stage of change.

ing you doing what you are doing?” The patient can be asked to examine the pros and cons, the advantages or disadvantages, or the positive and negative aspects of his current behavior.

The clinician should try to adopt an attitude of acceptance when collaborating with patients. It is particularly important to remember that “*acceptance* of a patient’s experience is not the same as *agreeing*.”³

Assess readiness for change

The clinician can further plant the seeds of change by asking, “How ready are you to take the next step?” For example, “How ready are you to change your diet? . . . start your child’s vaccines? . . . stop smoking cigarettes?” The clinician can also assess the patient’s degree of readiness for change by using a numeric rating scale.³ For example, the clinician may ask, “On a scale of 1 to 10, how ready are you to begin losing weight?” The clinician may then

wish to ask, “Why did you give yourself a 3 and not a 1?” as a way to elicit additional change talk. The clinician can follow up with, “What would it take to get you from a 3 to a 5?” Scaling questions are particularly useful because they allow patients to assign numeric values that can be recorded and reviewed in subsequent visits to evaluate how the patient’s motivation is changing over time.

Ask “might” questions

Alternatively, the clinician can ask “might” questions, such as, “Do you think you might consider losing weight? . . . vaccinating your child? . . . stopping cigarettes in the future?” If the patient responds in the affirmative, the clinician can try to elicit “change talk”³ by asking questions such as, “Why might you want to eat better? . . . vaccinate your child? . . . stop smoking?” Having the patient verbalize her thoughts can help set the change process in motion. Note that “might” questions use

precommitment language that is in sync with or paces the patient’s stage of precontemplation, a subtle but powerful way to stay connected to the patient.⁸

Establish a time frame

If the patient communicates a readiness to change, the clinician may wish to establish a time frame for change by asking, “What is your time frame?” or “When or how soon might you want to begin?”

Conclude the discussion

If the patient indicates a resounding lack of commitment to changing his or her behavior, it is best for the clinician to remain flexible and back off. This is often quite difficult for well-intentioned clinicians who want to fix the problem and are accustomed to telling patients what to do—the so-called “righting reflex.”³ However, further discussion at this phase can trigger a more defensive posture in patients, causing them to negatively dig in, which can be counterproductive. Since patients often have more than 1 problematic behavior, the

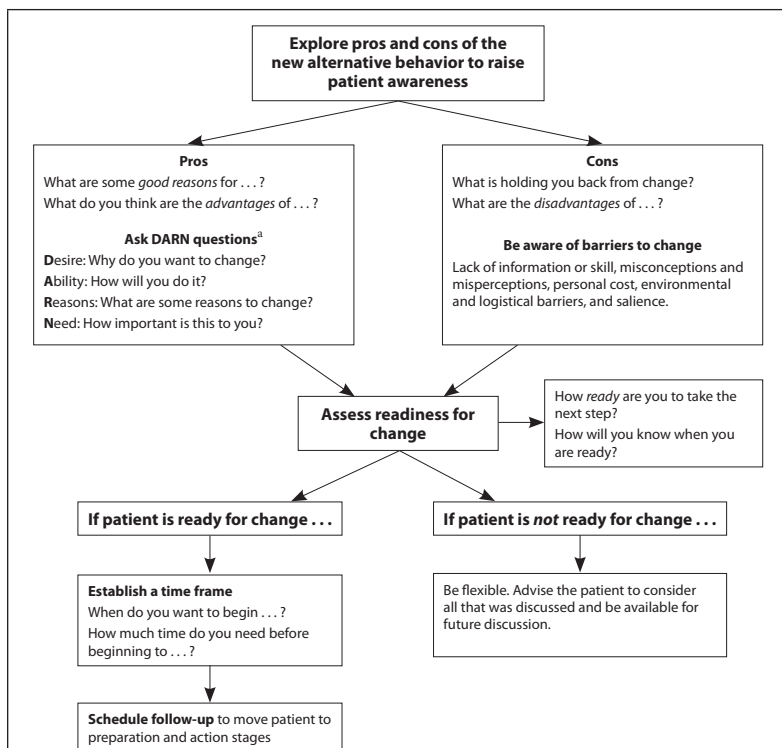


FIGURE 2

Motivational interviewing for the contemplation stage of change.

^aInformation from Rollnick S, et al.³

clinician may find it more effective at this time to shift the discussion to an alternate problem that the patient is more amenable to addressing.

Clinicians need to remember that change is a dynamic process and is not synonymous with action.⁷ Pushing a patient toward action when he or she is not ready is unlikely to result in meaningful change. In the face of firm resistance, leave the door open for further discussion later, let the patient know that you are always available for questions and assistance, and let the issue go, for now. Repetition of the change message helps create salience, so the clinician should be prepared to bring up the issue in future encounters by starting at the beginning of the process, once again using open-ended questions. It is important to remember that the process of change may occur over a great length of time.

Contemplation stage: Process ambivalence

Patients who seem ambivalent about the behavior in question are likely to be in the “maybe” stage of contemplation. Patients in this stage may make statements such as, “I think that my weight may be a problem,” “I guess that I am not totally opposed to vaccines,” or “I can’t stop smoking *yet*.” The task for the clinician working with patients who are in this stage is to process ambivalence and assess readiness for change (Figure 2).

Explore the pros and cons of the new behavior

The clinician can proceed by exploring the pros and cons of the new alternative behavior. This is in contrast to the “no” precontemplation stage, in which the pros and cons of the current behavior are explored.

The clinician may wish to elicit change talk from the patient by exploring the advantages of change. The clinician may ask, “What do you think are some good reasons for . . . ?” or “What do you think are the pros, advantages, or positive aspects of . . . losing weight? . . . getting your child vaccinated? . . . quitting cigarettes?” This approach allows the patient to consider and express why *he* thinks a change in behavior may be appropriate. A discussion of the pros of change may be particularly helpful for patients who are in the early stages of contemplation.⁹

The motivational interviewing model posits the use of DARN questions (Figure 2) to more thoroughly elicit change talk from patients.³ The key here is to ask the questions and let the patient make her case for change. If the clinician is doing most of the talking and making the case for change by trying to persuade the patient, the outcome is less likely to be productive. Thus, the clinician should let the patient take the lead.

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Barriers to change

Some of the common obstacles that patients face when trying to change a behavior include:

- **Lack of information or skill**

Overweight patients may need information about portion control or the actual caloric content of junk foods. Parents who are reluctant to vaccinate their children may need to know the actual risks of infections caused by pertussis and pneumococcus and also need accurate information about vaccine safety. A teenager who wishes to stop smoking may need information about available, appropriate pharmaceutical products for smoking cessation. The clinician can provide information directly or by distributing pamphlets and lists of appropriate books and Web sites.

- **Lack of confidence in ability to change**

The clinician can assess the patient's confidence about her ability to change by using numeric rating scales. The clinician may ask, "On a scale of 1 to 10, how confident are you that you can lose weight?" and "What would it take to get you from a 3 to a 5?" A discussion of what skills the patient needs in order to feel more confident may be helpful.

- **Misconceptions and misperceptions**

Parents and patients may need clarification of misconceptions. Overweight patients may need to know that skipping meals is not an effective way to lose weight. Parents may need misconceptions about vaccines and their relation to autism addressed. Teenagers may need to know that smoking may not really heighten their appeal to their peers.

- **Personal cost**

A frequent obstacle to change is the perception that the new behavior will require "too much time" or "too much work." The clinician can reassure the patient that the change

process need not be "all or nothing" and that an approach that is simple and gradual may be the best way to begin.

- **Environmental and logistical barriers**

Logistical barriers to change may include financial cost. Healthy food alternatives may be financially taxing to some families who may in turn seek fast food as a less costly option. Environmental factors such as a safe location to exercise may be realistic barriers to weight loss. A family without health insurance may choose to defer costly vaccines. The patient can be encouraged to look at available community resources such as a local recreation center for a safe place to exercise or a public health clinic for free vaccines.

- **Salience**

The patient may perceive the new behavior as not very important. The clinician can gauge the patient's perception of importance by asking, "How important is this to you?" Alternatively, the clinician can once again use a numeric rating scale and ask, "On a scale of 1 to 10, how important is it to you to . . . ?" An effective method for dealing with patients who resist change is to avoid the "you really need to" type of confrontation and instead make a reflective statement such as, "It sounds like you are not ready to tackle this right now" or "It sounds like this is not very important to you right now." Some patients may affirm that this is true at this time, but this approach may animate some patients to respond by arguing back that they are indeed ready for change. The clinician can then encourage the patient to expand on his or her thoughts with a simple, "Tell me what you are thinking or feeling." This type of interaction parallels the martial arts response to force by *absorbing* the force rather than *confronting* it with more force.

The clinician should listen carefully and reflect back and positively reinforce patient statements of change. For example, "It sounds like losing weight may help you to better enjoy playing sports like soccer" or "It sounds like you are worried that your child could get meningitis and that you feel that vaccines may help to prevent this."

Points Taken

➤ Allow the patient to summarize the pros and cons of the discussion.

➤ Help move the patient toward the stages of preparation and action by scheduling a follow-up visit to work on a plan.

The clinician may move the dialogue forward by then discussing the cons or disadvantages of change. "It sounds like you have some good reasons for . . . losing weight . . . getting your child vaccinated . . . quitting cigarettes. What are some things that are holding you back? What are the cons, the disadvantages, the downside, the negatives of . . . ?" A frank discussion about the obstacles to change is particularly helpful for patients who are in the

later stages of contemplation, because it is often these very obstacles that serve as the final barriers to taking action (see *Barriers to Change*, page 37).⁹

Assess readiness for change

The clinician can then ask the patient about how ready she is to take the next step. For example, the clinician can ask, "How ready are you to . . . ?" As in the precontemplation stage, a numeric rating scale can be used to gauge the patient's degree of readiness. In addition, asking the patient "How will you know when you are ready?" may assist the patient in working through his ambivalent feelings and serve to facilitate change by encouraging the patient to continue to wrestle with the behavior under discussion.


Establish a time frame

For the patient who expresses a desire for change, the clinician can establish a time frame for change by asking, "What is your time frame?" or "How much time do you think you need before beginning to lose weight? . . . beginning to vaccinate your child? . . . quitting cigarette smoking?"

Conclude the discussion

The clinician can wrap up the discussion by allowing the patient to summarize the salient pros and cons of the discussion and giving the patient an opportunity to let his thoughts percolate. If the patient indicates readiness for change, the clinician can help move the patient toward the stages of preparation and action by asking the patient if he would like to schedule a follow-up visit to work on a plan. Otherwise, the clinician can conclude with a statement such as, "It sounds like you have got a lot to think about. Take some time to consider our discussion and perhaps we can talk about this again at our next visit." Again, this is the time for the clinician to remain flexible and back off, leaving the door open for future discussion.

Getting to yes and beyond

Motivational interviewing techniques can often be successfully used to help patients move through the stages of healthy change. Clinicians can plant seeds of change for patients in the "no" precontemplation stage and process ambivalence with patients in the "maybe" contemplation stage. Part 2 will examine how to help patients who are in the "yes" preparation stage to move toward the action stage. 

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