CATALYST FOR CHANGE

Motivational interviewing can help parents to help their kids

KENNETH TELLERMAN, MD

For behavioral change to be successful, a collaborative relationship between clinician and patient is essential. Part 1 reviewed motivational interviewing for patients who are in the "No" precontemplation or "Maybe" contemplation stages of change. Here, part 2 examines how clinicians can help patients in the "Yes" preparation stage to develop a viable plan to progress toward taking action.

Clinicians can foster a working partnership with patients through the use of motivational interviewing. The process of asking, listening, and informing allows the clinician to help patients think about their attitudes toward change and generate their own motivations for changing behaviors. This collaborative approach, different than the more traditional, authoritative approach, enables clinicians to be catalysts for promoting behavioral change in patients who are in the precontemplation and contemplation stages of change.[1] Clinicians can continue their collaborative relationships with patients who are in the "Yes" preparation stage of change (Figure). Regarding these patients, the clinician's task is to help prepare a feasible plan for change, assess patient *readiness* to proceed, and assist patients in moving from *planning* to action.

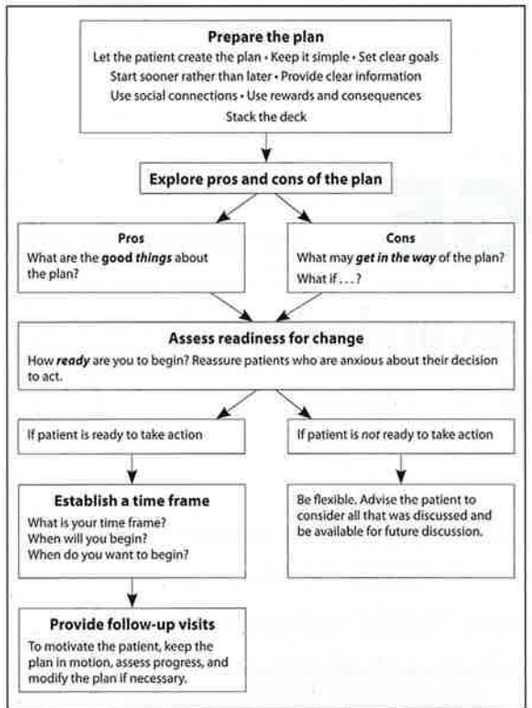
Preparation/Action stage: Ready for change

Some patients are ready to change their behavior. These patients have responded "yes" to the initial "Is this a problem for you?" or "Have you considered . . . ?" introductory questions that are used to determine the stage of change.[1] The clinician can then ask the patient, "How would you like to proceed?" or "Where would you like to go from here?" in order to move the patient to the next critical step toward action: preparing the plan.

Preparing the plan

Helping the patient prepare a plan that is a comfortable fit is essential to being effective. For the patient who is overeating, an appropriate plan that looks at caloric reduction and increased activity may be in order. For the parent who is anxious about vaccines, a modified

DR TELLERMAN is a general and behavioral pediatrician in private practice; chairman, Emotional Health Committee Maryland Chapter, American Academy of Pediatrics; and clinical assistant professor of pediatrics, University of Maryland School of Medicine, Baltimore. The author has nothing to disclose regarding affiliation with, or financial interest in, any organization that may have an interest in any part of this article.



FIGURE

Motivational interviewing for the preparation and action stage of change.

vaccine schedule may be an option. For the teenager who is smoking, a review of nicotine substitutes may be appropriate. This section looks at the many facets involved in helping patients successfully devise a plan that fits their individual needs for accomplishing behavioral change.

Let the patient create the plan

Allow the patient to brainstorm options and come up with strategies that he or she feels can be implemented. It is often reflexive for clinicians to jump in at this point and give advice. However, it is often more productive for the patient to come up with a plan that he or she *owns*. The clinician can ask the patient how he or she would like to proceed. An overweight teenager may then decide to reduce the amount of soda in the diet or cut back on visits to fast food restaurants for the next 2 weeks. A teenager who wants to quit smoking may choose to begin by reducing his or her cigarette use. The clinician should encourage these types of endeavors.

When dealing with patients who seem stuck, the clinician can stimulate brainstorming by asking questions such as, "What advice would you give to a friend who is trying to lose weight?" or "Have you done anything in the past to successfully lose weight?" or "What has someone you know done to lose weight?"

Keep it simple

Keep the plan simple, user friendly, and flexible. Economists have coined the term *choice architecture* to refer to effective models of change that are simple and comprehensible.[2] Patients are more likely to implement a plan that is not overly taxing and complex. It is often better to implement a plan in small incremental steps and subsequently build on that foundation.

Set clear goals

Goals should be *clear*. Some of the interventions in brief solution-focused therapy emphasize the development of goals that are meaningful and tangible.[3] The clinician may wish to use *miracle questions* such as, "If I were to wave a wand and create a miracle, what would you be doing differently to achieve your goal?" Alternatively, the clinician may ask, "If I were to videotape your activities in the next few weeks, what would we see you doing differently?" These types of questions help the patient to concretely visualize the changes she wishes to implement. The model of solution-focused therapy also uses *exceptions* to point out behaviors that the patient is already engaged in that are change promoting. For example, the clinician may ask, "What kinds of things are you currently doing to keep your weight under control?" The clinician should then use praise and encourage the patient to continue these already established behaviors.

Provide information in a clear, positive manner

The clinician may wish to offer suggestions but should proceed in a manner that allows the patient to maintain ownership of the plan. For example, the clinician may ask, "Is it OK if I make a suggestion?" The clinician can also use a third-person approach such as, "*Other* patients in your situation have found it helpful to . . . " These kinds of approaches reinforce the collaborative approach between patient and clinician, but leave the patient in charge.

When *informing*, the clinician should also minimize the use of medical jargon and aim for simple and clear discussion points. Statistics may have a brief role in discussions but can be confusing to some patients.

In addition, information framed *positively* may have more effect than information framed negatively.[4] For example, a discussion of an approach that has an 80% success rate may be more effective than emphasizing the 20% failure rate. Informing a patient that he or she will feel better after losing weight is more effective than highlighting the risk of developing hypertension if he or she continues to overeat.

Tell a *success* story.[5] People are often very receptive to narratives, and by telling a story about a patient with a similar problem who successfully met the challenge, the clinician can effectively impart information that is easy for patients to understand and remember.

Incorporate social connections

Recognize the importance of social connection and social influence when helping patients format an action plan.[6] Plans that incorporate other family members or peers for support may have a greater chance of succeeding. For an overweight teenager, a plan that incorporates nutritional changes for the entire family—not just the patient—is likely to be more successful. A plan that involves a close friend or friends for support or aims for the patient and his or her peers to lose weight or stop smoking together may also be effective strategies.

Statements that highlight what other patients are doing, or not doing, may have an influential effect, particularly for teenagers. A nonsmoking advertising campaign in Montana helped to reduce smoking with the message: "Most of Montana Teens Are Tobacco Free."[7] At the end of the 8-month campaign, 10% of teens living within the targeted area had started smoking compared with 17% of teens who lived outside the targeted area—a 41% difference in the proportion of teens in the campaign area who started smoking compared with those in the rest of the state. The clinician may wish to replicate this effect by stating, "Although some teenagers in my practice smoke, most do not."

In the same light, a discussion with a teen about the social ramifications of weight loss or about the yellow teeth and bad breath that are caused by smoking may have more salience than a more abstract discussion about the risks of hypertension, diabetes, lung cancer, and emphysema.

Incorporate rewards and consequences

Patients may be motivated to lose weight if they reward themselves with a celebratory night off or some new clothes after they meet their goals. Patients can also link their changed behaviors with altruistic endeavors. A patient attempting to lose weight may wish to donate cash for pounds lost to a favorite charity or help relieve hunger in others by volunteering at a soup kitchen.

Clinicians can also take advantage of *loss aversion* when helping patients prepare a plan. People are particularly reluctant to experience monetary loss.[2] Patients may therefore commit to sending cash to their opposing political party each month if they don't meet their targeted goals. Peers or family members working together may agree to pay cash penalties to one another at periodic intervals if they have not reached their chosen goals. With teenagers who smoke, it may be worthwhile to walk patients through the mathematics of the cash outlay for cigarettes: "So, you spend $5 per day on a pack of cigarettes; that's $35 per week, or $140 per month. What could you do with $140 extra dollars each month?"

Stack the deck

The clinician can encourage patients to try to control their environments. This may translate into keeping cigarettes or tempting foods out of the house or avoiding walking past their favorite fast food eatery. It may also be helpful to ask patients to let family and friends know what they are doing. Patients who make their action plan public may be more inclined to follow through.[8]

Explore the pros and cons of the plan

Once the plan is formulated, it can be helpful for the clinician to ask the patient, "What are the *good things* about the plan?" The clinician should also ask, "What may get in the way of the plan?" It is important to address contingencies for what the patient will do if the plan does not proceed as designed.

Discussing up front that change is difficult, and that all facets of the plan may not proceed smoothly is an important step in keeping patients from giving up. The most common threats to *maintaining* a plan of action are social pressures, internal challenges, and special situations.[8] For patients who cannot foresee potential problem areas, the clinician may ask, "What if" questions such as, "What will you do if you find yourself in a fast food restaurant with your friends in the next few weeks?" or "What if you have a sudden urge for ice cream?" With the teen who smokes, it may be worth asking, "What if you're at a party and everyone else lights up a cigarette?"

This kind of proactive planning for interim setbacks can help to keep patients from feeling guilty and reinforce that the stated goals are still worth pursuing even if there are episodic slipups. Clinicians should also reassure patients that plans are often difficult to implement at the beginning but become easier over time and with practice. It may also require repeated attempts and revisions before "getting it right."

Assess readiness for action

The preparation of a plan does not always translate into action. The anticipation of beginning a new behavior can be anxiety provoking. Patients may react by delaying action. The clinician can help patients articulate these feelings and assess their level of commitment by asking, "How *ready* are you to begin?" This question can also help to distinguish between patients who are in the stage of *preparation* versus *action*. An encouraging and reassuring attitude on the part of the clinician can help patients make the jump from *preparation* to *action*. A numeric rating scale can be used to gauge the patient's degree of readiness. The clinician might ask, "On a scale of 1 to 10, how ready are you to put your plan into action?" Further discussion can be generated by asking, "Why did you give yourself a 5 and not a 3?" This can be followed up with, "What do you think it will take to move from a 5 to an 8?" Keeping a record of the patient's numeric ratings is useful for reviewing and analyzing how the patient's readiness for action is changing over subsequent visits.

Some patients, after wrestling with a decision, experience a rush of anxiety when settling on an action. This phenomenon is known as *cognitive dissonance*.[9,10] For example, a parent who has decided to immunize her child or start her child on an attention deficit/hyperactivity disorder medication may suddenly feel doubtful and nervous about her decision. Reassurance at this time by the clinician can be particularly helpful.

Establish a time frame

Finally, the clinician should help lay the groundwork for the plan by asking the patient, "What is your time frame?" or "When or how soon *will* you begin?" or "When do you want to start?"

The momentum of the plan is often sustained by encouraging the patient to set short-term goals and to implement the plan in the near future while he or she is engaged rather than delaying. Waiting too long to begin may result in early enthusiasm being overridden by the inclination to "default to zero." A plan that is set to begin in the next 2 weeks is more likely to be implemented than a plan set to begin in 2 months.

Conclude the discussion

The clinician can conclude the encounter by having the patient summarize the plan and review strategies for any slipups. The patient then can be asked when he or she would like to return for follow-up.

At the conclusion of the visit, the clinician should also consider how this and follow-up counseling

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Reimbursement for preventive counseling

Financial reimbursement is a critical requirement for time-consuming services rendered to patients. However, many insurance companies do not specifically reimburse clinicians for preventive counseling. Discussions with patients need not be extremely time consuming to be effective. Many of the approaches discussed in this article can be incorporated into well-child visits. In addition, clinicians who set up additional time to meet with patients should document the time spent and can use extended office visit CPT codes such as 99214 (25 minutes) and 99215 (40 minutes) if more than 50% of the session is spent in counseling. The CPT code 99354 can be added on to 99215 for face-to-face sessions that extend an additional 30 to 74 minutes. The clinician who is working with an overweight patient may wish to use pathology-based ICD codes, such as hypertension (401.9), hyperlipidemia (272.4), obesity (278.00), or type 2 diabetes (250.00), if appropriate. Clinicians can also bill when appropriate for diagnoses such as cough (786.2) if working on smoking cessation or adjustment reaction (309.9) if working on drinking or drug-use issues. For parents who opt to split up vaccines over several visits, the clinician can use CPT codes 99211 or 99212 for subsequent vaccine visits and collect patient copays when appropriate.

Information from Ingenix.[11,12]

The Power of Language

Language is a powerful mediator of change. The clinician should remain attuned to the subtleties of language and its influence on behavior. Clinicians can use language to gently nudge patients toward healthy change.

Elicit change language. Listen carefully for and try to reinforce patient-change language such as, "I *wish* I could . . . ," "I really *should* . . . ," "I am *going* to . . . ," or "I *will*. . . . " If the patient says, "I really *should* lose weight," the clinician can provide positive reinforcement by responding, "That's great. It sounds like you are giving some serious thought to your weight."

Challenge overgeneralizations. Some patients *overgeneralize* their lives and may arrive at self-defeating, erroneous conclusions such as, "I *can't* lose weight," "I will *never* lose weight," or "I *always* mess up." The clinician can challenge such thinking by asking, "What *evidence* do you have that you can't lose weight? Do you have any *evidence* to the contrary that you *can* do things to lose weight?" The clinician may also ask, "Can you think of a time when you really did change something about yourself?" These types of questions can successfully help patients recognize and counter negative "automatic thoughts" such as overgeneralization, leading patients toward healthier behaviors.

Use commitment language. For patients in the action stage, the clinician can use *commitment* language such as, "What are you *going* to do?" instead of "What do you think you *might* do next?" The clinician may also wish to use "*when*" versus "*if*" statements when talking with patients in the action stage. For example, the clinician can convey an expectation of success by saying, "*When* you lose 2 pounds . . . " instead of "*If* you lose 2 pounds. . . . " Similarly, when seeing a patient in follow-up, the clinician can refer to prior behaviors in the *past tense*. For example, the clinician might say, "It is great to hear about the changes you have made in your diet compared with how you *used to* overeat" or "It sounds like you don't cough as much now compared with when you *used to* smoke."

Use priming language. *Priming* is a way to use language to instill a subtle message of change. Studies have found that asking questions about *intention* can lead to changes in behavior. People who were simply asked whether they *intend* to consume fatty foods in the next week were found to actually consume less fatty food in the following week.[2]

Another priming approach makes use of positive *self-fulfilling prophecy*. The clinician, for example, can express an expectation for successful change with a statement such as, "I know you are a caring parent and want to do the best for your child, so I am sure that you will make the right decisions about your child's diet."

Similarly, use of the word "yet" can set an expectation of success. The clinician might say, "It sounds like you plan to cut back on fast food, but you just have not been able to do so *yet*."

When given a choice between two extreme alternatives, people will often opt for what they perceive as the less extreme option. Clinicians can also use this tendency to help promote change behavior. For example, the clinician might ask a parent, "Your baby is due for 4 vaccines today, and I know that you are nervous about giving multiple vaccines. Would you consider giving 2 vaccines today and 2 more in a few weeks?" To the overweight patient, the clinician might say, "Do you think you can stop going to fast food restaurants for 2 months? How about 2 weeks?"

A suggestion for change can also be planted through the use of *anchoring*.[2] The clinician can give a specific example of what other people have done in a similar situation. For example, the clinician may say, "A lot of people find it reasonable to eliminate fries from their diet for a month; how long do you think *you* can do it?" or "Many people find that 3 hours per week is a reasonable amount of time to devote to exercise; how many hours per week will work for you?"

Encourage self-talk. Clinicians can encourage patients to learn to use self-talk. For example, a patient reaching for junk food from the pantry or refrigerator can be advised to slow down and engage in a self-dialogue such as, "I have spent so much time trying to drop this weight, do I really want to be eating this now?" Interjecting this type of self-talk can be helpful in mediating impulsive counterproductive behaviors.

Information from Thayer R, et al[2]; Prochaska J, et al[8]; Beck J.[13]

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sessions should be documented for financial reimbursement (see, "Reimbursement for Preventive Counseling," page 50).[11,12]

Follow-up and maintenance: Staying on course

Follow-up visits provide the motivation that helps keep the plan in motion and allow the clinician to assess how the plan is proceeding. Some patients find it helpful to keep a log of their progress, such as a food, exercise, or cigarette diary. These logs can be reviewed during follow-up encounters. Numeric rating scales can be reassessed to evaluate how the patient is moving through change. Clinicians can use follow-up sessions to provide encouragement and positive feedback for those elements of the plan that are going smoothly. Conversely, follow-up visits are also a time to evaluate and help modify aspects of the plan that are not going as intended and to help expand the plan in small increments if indicated. In order to assess ongoing commitment, clinicians can ask the patient, "How prepared are you to continue?"

The *maintenance* stage of change can be quite challenging and requires perseverance. Clinicians can recognize patients in the maintenance stage by their ability to repeatedly practice and engage in their chosen alternative behaviors. Patients in the maintenance stage are also successful in reminding themselves of the work it took to achieve success and in developing contingency plans for handling potential lapses and setbacks. For patients in the maintenance stage, intermittent follow-up visits can be very reinforcing. However, some patients may wish to defer follow-up visits because they feel that they can proceed independently. Other patients may defer follow-up because they are not fully committed to taking action. Clinicians should respect the patient's wishes.

When to refer

Patients at the preparation or action stage may require assistance that is outside the clinician's knowledge base or comfort level. For example, an extremely overweight patient may require the help of a nutritionist and/or a mental health consultant in order to achieve his goals. Adolescents who are involved in substance abuse, particularly if engaging in dangerous risk-taking behaviors such as drunk driving, may also require a referral to a consultant with expertise in these areas. These patients pose a challenge because they are frequently not ready to make any changes in their behavior. In such cases, parents may need to assume control even if the patient is not amenable to counseling. The primary care clinician, however, may be helpful in using certain approaches (see, "The Power of Language," page 52)[2,8,13] and some of the approaches reviewed in part 1 to nudge the patient toward the action steps of receiving help, rather than focusing directly on changing the specific drug or alcohol abuse behaviors.

Success

Patients who are ready to change can continue to benefit from a collaborative partnership with the clinician. Clinicians can motivate these patients to act on their readiness for change by helping them create an individualized plan of action that is realistic, simple, and user friendly. Evaluating patients' commitment to proceed with the plan, encouraging them to start by setting a time frame, and providing follow-up and ongoing encouragement are the keys to successful intervention that can lead to change. CP

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