Motivational Interviewing for Childhood Obesity Treatment

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Learning Objectives

- Understand the origins and guiding philosophy behind motivational interviewing.
- Identify prescriptive versus non-prescriptive approaches to childhood obesity treatment.
- Understand the developmental considerations associated with the use of motivational interviewing with children.
- Cite ways to incorporate motivational interviewing into brief and extended encounters with patients.
- Identify resources for additional training on motivational interviewing for clinical practice.

Childhood Obesity and Motivational Interviewing

- Childhood obesity continues to be one of the biggest public health concerns in the US.
- Empiric evidence suggests that Motivational Interviewing (MI) is one of the few "tools" that can be used to improve childhood obesity outcomes.
- AAP and NAPNAP guidelines support the use of MI in treatment of childhood obesity.

NAPNAP's Position Statement on the Prevention and Identification of Overweight and Obesity in the Pediatric Population

Position Statement #5: "Use patient-centered practices such as motivational interviewing when partnering with children and families to identify goals for lifestyle and health behavior changes that are targeted, realistic, and attainable" (Armstrong et al., 2011; NAPNAP, 2006).

What is Motivational Interviewing (MI)?

- MI is described as "a collaborative, person-centered form of guiding to elicit and strengthen motivation for change" (Rollnick & Miller, 1991, p. 137)
- MI emerged in the 1980s within the setting of alcohol addiction treatment, where it was noted that encouraging patients to think and talk about their own reasons to change minimized their resistance and increased their motivation.
- MI has also been effectively used for behaviors such as smoking, risky sexual activity, eating disorders, obesity, and chronic illness management.
Research on Motivational Interviewing

- Evidence-based communication style—over 1200 peer-reviewed studies published on MI.
- The use of MI for childhood obesity treatment has been widely recommended by experts in the field.
- A meta-analysis of the use of MI for behavior change demonstrated its effectiveness in decreasing BMI and total blood cholesterol (Rubak et al., 2005).
- Research exploring patients’ experience with MI as a technique for behavior change is lacking—particularly from the “voice of the child.”

The MI “Spirit”

- Partnership-
  - Avoid ‘expert’ status
- Acceptance
  - Accepts autonomy and strengths
- Compassion
  - Work together toward patient’s goals
- Evocation
  - Creates opportunity for patient to use their own language in favor of change

What is “Ambivalence”

- Natural condition of thinking about pros and cons of change
- Wanting to change but not yet taking steps towards changing
- Produces anxiety or discomfort
- Individuals often will procrastinate about making decision to change
- MI can help resolve ambivalence!

The Core MI Principles

- Develop Discrepancy
- Express Empathy
- Roll with Resistance
- Support Self Efficacy

Required Characteristics of Provider

- Provider must see the patient as the key to behavior change, with each individual possessing the internal resources to make change with or without professional advice
- Provider must be willing to remove “expert” hat and be an equal partner in the therapeutic relationship
- Provider must take time to build RAPPORT with child and family and learn child’s inherent drive for change

MI Steps

1. Engaging—establishment of a mutually respectful relationship
2. Focusing—process of seeking and maintaining direction
3. Evoking—eliciting patients own motivation for change
4. Planning—developing change plan that patient agrees with
**MI in Clinical Practice**

- **Open Ended Questions**
- **Affirmations**
  - Statements about anything positive to patient
- **Reflections**
  - Understanding what patient is thinking and feeling and saying it back to the patient
  - Conveys empathy and understanding
- **Summaries**
  - Long reflections of more than one of patient’s statements

**Where to Begin...**

- Use MI as a way of structuring conversations about change
- Guide conversation so patient hears themselves use “change talk”
- Help client build their own argument for why they should make the change
- Work together to determine a plan

**Examples of Change Talk**

- Why do you want to make a change?
- What would some of the benefits of the change be?
- How might you go about making a change?
- What would be your first step?
- How do you think you would feel if you made that change?

**What NOT to Do...**

- Avoid telling patient what to do
- Avoid power differential
- Avoid labeling

**Developmental Considerations**

- Why does MI work well with children?

**Research Study: Child’s Perception of MI for Childhood Obesity Treatment**

1. What are children’s experiences with the use of MI as a communication tool for healthy behavior change?
2. Should MI be used for other types of behavior change programs involving children?
3. What is it about this communication style that has shown positive outcomes in previous research in similar populations?
4. How is this different from other types of programs they have participated in before for behavior change?
Emerged Themes

Five major themes emerged from the study:

1) Empowerment
2) Freedom to be me
3) Educating without "educating"
4) Unconditional Support
5) Blossoming

Empowerment

- Emerged as strongest theme in the data
- Woven throughout each interview
- Children demonstrated authority when "teaching" researcher guidelines

Subthemes:

- Feeling of importance
- Knowledge as power
- Freedom to choose

Example of MI in Practice

- https://youtu.be/bTRRNWrwRCo

Unconditional Support

Subthemes:

- Desire for long-term relationship
- Unconditional acceptance
- Trust

“It they don’t say I’m heavy weight. They don’t pay attention to that. They just help me out, they don’t call me fat…Cause I believe a cardiologist, or something, said the only reason I have bad cholesterol was because I was fat. He called me fat.” (male, age 13)

Blossoming

Subthemes:

- Tangible benefits of clinic visits
- Improvement in family relationships
- Planning for a successful future

“I don’t like to come here on some days. But it helps a lot. I can see a change in my family’s ways. We don’t argue as much anymore. We don’t eat as much stuff that’s not good for us anymore. And we spend more time together…(I) feel like I’ve accomplished something…We talk about goals and they ask us how we’ve been doing with them. And we tell them, and they cross it off on our plan, and that means I’ve accomplished something.” (male, age 13)
Barriers to Use of MI by PCPs

- Time constraints
- Lack of training/comfort with MI
- Insurance reimbursement
- Frustration with failure to meet goals
- No quick fix
- Resistance to change from prescriptive to non-prescriptive approach

Practice Time!

C.M. is a 14-year old male patient presenting for a rash in his axillary region bilaterally. He is morbidly obese: weight=247 lbs, height=5ft 2 in.

Rash is suspected to be acanthosis nigricans with secondary candida infection.

Mother is morbidly obese. Family history is positive for DM2 and hypertension in mother. Paternal family history is unknown. Mother appears to be in a hurry but concerned about the recurrent rash in child's underarms.

How do you begin the conversation?

References


References, cont.


