

# Motivational Interviewing (Patient-centered Counseling) to Address Childhood Obesity

## CME EDUCATIONAL OBJECTIVES

1. Discuss the utility and power of using open-ended questions and reflective listening in interactions with patients.
2. Demonstrate the use of the elicit-provide-elicited tool.
3. Outline the use of the importance and confidence scale in assessing motivation and readiness to change behavior.

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**B**ehavior change is difficult to achieve and even more difficult to maintain. Motivation is a major factor in determining whether we change our behavior. When a person seems unmotivated, it is often assumed that there is little we can do. This assumption is often false. The way physicians talk with patients can have a sig-

nificant influence on their motivation for behavioral change.<sup>1,2</sup> People do not like to be forced or coerced to change their behavior. Sometimes, merely acknowledging this autonomy or freedom not to change makes change possible.<sup>2</sup> Physicians have been trained to provide information, but not how to help patients change their behavior. This article is an introduction to the spirit, principles, and tools of motivational interviewing (MI).

## DEFINITION OF MOTIVATIONAL INTERVIEWING

MI is a “patient-centered method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.”<sup>3</sup> MI is patient-centered, not doctor-centered. This means that the physician listens to the patient’s perspective on how the problem affects daily life and seeks to understand the patient’s point of view without judging or criticizing the behavior. The goal of MI is to elicit the patient’s motivation to change and to encourage the patient to take responsibility for his/her behavior. Ambivalence is seen as a normal stage in the process of change. An un-

motivated person may have unresolved ambivalence, so ambivalence needs to be resolved for change to occur. One of the effects of MI is to help people realize that they are being ambivalent.<sup>3-6</sup>

## THREE COMMUNICATION STYLES OF MOTIVATIONAL INTERVIEWING

Three communication styles are used in motivational interviewing: following, directing, and guiding. The following style includes listening, gathering information, and obtaining a history. Techniques used in this phase include open-ended questions, reflective listening, agenda setting, and asking permission.

When using the directing style, the clinician tells the patient what to do and how to do it. Clinicians frequently overuse this style. Tools include building a menu, using action reflections, and discussing next steps.

In the guiding style, the clinician helps the patient to find his/her way and acts more like a tutor. The guiding style is well suited for discussions involving health behavior change. The patient is encouraged to explore his/her own motivation and goals. Techniques used in the guiding

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phase include discussing pros and cons, importance and confidence scale, elicit-provide-elicited, and summarizing.<sup>2,8,9</sup> A major difference in these approaches is that in the directing style, the clinician makes the case for change, while with a guiding style, the patient does this.<sup>2</sup>

#### FOUR GUIDING PRINCIPLES OF MOTIVATIONAL INTERVIEWING

##### Resist arguing and trying to persuade your patient to change behavior

When you argue or try to persuade, the patient usually becomes defensive. When this happens, it should be seen as a red light, and the interviewer should back off. This is called “rolling with resistance.”<sup>3,5,7</sup> An approach in this situation is to use a communication technique called reflective listening. For example, if the patient says, “I am not giving up chocolate,” you might respond, “It sounds like chocolate plays an important role in your life.”

##### Understand your patient’s motivation

Instead of telling the patient to change, you might ask why they might want to change and how they might do it.<sup>2</sup>

##### Listen to your patient

When it comes to behavior change, the patient most likely has the answer. You may be knowledgeable about the medical benefits of exercise, but the patient is the expert on the barriers to a physical activity program in his daily life.<sup>2</sup>

##### Empower your patient

A person’s belief in her ability to change is a good predictor of success.<sup>3</sup> The clinician’s belief in the patient’s ability to change can become a self-fulfilling prophecy. Low self-esteem often underlies poor self-efficacy. The clinician can promote self-efficacy by supporting the patient’s belief that change is possible.<sup>6</sup> Encourage small steps to increase the chance of success.<sup>2</sup>

#### MOTIVATIONAL INTERVIEWING: WHAT IT IS NOT

MI is not a technique to trick people into doing what they do not want to do. It is a clinical style for eliciting from patients their own motivation to change their behavior. It involves guiding more than directing and listening as much as telling.<sup>2</sup> MI is not arguing that a person has a problem and needs to change.

Confrontation leads to resistance, and the interviewer will be viewed as critical and unsupportive. The interviewer needs to purge herself of statements, such as “you must,” “you should,” “you need to,” and instead emphasize personal choice and responsibility. MI is not offering advice without the patient’s permission. Knowledge only weakly correlates with behavior change. Behavior change is driven more by motivation than information. MI is also not prescriptive. Instead, MI is a shared process of decision-making and should be negotiated not prescribed. Ultimately, it is the patient’s choice to change or not change the behavior, and the reasons for change should come from the patient’s own goals and values.<sup>2,3</sup> In summary, MI is an empathetic, nonjudgmental, supportive style of communication for guiding patients as they struggle to make decisions about their behavior.<sup>2,3,5,7</sup>

#### MOTIVATIONAL INTERVIEWING TOOLS

- Establishing rapport with parents or a teenage patient can increase family involvement in the treatment process. Having the patient or parent describe a typical day or using reflective listening can be techniques for establishing rapport.<sup>1,4</sup>
- Setting the agenda: You might set the agenda by stating, “We have 15 minutes for our discussion today. We can talk about your diet, physical activity, or screen time. Which of these topics would you prefer to discuss?”
- Asking open-ended questions: These are questions that cannot be answered with a “yes” or “no.” Open-ended questions use the patient’s own words and are not biased or judgmental.<sup>5,6</sup>
- Using reflective listening: On a simple level, reflective listening is restating and rephrasing what the patient said. On a deeper level, reflective listening clarifies the meaning and feeling of what the patient told you.<sup>4,7</sup>

## SIDEBAR 1.

**Importance and Confidence Scale****IMPORTANCE**

On a scale of 0 to 10, with 10 being very important, how important is it for you to change (INSERT BEHAVIOR)?

0 1 2 3 4 5 6 7 8 9 10  
Not at all Somewhat Very

**CONFIDENCE**

On a scale of 0 to 10, with 10 being very confident, assuming you wanted to change (INSERT BEHAVIOR), how confident are you that you can do it?

0 1 2 3 4 5 6 7 8 9 10  
Not at all Somewhat Very

**PROBE 1: COULD HAVE BEEN LOWER**

**PROBE 2: COULD HAVE BEEN HIGHER**

## SIDEBAR 2.

**MI Road Map**

Remember to use open-ended questions, reflective listening, and guiding style.

- 1) Establish rapport and reinforce positive behavior.
- 2) Raise concern about unhealthy behavior.
- 3) Shared agenda setting.
- 4) Pros and cons of change.
- 5) Use elicit-provide-elicited when providing information.
- 6) Assess importance and confidence in changing behavior.
- 7) Summarize the discussion.
- 8) Closure — what do you think might be a first step?

\*When time is limited, ask about "importance and confidence" in changing behavior to assess readiness for change.

- Affirmations recognize patient strengths and past efforts, such as previous efforts to lose weight.<sup>3,6</sup>
- Considering the pros and cons or costs and benefits of change.
- Developing discrepancy: Ambivalence may resolve and motivation for behavior change begins when a patient's actions are seen by the patient as being in conflict with his/her goals, ideals, or values. The clinician might pro-

note the awareness of discrepancy by asking, "What might be a health benefit if you were to decrease your soda intake?" or "dine out less frequently?" or "increase your physical activity?"

- Eliciting change talk: Change talk can be initiated by asking patients how important it is to change and their level of confidence in making change.
- Providing menus vs. single solutions: When discussing approaches to a problem, provide a menu of strategies, not a single solution, and allow the patient to choose the approach that seems best.<sup>2</sup>
- Providing information: When providing information, give only the facts. Do not interpret the information.
- Summarizing: A summary is restating what you heard and is allowing the patient to hear her own words again.<sup>6</sup> This can be very powerful because patients are more likely to believe what they say rather than what you tell them.<sup>2</sup>

We will now examine some of these MI tools in more detail.

**ASKING OPEN-ENDED QUESTIONS**

For taking a medical history or in an emergency, closed-ended questions are appropriate. However, for behavioral and

emotional issues, open-ended questions yield more information and a broader understanding of the patient's perspective.<sup>2</sup> For example, instead of asking, "Are you feeling OK?" the clinician could substitute, "Help me understand how you feel." Instead of asking, "Did you have a great vacation?" the clinician could say, "Tell me about your vacation." When speaking with an overweight adolescent, instead of asking, "Are you happy with your weight?" you might ask, "How do you feel about your weight?" In these examples, open-ended questions get the conversational ball rolling and elicit more details than closed-ended questions.

**USING REFLECTIVE LISTENING**

Reflective listening is the core skill of MI. On a simple level, it is a rephrasing of what the patient told you and shows that you are listening. On a deeper level, it clarifies the meaning and feeling of what the patient told you.<sup>4,7</sup> Reflective listening is a form of hypothesis testing: "If I heard you correctly, this is what I think you are saying." The goal of reflective listening is to keep the patient talking and allow her to express her feelings. Examples of reflective listening include the following: To a withdrawn, overweight teenager: "You are feeling that nobody understands how hard it is to be big at your school." To the mother of an overweight child who has tried to help her child lose weight: "You have tried many things to help your daughter lose weight, but they have not been successful, and you are feeling frustrated and worried." To a working mother who does not have the energy to cook a meal at home in the evening and takes her children out for fast food three to four times a week: "On one hand, you are tired after work, and it is easier to dine out or bring home a pizza. On the other hand, you would like your family to have healthier meals." To a working mother who lets the children watch TV while she cooks dinner and does her house cleaning: "It can be exhausting having to entertain the children all the time, and let-

ting them watch TV gives you some time to get your work done.” Using reflective listening takes practice and experience. However, your reflections do not have to be perfect to be effective. Patients appreciate a clinician listening to them and trying to understand how they feel about their problem.

### CONSIDERING THE PROS AND CONS

The clinician could start this conversation by stating, “Sometimes it helps to talk about the pros and cons or advantages and disadvantages of making change. Would it be OK to do this?” When discussing sugar-sweetened drinks, the clinician could ask, “What are some things that you like about sodas.” This question could be followed by, “What are some things that are not so good about sodas?” This could be followed by, “What might happen if you don’t make any change in your soda intake?” This last question allows the patient to make the argument for change. Another question might be, “How would changing your soda intake affect your family?” This question may bring barriers into the open.<sup>5</sup>

### PROVIDING INFORMATION

When providing information, the clinician should ask permission from the patient to discuss the topic. Asking permission reinforces patients’ autonomy, lowers resistance, and makes the patient more willing to hear the information.<sup>2</sup> Provide only the facts and let the patient interpret the information. The tool used in this situation is called “elicit-provide-elicit.”<sup>2,8</sup> After getting permission, provide the information and then ask, “What does this mean to you?” For example, in discussing screen time for a 5-year-old child, the clinician might ask “Would it be OK if we discussed your child’s TV viewing?” You might then state, “The American Academy of Pediatrics recommends that children watch fewer than 2 hours of TV daily.” Then elicit the patient’s response by asking, “How do you feel about that?”

SIDEBAR 3.

### MI Counseling Script

Remember to use open-ended questions and reflective listening.

“I would like to take a few minutes today to discuss your child’s eating, your family meals, and your child’s activity and TV habits. In looking over the diet and activity history form that you filled out...”

- 1) **Reinforce positive behavior.**  
“I can see that Susie is eating a number of fruits and vegetables.”
- 2) **Raise concern about unhealthy behavior.**  
“However, I also see that Susie is drinking two sodas a day and watching more than 3 hours of TV.”
- 3) **Shared agenda setting.**  
“Which of these subjects — the sodas or TV — would you like to talk about?”  
“What problems, if any, do you have with Susie drinking sodas (or watching TV)?”
- 4) **Pros and cons of change.**  
“What are some good (positive) things about Susie drinking sodas (or watching TV)?”  
“What are some negative or not so good things about sodas (or TV)?”
- 5) **Providing information.**  
“Would it be OK if I shared some information with you?”
- 6) **Assess importance and confidence in changing behavior.**  
Probes regarding lower and higher scores.  
“Why didn’t you pick a lower number?”  
“What would it take to get you to a higher number?”  
If response is a 9 or 10, skip probe. Reflect: “It seems that this is very important to you” or, “You are very confident.”
- 7) **Summarize .**  
“I would like to take a moment to go over what we have discussed today, if that is OK.”  
Review pros and cons (emphasize the pros) of changing the behavior. Ask “Is there anything that I have left out or that you would like to add?”
- 8) **Closure — and next step.**
  - a. **If ready to move toward change:**  
“What might you want to do about this?”  
“What do you think might be a first step?”
  - b. **If patient doesn’t respond:**  
“Would it be OK if I shared some strategies that have worked for other families?”  
**or**  
“Sometimes changing many things at once is more difficult than doing one thing at a time. How do you feel about that?”
  - c. **If not ready for change:**  
“It seems that you are not ready to make a change in Susie’s drinking sodas (or cutting back on TV) now. Perhaps you can think about what we have discussed today, and next time we can talk about some of these issues again. Maybe there is something else that seems more important to you at this time.”

### ASSESSING IMPORTANCE AND CONFIDENCE IN MAKING CHANGE

A person’s belief or confidence in her ability to change is a good predictor of success.<sup>3</sup> Therefore, the clinician can promote self-efficacy by supporting the

patient’s belief that a change in behavior is possible.<sup>6</sup> A strategy to elicit “change talk” is by asking patients their level of importance and confidence in making a behavioral change. Importance and confidence describe a patient’s degree

of motivation and readiness to change. People are not motivated to change unless they believe it is important and think that they can do it (confidence). In other words, they need to be ready, willing, and able. To implement this technique, patients are asked the following two questions. (see Sidebar 1, page 156).

1) "On a scale of 0 to 10, with 10 being the highest, how important is it for you to change your...[behavior]?"

2) "On a scale of 0 to 10, assuming you wanted to change your behavior, how confident are you that you can do it?"

After asking these questions, the clinician asks two follow-up questions:

1) "Why did you not choose a lower number?" This question allows the patient to make the argument for change.

2) "What would it take to get you to a higher number?" This question identifies barriers and obstacles to change.

### SUMMARIZING AND CLOSING THE DEAL

A good summary shows that you have been listening, restates what has been discussed, and allows patients to hear their own words again.<sup>2,4,6</sup> The clinician can start this discussion by saying, "If it's OK, I would like to go over what we have discussed today." After summarizing the discussion, the clinician might close the encounter by asking, "What do you think might be a first step?" If the patient cannot come up with a plan of action, the clinician might ask permission by saying, "Would it be OK if I shared some strategies that have worked for other families?" Another approach might be to say, "Many people find that changing a lot of things can be more difficult than changing one thing at a time. How do you feel about that?" If the patient is still not ready to make change, the clinician can respond, "It seems that you are not ready to make a

change at this time. It is really up to you, and it's your decision to change or not to change. If it is OK with you, perhaps we can continue this discussion at another visit." It is important to keep in mind that behavior change is a process and happens over time. Decisions to change behavior do not usually occur in the clinician's office, but take place at home. A good starting place might be to schedule a family conference. You can close the discussion by emphasizing that it is the family's decision to change or not change their behavior, and that you are there to help them with guidance, information, and support.

### CONCLUSION

MI is a supportive and empathetic style of communication for guiding patients as they struggle to make decisions about changing their behavior. Your patients are your teachers. If you try some of the strategies discussed in this article, you will receive immediate feedback from your patients and over time you will improve your MI skills. Remember that behavior change is a life-long process. Small steps should be encouraged, and, if successful, can lead to further behavior change. Your goal is to help your patient and their family begin to think about behavior change. Using these tools may be challenging at first but, with practice, will become more natural as you develop your own style.

A major concern of most clinicians about using MI is a lack of time. Some suggestions include the following:

- Practice using open-ended questions and reflective listening at home and in interactions with your patients.
- Make a "cue card" for the "importance and confidence" scale (see Sidebar 1, page 156) and for the "MI road map" (see Sidebar 2, page 156).
- Attend a MI workshop.

- Schedule a follow-up visit with a patient for a more extended MI discussion, and "code" the visit as counseling time. (see Sidebar 3, page 157).

Recent studies have demonstrated the efficacy of MI in helping patients change their health behaviors.<sup>4,6,7,10,11</sup> Incorporating MI into your practice can ease the burden of trying to fix the health behaviors of your patients, promote patient satisfaction, and ultimately improve clinical outcomes.

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