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Motivational Interviewing for Adolescents: Behavior Counseling for Diet and Exercise

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ABSTRACT

Primary care is an essential setting for the prevention and early detection of the challenging and multifactorial components of obesity. The majority of pediatric providers understand behavior change counseling is a crucial component to obesity management; however, 38% report low proficiency with counseling interventions. Motivational interviewing is an evidence-based method of behavior change counseling. Training in motivational interviewing by primary care providers has shown an increase in provider efficacy and confidence in behavioral change counseling. With motivational interviewing skills, providers will be more equipped to promote healthy diet and exercise for teens and aid in preventing obesity-related chronic conditions in adulthood.

Keywords: adolescent health, behavior change counseling, childhood obesity, motivational interviewing

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The long-term relationships created by pediatric providers in the primary care setting are crucial for the prevention and early detection of obesity in adolescents.[1-4] Recommendations from the American Academy of Pediatrics and the American Heart Association clearly advise discussion with children, including adolescents and their families, about healthy lifestyle choices for cardiovascular disease and diabetes prevention.[5,6] Providers understand that obesity is a problem; however, 80% of pediatric providers report frustration discussing weight management in their daily practice.[7,8] Of the 131 million visits of children 2-18 years old identified in the National Ambulatory Medical Care Survey from 1997-2000, only 35% of well-child visits involved behavior change counseling to improve diet and physical activity.[9] Barriers to counseling are time, provider-perceived patient lack of motivation, provider skill set, lack of reimbursement, and low self-efficacy in behavior change counseling techniques such as motivational interviewing (MI).[2,8,10,11] With obesity on the rise, evidence-based practice to improve the long-term health of future adults in the United States is paramount.

OVERVIEW OF THE PROBLEM

Obesity

There has been a dramatic rise in adolescent obesity over the past 30 years.[12] Between 1988 and 2008, the rate of obesity rose from 11% to 20% in adolescents 12-19 years old.[12] Recent 2010 data suggest that 31.7% of children 2-19 years old are overweight, illustrating an upward trend.[13] Among adolescent children, non-Hispanic black and Mexican American teens had significantly higher rates of obesity compared with non-Hispanic white youth ($P < .05$).[14] In addition, there are overwhelming data that overweight and obese body mass indexes (BMIs) plague 60% of the adult US population and are very serious risk factors for both cardiovascular disease, the leading cause of death in the US for men and women, and diabetes.[15,16] A summary of the evidence for the US Preventive Task Force in 2005 found that the probability of adult obesity is greater than or equal to 50% among children older than

13 years whose BMI percentiles meet or exceed the 95th percentile for age and sex.[14] This probability increases if 1 or more parent is obese or if the child is obese later in childhood. Authors of the study stressed the importance of lifestyle interventions for overweight and obese adolescents.[14]

Healthy Lifestyle Behavior Counseling

Despite the national guidelines to improve diet and physical activity in the US pediatric and adult populations, the prevalence of behavioral change counseling on these topics is low.[3,8-11,17,18] In 2005, Story et al[10] conducted a national needs assessment of pediatric provider management of obesity. Only 940 providers out of over 3,500 pediatricians, pediatric nurse practitioners (NPs), and registered dieticians responded to a mailed questionnaire. Results of the responses revealed that 75%-93% of providers reported obesity was a problem in children and adolescents, 61%-85% stated their primary barrier was parent/patient lack of motivation, 15%-38% reported having low proficiency in behavior change management, and over 50% revealed high interest in training in behavior change management skills.[10] Furthermore, the questionnaire's low response rate of 19%-33% led the authors to believe that it may have been answered by a sample of providers who are more comfortable with obesity management than the average pediatric provider and that overall provider knowledge and management of obesity may be less than the study revealed.

O'Brien et al[11] retrospectively reviewed 2,515 health supervision visits of children ages 3 months to 16 years for 3 consecutive months in a large, 70% African American, urban pediatric practice. Approximately 10% (n = 244) met the criteria for obesity, yet providers only documented obesity in 5% (n = 129) of the children. Providers focused care on diet (71%) and addressed the other multifactorial components of obesity, such as exercise, in only 33% of the visits and screen time only 5% of the time. These data highlight that Story et al[10] may have been correct in their prediction that obesity knowledge and management was overrepresented in their research.

Cook et al[9] analyzed data from 3,514 well-child visits of 2- to 18-year-old patients from the 1997-2000 National Ambulatory Medical Care survey to assess obesity diagnosis and determine the rates of diet and physical activity counseling in all pediatric age groups. Obesity, morbid obesity, or excess weight gain was diagnosed in only 0.9% of all encounters. The authors found that adolescents were only counseled on diet and exercise in 27% and 22% of all well-child visits, respectively. When compared with other age groups, adolescent visits were 30% less likely to include diet counseling than 2- to 5-year-olds and 6- to 11-year-olds. Black children were less likely to receive exercise counseling than white children ($P = .03$). There was no significant difference in exercise or diet counseling between Hispanic and non-Hispanic children.

Jelalian et al[7] surveyed 1,066 pediatric providers in southern New England on their attitudes on the management of obesity. Only 34% of providers reported frequently discussing weight management with adolescents who are mildly overweight, yet providers ranked obesity as fourth in its importance for health promotion in adolescents. Only smoking, risky sexual behavior, and drug and alcohol use were deemed more important. Seventy-nine percent of providers reported including the parent in the conversation with adolescents and 93% of the time in children less than 12 years old. When correlations were made in the data, it was found that providers who had past successes in diet and exercise behavioral change counseling were more likely to continue using it, suggesting that further training in behavior change counseling, such as MI, would be beneficial.[7]

MOTIVATIONAL INTERVIEWING

The nonjudgmental, empathic, and collaborative approach of MI is perfect for youth.[19] Miller and Rollnick[20] define MI as a patient-centered guiding method of behavior counseling used to elicit and strengthen the patient's motivation for change. The patient, rather than the provider, presents the reasons for change. The provider does not assume the authoritarian role but rather uses an empathetic, nonjudgmental style of communication that is patient centered yet has a strong sense of purpose and direction.[21]

Miller first published research on MI in 1983 as an intervention for alcohol abuse. Since Miller and

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