Motivational interviewing to improve blood-glucose control in childhood diabetes

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Abstract

Motivational interviewing (MI) is a relatively new approach to counselling which has been developed largely in the addiction field. The method is patient-centred and helps resolve ambivalence about behaviour change whilst avoiding conflict and advice-giving by the clinician. This approach has qualities which seem particularly appropriate when dealing with teenagers. Recent evidence from clinical trials shows that motivational interviewing may be effective in facilitating healthier approaches to diet and exercise in young people and improved glycaemic control and quality of life in teenagers with diabetes. These findings suggest that MI has a role to play in the management of childhood chronic disease such as diabetes, but the future challenge is how to incorporate these principles into routine clinical practice given the general shortage of skilled, trained psychologists.

Keywords childhood; glycaemic control; motivational interviewing; psycho-educational interventions; type-1 diabetes

Introduction to motivational interviewing

Motivational interviewing (MI) has been defined as a 'client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence'. It was developed in the 1980s, initially in adult services for problem drinkers, and is now established as a method in many different clinical contexts, with the common denominator that a key issue is patient motivation to change. In recent years the expansion of MI has continued, particularly within health-care settings, including paediatrics. Clinical trials have been published across a broad spectrum within adult specialties, and there is also an emerging evidence base to support its use in paediatric settings.

MI was originally conceived as a preparatory step in a treatment programme designed to engage patients with the idea of change, and then for them to move into the other approaches to treatment. However, from the research that emerged it became clear that, for some people, change occurred after one or two sessions of MI when compared to a no-treatment control group. So, as well as being used as an adjunct to other approaches (e.g. weight-loss programmes, cognitive-behavioural interventions etc), MI has also developed into a stand-alone treatment. In the reviews of the studies combining MI with other approaches, it has been demonstrated that MI can increase patient engagement with programmes through greater attendance and programme adherence, and can also achieve better outcomes. Therefore MI can be both an effective intervention in its own right but also a means of enhancing other services where behaviour change is key to outcomes. One of the significant advantages of MI is that it has been found to be effective in brief clinical encounters, and therefore has the potential to be integrated into the practitioner's role as a health-care provider in a variety of clinical settings, from accident and emergency departments to routine follow-up consultations for chronic disease.

The issue at the heart of MI practice is that of ambivalence about change. Personal motivation for change is a fluctuating state which ebbs and flows for all of us, depending on many different individual factors. In MI the practitioner's goal in working with a patient who feels uncertain about introducing change is to harness the person's own motivation to change, as opposed to creating external motivations (as a more behavioural model of therapy might), introducing the practitioner's own professional reasons for change (e.g. medical model) or working on coping skills or cognitions (as in cognitive behavioural therapy). The rationale for this is that if patients make change for their own reasons, the changes are much more likely to happen and much more likely to last.

The approach used to achieve this outcome in MI is both 'client-centred' and 'directive'. 'Client-centred' refers to the core principles, significantly influenced by the work of Carl Rogers, which underpin the ethos of MI and describe the way the practitioner engages with the patient. It focuses on the issues for the patient in the present, using past events only in their capacity to help the patient explore beliefs and values that are part of the current dilemmas (and in this way is unlike more psychodynamically oriented psychotherapy). The key skill that the practitioner uses is accurate empathy, defined by Rogers as skilful reflective listening that clarifies the patient's experience without imposing the practitioner's own interpretation (described in more detail in later section).

One of the key differences to the Rogerian approach is that MI is 'directive', specifically focused on helping the patient resolve ambivalence. The practitioner takes an active role to help the patient move towards making a change that is good for their health by selectively responding to the client (i.e. responding positively to any evidence that they are considering change and responding to resistance to change in a way that is meant to reduce it). The strategies used within MI are designed to elicit reasons for change and then to reinforce the evidence of change.

The ethos of motivational interviewing

Collaboration

In any health-care context there exists a power imbalance between the practitioner and the patient, and this is particularly

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pertinent in paediatric services where children often feel disempowered within consultations. Within MI, the aim is to create a collaborative relationship with joint decision-making, where all participants have made a contribution and feel that their concerns have been listened to.

Evocation

As all practitioners know, no matter what you say or do the only person who can change a patient's behaviour is the patient themselves. The practitioner can help to create the best environment possible by providing information, support and insight, but for these to make a difference the patient needs to have their own motivation and to use their own resources to make the change. MI works to evoke from patients their own goals, values and resources, and to match the goal of change with the patient's own concerns. For example they are much more likely to make a change if it impacts on their capacity to play football for longer (if that's their hobby) than they are for their long-term health (if that doesn't interest them).

Respecting patient autonomy

Most practitioners in health care are focused on health outcomes, as that is their job. However, it is the patient who makes choices and decides how they are going to behave in relation to those outcomes. The practitioner can inform and advise, but only in very rare instances (such as child protection) will the practitioner impose their opinions on others. This is often the hardest part of MI for health-care practitioners to take on board, but it is acknowledgment of a patient's right and freedom not to change that sometimes makes change possible.

Four fundamental principles of motivational interviewing

Expression of empathy

Listening carefully, really carefully, is an important skill in any clinical encounter. The aim is for the patient to feel heard and understood, and also that their uncertainties and ambivalence are accepted. Reflective listening is a particularly important tool for this (see Table 1).

Developing discrepancy

The discrepancy being referred to is the gap between the patient's actual and ideal scenarios in terms of behaviour, goals, or values: for example, current behaviour and future goals (I don't go to the gym but I want to be fit) or a discrepancy between behaviour and values (I believe that Dads should be involved in their children's lives but I am working until 8 p.m. at night). Living with discrepancy is uncomfortable, and the degree of discomfort indicates the degree of discrepancy. Ambivalence and discrepancy go hand in hand; ambivalence is an indicator of discrepancy. The practitioner encourages the patient to explore their ambivalence, to develop the discrepancy to the point where change becomes an option in order to reduce the discrepancy.

Supporting self-efficacy

The practitioner needs to believe in and to support the patient's belief in their capacity to change. They can highlight other changes that the patient has made or reference the skills that the person has which will contribute to success. The patient needs to become the expert in how they are going to achieve the change, and they need to actively address this in the counselling session to bring it alive for them rather than to receive advice on how to achieve it.

Reflective listening Statement: 'Even though nothing has happened my diabetes doesn't feel so good'

Technique	Definition	Example of response
Repeat	Repeat an element of what the speaker said	'Your diabetes isn't so good'
Rephrase	Stays close to what the speaker has said with some rephrasing and synonyms	'So you feel your blood-glucose control hasn't been so stable'
Paraphrase	Therapist infers meaning of what patient said and reflects back	'You'd like to know why your diabetes changes like that'
Reflect feeling	Emphasizes emotional dimension through feeling statements and metaphors	'It's scary not being able to understand why your diabetes changes like that'

Table 1

Rolling with resistance

When practitioners see a patient doing something they know to be harmful to their health they naturally want to persuade them to stop. Unfortunately, however well intentioned this may be, human nature is to resist persuasion, and this is as true in a medical clinic as it is in any other interaction. If the practitioner takes up the position of advocating change, the patient will naturally defend their behaviour, and so the stage is set for resistance. When discussing possible changes with patients, change is more likely to happen if the patient is the person expressing their reasons for change, not the practitioner.

Strategies used in motivational interviewing

Open questions

Closed questions are those to which can be given a 'yes' or 'no' answer, or those that are seeking specific information. Open questions are the opposite, and aim to broaden the discussion, to help the patient think about things in a different way and to tell you things you didn't know to ask about. Typically they would start with 'how', 'why' or 'what' and would convey interest on the part of the practitioner.

Reflective listening

Listening is an active process, and reflective listening is the skill of responding to what the patient has said in a way that conveys an understanding of their meaning. Sometimes this can be simply a repetition of one or two words, to encourage the patient to say more. Other approaches involve a more complex reflection, extracting the meaning underlying the words or linking different aspects of the conversation together (see Table 1).