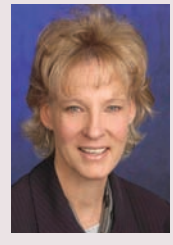
By Bonnie Gance-Cleveland, PhD, RNC, PNP, FAAN

Motivational Interviewing for Adolescent Obesity

Using a collaborative approach with patients and families can empower them to change.

We are facing an epidemic of childhood obesity so severe that this generation may be the first in the modern era to have a shorter life span than their parents. Nearly one-third of children in the United States are either overweight or obese, a dramatic increase over a few short decades that has led to the emergence of comorbidities such as dyslipidemia, hypertension, and type 2 diabetes in youth, as well as to increased risks of cardiovascular disease and cancer in adulthood. Obesity-related health care costs in the United States are estimated at $147 billion annually.

Our standard approach to health problems is to conduct an assessment, determine a diagnosis, develop a plan, and tell the patient or her or his family what to do. Such a prescriptive approach often has the effect of focusing blame for the problem on the patient or parents. We know that traditional counseling for obese children to exercise more, eat more fruits and vegetables and less fat, and decrease sedentary time has been unsuccessful, yet this approach continues.



It's imperative that we shift to counseling techniques with promise.

The recommendations of expert panels (the Centers for Disease Control and Prevention, the American Medical Association, the American Academy of Pediatrics) and guidelines developed by the National Association of Pediatric Nurse Practitioners encourage a shift from this traditional model of counseling to a collaborative, family-centered model that includes the use of motivational interviewing (MI), in which the nurse and family jointly formulate a plan of care that is consistent with the family's values and priorities.

Although research on using MI for obesity is not conclusive, it's imperative that we begin to use counseling techniques that do more than reinforce old ways of thinking.

However, MI is not consistent with the way many nurses have been taught to counsel patients and their families. MI acknowledges that the family is in control; that ambivalence about changing behavior is normal; and that the role of the nurse is to elicit reasons for change and collaborate with the family, not tell them what to do. It shifts the focus from blaming the patients to identifying their health goals and *developing discrepancy* (that is, articulating the discrepancy) between their current behavior and health goals.

Applying the principles of MI, we can say that change is more likely when the patient presents arguments for change while the nurse *avoids argumentation* and *rolls with resistance*. Instead of confronting the family on its behavior, the nurse tries to gain a better understanding of the barriers to changing it. This might mean first helping a family with more pressing issues while promising to be available to help with their child's obesity when they are ready.

In this model, instead of educating the family on what they need to do, the nurse invites the family to discuss new information. *Expressing empathy* and *reflective listening* (paraphrasing back to the family what they seem to be saying) make it clear that the patient's perspectives have been understood and are considered valid. Finally, *supporting self-efficacy* (for example, praising past successes in changing health behaviors) helps families increase their confidence in their ability to change behavior—a good predictor of treatment outcome.

Using MI is not typical health education. It takes time to establish a relationship and explore patient and family perspectives as a basis for formulating a plan. Despite the investment of time required and the lack of conclusive evidence of MI's efficacy for obesity prevention and treatment, it is imperative that we shift to counseling techniques with promise; therefore, many experts recommend its use. Given the urgency of this epidemic, the risks of continuing to rely on ineffective traditional counseling are not acceptable. ▼

Bonnie Gance-Cleveland is Loretta C. Ford Endowed Professor at the University of Colorado Denver College of Nursing. Contact author: bonnie.gance-cleveland@ucdenver.edu. *This work is supported in part by grant 1R18HSO18646-01A1 from the Agency for Healthcare Research and Quality. The author has disclosed no potential conflicts of interest, financial or otherwise.*