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USING MOTIVATIONAL INTERVIEWING IN NUTRITION CONSULTATIONS

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This article covers the principles and evidence-base related to motivational interviewing, in the context of dietetic practice.

Supporting behaviour change is a crucial part of nutritional interventions. Motivational interviewing (MI) is one of the most evidence-based approaches that is used to encourage long-term behaviour change.[1-2] MI is described as 'a collaborative, person-centred form of guiding to elicit and strengthen motivation for change'.[3] This is a collaborative process that supports autonomy by helping clients to find their own solutions, rather than being prescriptive or imposing ideas.[4] It also incorporates aspects of other psychological principles related to behaviour change, such as humanistic therapy and cognitive behavioural therapy (CBT).[1]

REFERENCES

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PRINCIPLES OF MI[1,5]

Expressing empathy

This involves genuinely empathising in order to build rapport and establish a supportive environment. An important part of this is embracing the fact that a certain level of ambivalence (ie, having mixed feelings about something) is normal, as nothing is black and white. This can create a more understanding and respectful atmosphere, rather than viewing reluctance to make a change as a harmful or defensive behaviour.

Developing discrepancy

This involves helping the client to discover the discrepancy between their current behaviour (ie, the behaviour they want to change) and their personal values in order to emphasise the importance of making that specific change. For example, facilitating reflection about the discrepancy between smoking and the client's desire to live a long and healthy life. This is achieved using the skills of MI which are discussed below, and is done in a way that respects the autonomy of the client, rather than simply pointing out the discrepancy to them.

Rolling with resistance

As discussed above, some ambivalence is a normal human reaction to change, therefore, at times, clients may seem resistant to making certain changes. In MI, it is important not to push back against resistance, as this usually heightens it by causing conflict and encouraging the client to come up with arguments against making the change. A better approach is to 'go with the flow' and use skills of reflective listening to respond to resistance.

Supporting self-efficacy

An important factor in feeling ready to make a change is feeling confident in our ability to do so; this confidence is called self-efficacy. In order to increase self-efficacy it is important to empower clients by giving positive feedback (called affirmation), being

Table 1: OARS explained

Open questions	Questions are posed in a way that encourages change-focused answers. This also encourages the client to do most of the talking and avoids a back and forth 'question and answer' situation in which the client passively answers questions.
Affirmation	Statements of genuine encouragement and praise for every effort or small step in the right direction.
Reflective listening	Listening actively with interest and reflecting the meaning and emotion behind their statement back to the client.
Summarising	A longer reflection aiming to sum up the client's thoughts and feelings, link different parts of the discussion together, or to emphasise a point.

non-prescriptive and facilitating client-led self-discovery and problem-solving. This often involves learning to resist the 'righting reflex', which is a well-intended urge to help a client by trying to solve a problem for them. A more MI consistent approach is to support them in discovering their own solutions, based on their individual motivations.

SKILLS USED IN MI

Micro-skills called 'OARS', are used to encourage and strengthen 'change talk', which is when clients devise and explain their own arguments for making a specific change. For example: "I want to do more physical activity so that I feel more energetic", or "I could eat more vegetables with my dinner". The OARS acronym is explained in Table 1.[6]

It is also important to recognise and avoid traps. Here are some examples:[6-7]

- **The 'Expert Trap'** This involves reducing the client's self-efficacy by placing yourself as the expert, rather than empowering them by acknowledging that the client is 'the expert in themselves'. Ensuring that information is provided in a respectful way by asking permission before giving advice, can also be a helpful way to avoid this trap and support the client's autonomy. For example, "Would you like me to explain about how insulin works in the body?" instead of launching into the explanation without checking if the client wants to hear about this.
- **The 'Labelling Trap'** This can damage rapport and the client's self-efficacy by imposing a label on them. For example, telling a client that they are obese can cause the client to feel judged or ashamed, which may damage their readiness to change.
- **The 'Premature Focus Trap'** This can easily occur when a consultation starts to focus too quickly on an issue which isn't related to the client's true motivation. This can also happen if a healthcare professional is being prescriptive, is not actively listening to the client, or if action planning occurs before the client is fully ready to begin this process. Trying to encourage a change that a client does not want to make yet is another example of a premature focus trap.
- **The 'Confrontation Trap'** This occurs when a client feels that they need to defend themselves by making their arguments against change. Rolling with resistance (as described above) should help to prevent this trap from occurring.
- **The 'Blaming Trap'** This is an unhelpful situation where a client, family member, or healthcare professional tries to assign blame to somebody for an issue. It is best to try and avoid this by creating a non-judgemental environment so that nobody feels the need to resort to blaming.

There are a number of useful strategies that can be implemented during consultations[8] and that should always be used in line with the collaborative spirit, principles and micro skills of MI. Here are some examples of strategies that can be used in MI consultations:

- **Opening strategy** This involves having some open questions ready to begin the consultation with. For example, "Could you give me some background that led up to this appointment today?".
- **A typical day** This involves encouraging the client to talk about their current behaviour and routine. A diet history can be taken

in this way, but rather than asking direct questions about intake, you begin with an open question such as, "Can you tell me what you have to eat in a typical day, starting in the morning, so that we can chat about any possible areas for change?", then reflectively listen as the client describes their typical day.

- **Readiness scales** By asking the client how important on a scale of 1-10 making a certain change is to them, you can encourage change talk by asking them why they chose that number rather than a lower number. The same strategy can be used when asking clients how confident they feel about making a change, or how ready they feel overall.
- **Two possible futures** This involves talking about how the client would like things to be in the future and discussing the two possible ways that things could go, ie, how might things be if they make the change and how might things be if they don't make the change.
- **Decisional balance** This involves eliciting the client's views on the pros and cons of making a specific change, it can be useful to write these down using a quadrant. This exercise should elicit arguments for and against change and highlight the client's motivations and barriers to change. However, the emphasis is still usually on encouraging change talk by focusing on the pros of change and the cons of no change.

EVIDENCE RELATED TO DIETETIC PRACTICE

Much of the research related to MI has been carried out related to substance abuse, where behaviour change outcomes have improved when a client has seen a therapist who uses an MI-based approach.[1,9-10] A systematic review by Lundahl et al (2013) found that MI-focused interventions had a 55% higher chance of a positive outcome when compared with standard treatments.[11] MI has been seen to improve treatment outcomes with HIV, dental issues, body weight, alcohol use, tobacco use, low activity levels, self-monitoring, self-efficacy and morbidity.[11] However, this review also found that MI was not associated with positive outcomes for eating disorders, healthy eating, encouraging safe sex, injury prevention, self-care, breastfeeding, medication adherence, marijuana abstinence, improvements in heart rate, or blood glucose.[11]

Research has shown that MI can help to facilitate change and lead to improvements in metabolic control when used alongside other interventions for the management of diabetes, but more research is needed.[12] Similarly, using MI as part of weight management programmes has been seen to increase the effectiveness of these in terms of influencing weight as well as healthy behaviours.[12] Using MI has also been found to lead to 'modest improvements [in increasing] physical activity levels in people with chronic health conditions'.[13]

A study comparing dietitians who used MI and dietitians who used a more prescriptive approach found that patients who had seen the MI dietitians had a significantly lower saturated fat intake by the end of the study.[14] However, no differences in HbA(1c), BMI or waist circumference were identified.[14]

Although there is some promising research related to MI, more research is needed overall. It can also be difficult to study the effects of this approach, especially as there can be inconsistency between MI descriptions and interventions.[15]

CONCLUSION

MI is an evidence-based approach for supporting behaviour change and is collaborative, empathetic and client-centred. It takes training and practice to become skilled in the use of MI. There is some evidence that using MI can lead to positive health-related changes, but more research is needed in this area.