Using motivational interviewing to engage adolescents and young adults with diabetes

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Abstract
For young people trying to keep diabetes under control the behaviours can appear simple; e.g. following a healthy diet, regular self-monitoring and exercise. However, clinicians and parents are often frustrated by the gap between the 'ideal' and 'reality'. Young people have conflicting motivations and pressures; a change in behaviour feels too big, the rewards too distant, the personal or financial costs too high, or maybe it was never their idea to change in the first place. Attention has turned to the potential of motivational interviewing in the paediatric setting, particularly with the adolescent age group. Motivational interviewing is a directive person-centred therapeutic style that invites individuals to explore ambivalence and find solutions that fit for them if they identify the situation as a problem. Early trials support the use of motivational interviewing in type 1 diabetes in adolescents, either as a stand-alone treatment or as an adjunct to other treatments where it can be a method of engaging patients in the programmes thus enabling the programmes to be more effective. This paper describes the core principles and key skills of motivational interviewing and offers clinical examples with young people and parents living with diabetes. Copyright © 2014 John Wiley & Sons. Practical Diabetes 2014; 31(6): 252–256

Key words
adolescents; young adults; diabetes; motivational Interviewing

Introduction
Knowing what to do and having a desire to engage in healthy behaviours may not always translate into doing what is needed. For young people trying to keep diabetes under control the behaviours can appear simple; e.g. following a healthy diet, regular self-monitoring and exercise. However, clinicians can often find themselves thinking ‘if only they would just...’: ‘do their injections’; ‘take more exercise’; ‘stop worrying’; or simply ‘just listen’. These demands are also often voiced by parents, with a gap between the ‘ideal’ and ‘reality’. Making a decision to carry out particular diabetes-related behaviours involves asking a number of questions. The first questions are do they know what they need to do, why they need to do it and how to do it? The next questions are slightly more complex. Do they have a reason to do it? Do they have a reason not to do it? And who does it matter the most to?

An example of this might be doing blood glucose testing. Doing blood glucose testing might help stop young people having a hypo but it interferes with what they are doing when they are with friends, and might be a lot more important to their parents than it is to them.

The dilemma of having both reasons to do something, as well as reasons not to it, creates ambivalence which results in a failure to change. When the behaviour is more important to other people than it is to the young person, the ambivalence intensifies and the chance of it happening decreases further. Young people have conflicting motivations and pressures; the change feels too big, the rewards too distant, the personal or financial costs too high or, maybe, it was never their idea to change in the first place.

Why use motivational interviewing?
The process that maintains the gap between what people ‘know’ and what they ‘do’ is ambivalence. Motivational interviewing (MI) is a directive person-centred therapeutic style that invites individuals to explore ambivalence and find solutions that fit for them if they identify the situation as a problem. A guiding communication style invites people to consider the importance of change, confidence to change and whether change is a priority. Clinicians must accept and acknowledge that clients may choose not to
change, and attempt to see the situation from the client’s perspective including their goals and values. The clinician connects what they know about diabetes with the young person’s goals to guide positive change, always respecting the young person’s right to choose. MI ‘rolls’ with the resistance that occurs when someone is given advice or told what to do. The young person is helped to understand that it is up to them to decide what to do. By acknowledging they have every right to make no change, the young person may make the first move towards changing their behaviour.

Attention has turned to the potential of MI in the paediatric setting. Most controlled trials that have specifically addressed type 1 diabetes relate to the adolescent age group. Participants experienced improved perceptions of their diabetes and quality of life changes and significant reductions in HbA1c were maintained a year after the end of the intervention, particularly with older teenagers.

Core principles of motivational interviewing
MI is an individualised approach without a manual, with core principles and key skills in its application. These are illustrated with short examples using two scenarios: James, a 15-year-old young man who is forgetting to check his blood glucose levels when he is playing football, and Caroline, a mother whose 12-year-old daughter, Jessica, has been fairly recently diagnosed.

Empathy Empathy is a cornerstone of MI. It requires active, careful listening so the young person’s emotional experience is understood and respected in a way that makes them feel accepted and understood. Verbal and non-verbal responses convey acceptance and a genuine understanding of the patient’s position. Here are two responses to a statement by James:

James: ‘I just get fed up testing before a match – it takes time and might stop me going on.’

Non-empathic. Clinician: ‘But you need to do it or you might have a hypo.’

Empathic. Clinician: ‘It feels like a real nuisance and gets in the way of you enjoying playing.’

The empathic response is more likely to make the person feel understood, rather than criticised, and will facilitate the relationship and open up opportunities for progress.

Rolling with resistance
The ‘righting reflex’ wants to put problems for you when you do.’

Clinician: ‘You’ve tried to do it sometimes but it can create problems for you when you do.’

After a simple reflection you can shift away from the difficult issue and focus on a potentially more productive area.

Clinician: ‘You’ve tried to do it sometimes but it can create problems for you. You were talking earlier about...’

It may be more productive to go where there is the possibility of change and wait for a more suitable time, or find a time in the future to address the issue that is triggering the resistance.

A double-sided reflection brings in previous information to reflect ambivalence.

Clinician: ‘You said that having a good BM before the match means you will play better so you have been trying but there are some downsides...’

Supporting self-efficacy
MI requires the clinician to believe in the capacity of the young person and their family to introduce change and support them with the process by referring back to past successes, focusing on current skills and reinforcing intention to change. With adolescents it can be possible to notice developmental changes.

Clinician [to James]: ‘I remember when you started to do your own injections, so you could go to football camp – that took some doing!’

Clinician [to Caroline]: ‘So you were thinking that you would be happy to let Jessica do more of her own injections over the summer holidays...’

There is a conscious effort to identify progress and achievements to help boost belief in the possibility of change. This means focusing on the positive and identifying when they were able to do something once or twice rather than talking about the times things didn’t happen.

Developing discrepancy
Most people are aware of the gap between what is real and ideal in relation to health care behaviours. Becoming aware of this mismatch between what we are doing and what we would like to be doing can feel uncomfortable, which is called dissonance. MI addresses the gap between knowing, wanting and doing and invites the young person to think about what they could be doing differently to reduce the feelings of dissonance.

Clinician: ‘Checking your blood glucose would mean you could correct it and play better but you are finding it hard to find the time to do it and think about having to do corrections.’

Clinician: ‘As her mum you want to be more relaxed about her diabetes so you can get back to enjoying things together but it’s really hard to not check on her all the time.’

Key skills
Four key skills are at the heart of MI. These are known by the acronym OARS:
• Open-ended questions.
• Affirmations.
• Reflective listening.
• Summarising.
Open-ended questions
Open questions create space for people to provide information that helps them think in detail about the issue. Closed questions can only be answered with a ‘yes’ or ‘no’. Open questions usually begin with ‘how’, ‘why’ or ‘what’ and broaden and deepen the conversation.

‘What happens when you don’t test your blood glucose?’
‘How does it feel when you don’t test her blood glucose every couple of hours?’

Affirmations
Affirmations acknowledge positive actions and intentions, and are connected to the young person’s values and hopes for the future. They are more specific and describe specific actions rather than just general praise.

‘You really wanted to get picked for the team and have worked really hard. You deserve to be proud of yourself.’

‘Being a supportive parent is really important to you so you have spent a lot of time with her helping to adjust.’

Reflective listening
Reflective listening communicates understanding by repeating or rephrasing what has been said. More complex reflections can infer meaning or the emotional dimension of what has been described.

James: ‘I’ve tried loads of ways to remember but I just can’t manage to do what my mum and teachers want.’
Clinician: ‘So you have tried loads of ways to remember…’ (simple reflection).
Clinician: ‘It seems like you have tried lots of ways to try and improve things…’ (rephrase).
Clinician: ‘It’s difficult to find something that makes a difference’ (complex reflection).
Clinician: ‘Sometimes it’s really disheartening when you put all the effort in and it makes no difference’ (complex reflection of emotion).

Summarising
Summarising throughout the consultation helps to make sure that you have understood what has been said and can link topics and concepts that have been raised. Longer summaries can be used to ‘punctuate’ and move from one topic to another, to clarify a goal that’s been set or to end the consultation.

‘So … you would like to remember to test so you can play better and because it upsets your mum and teachers’ (short summary).

‘…can I just make sure I’ve understood? You have talked about how you would like Jessica to be more independent with her diabetes because that will help free her up to do other things and also because you know that’s the way things need to go. You might be thinking about her doing her own injections but the thing that worries you the most is hypo, and so you are keeping a very close eye on her blood sugars and what she is eating’ (long summary).

Specific strategies
The following are examples of specific activities that would typically be included in MI-based consultations.

Agenda setting
It is important that everyone share an understanding of what is going to happen in the consultation so everyone has a chance to identify what they want to get from the meeting. Agenda setting is a collaborative process that increases motivation as everyone feels they will have a chance to have their say and get what they want from the meeting.

Clinician: ‘What would you like to have got sorted by the end of our meeting?’
Caroline: ‘Well she isn’t doing many tests at the moment … and we are having lots of arguments.’
Clinician: ‘So what would you want to have sorted today?’
Caroline: ‘How we can have fewer arguments … ways to help her do more tests so I know she’s not having a hypo or is high.’
Clinician: ‘Jessica – what about you – where would be good for you to get to today? Do you have similar or different views to mum?’
Jessica: ‘I’d like her to stop always nagging.’
Clinician: ‘OK, that’s good – so you both want to think about the same thing. Caroline, you’d like to not have to remind Jessica so much and Jessica you’d like mum to not to have to remind you so much – is that OK for us to think about what makes that possible?’

Asking permission
An important part of using a guiding style is asking permission to give information. This reduces the sense of an ‘expert’ giving advice, moving towards a shared venture. This enhances the young person’s sense of autonomy and self-efficacy and lowers resistance because they have had the chance to say ‘no’.

‘I was wondering if it would be helpful for you if I mentioned some of the things other parents have found useful’

Pros and cons
Whatever behaviour is being discussed, it is likely that there is ambivalence towards it otherwise it would have been dismissed out of hand or would have happened. Inviting the young person to review the advantages and disadvantages of how things are, as well as thinking about the advantages and disadvantages if things were to change, heightens awareness of why change is difficult and helps the clinician understand their position. Identifying ‘pros and cons’ can help clarify what needs to be different in order for change to happen.

Clinician: ‘We have been talking about whether you are happy to do more tests, Jessica. Would it be OK if we thought about the advantages and disadvantages for you of making that change?’
Jessica: ‘Yes, OK.’
Clinician: ‘Perhaps first of all – can you think about the advantages of keeping things as they are?’
Jessica: ‘I don’t prick my fingers very much … which hurts.’
Clinician: ‘Any other advantage…’

Once you finish listing the advantages of staying the same, you move onto the disadvantages of staying the same.

‘So those are the advantages for you of keeping things as they are. Can we turn now to the disadvantages of keeping things the same?’

What are the disadvantages do you think of not making the change?’

Then this would continue through advantages and disadvantages of the status quo and of
Making the change until you had reasons in all four quarters of the grid. This can be a lengthy process but highlights issues that people may have not been aware of and underlines that there is clinician neutrality. By taking time and exploring the same question from all angles, different issues can emerge in categories that may feel the same; e.g. disadvantage of things staying as they are and advantages of change.

**Importance and confidence**

The concepts of importance, confidence and readiness are central to understanding the reasons for uncertainty. The young person rates on a scale of 1 to 10 how important change is, how confident they are they could change and how much of a priority change is at the present. This is followed up with questions about why it was a ‘4’ rather than a ‘2’, or how it would become a ‘5’. This neutral way of talking about change invites the young person to think about the nature of their ambivalence.

Clinician: ‘Jessica, you have been talking about doing more blood tests. Can I ask you… how important would you say it is to you to make this change? For example, what number would you give it on a scale of 1 to 10 where 1 is not at all important and 10 is vitally important?’

Jessica: ‘Mmm… I would think about a 7.’

Clinician: ‘Right about a 7. I was wondering, what makes it a 7 rather than a 5 or 6?’

The young person describes reasons why it is important to them.

Clinician: ‘Next can I ask you to think about confidence in making that change. So, on a similar scale of 1 to 10, how confident would you say you are that you can make this change – where 1 is not at all confident and 10 is extremely confident?’

Jessica: ‘About a 4.’

Clinician: ‘OK about a 4. What would have to happen for you to give that a score of 5?’

The young person describes reasons why their confidence is low and how it could be improved. The clinician can explore the relationship between importance and confidence. In this example with confidence lower than importance the focus of the work would be helping them build confidence to make the change.

**Typical day**

Young people and families want us to understand what it is like living with diabetes. Being taken through a typical day in some detail, in 5–10 minutes, can help you grasp the practical and psychosocial aspects of living with diabetes. It illustrates who does what in the family and clarifies an adolescent’s level of independence.

Clinician: ‘It is really helpful for us to understand how diabetes affects your day-to-day life. That can be a pretty difficult question to answer in general so we sometimes find it helps if you take us through a typical day, starting with when you get up and then we can think about the times when things go well, times which are a struggle and the things you are doing to manage the diabetes day to day. Would that be OK? … So take me through a typical day…’

**The journey of change**

It is easy to be swamped by the overwhelming burden of diabetes, focusing only on problems and difficulties. It is important to remember that diabetes is ‘just one piece of the jigsaw in someone’s life’ and to remind them of successes in other areas of their life. By reflecting on strengths, clinicians can identify how skills, abilities and resources in other areas of the person’s life may be helpful in dealing with the challenges of living with diabetes. Examples might be making friends, sporting ability, playing a musical instrument, or coping with exams. The focus is on the ‘how’ of change rather than the ‘why’ or the ‘what’.

Clinician: ‘I was wondering – we all make changes in different ways and learning to manage diabetes involves learning a lot of new skills. Can you think of something new that you have done recently?’

Caroline: ‘Well, before Jessica was diagnosed I had just started a job in a school as a teaching assistant.’

Clinician: ‘…tell me about how that was going…’

Caroline: ‘I was doing really well helping this little girl who couldn’t read – it took a lot of patience.’

Clinician: ‘Have you always been able to bring patience to challenging situations? What was it that helped you in this situation?’

Caroline: ‘I’d studied up on teaching approaches and remembered that this was something that she really wanted to do but was difficult for her.’

Clinician: ‘So it sounds like you are good at researching new things and also using patience when someone takes time to get the hang of something you are trying to help them with. Would you say it’s a bit the same with helping Jessica with diabetes…?’

This exchange helps Caroline see herself as someone who can face new and difficult situations successfully; it normalises the learning process and creates opportunities for affirmation as well as developing an awareness of what type of support she might want.

**Summary**

MI has a number of core principles and key skills. These include careful active listening and the ability to avoid the ‘righting reflex’ in order to roll with resistance. The approach supports the development of self-efficacy and directs young people to...
address ambivalence about behaviour change by developing discrepancy between how things currently are and how a young person would like things to be in order to drive a change in behaviours to make the desired future possible. Key skills that underpin these principles include asking open questions, affirming and positively connoting behaviour, reflecting, and summarising what young people are saying. Sessions are organised by carefully setting a focus and asking permission to give information. Looking at the pros and cons of current behaviour as well as thinking about the advantages of change allow young people to think about how ready, willing and able they are to change by identifying the importance of change as well as their confidence to put change into action. Reviewing a typical day and thinking about change as a journey are other ways in which the clinician can demonstrate they are alongside the young person and motivate them to think about taking steps to alter current behaviours.

Early trials support the use of MI in type 1 diabetes in adolescents, either as a stand-alone treatment or as an adjunct to other treatments where it can be a method of engaging patients in the programmes, thus enabling the programmes to be more effective. Non-psychologists can be successfully trained to provide motivational interviewing with nurses seeing motivational interviewing as consistent with their values and better than traditional advice-giving approaches.15

Motivational interviewing can appear to be a deceptively simple approach; however, while some of the concepts are straightforward to grasp intellectually, the skilful practice of motivational interviewing takes time, effort and responsiveness to regular feedback as well as requiring appropriate training.

Declaration of interests
There are no conflicts of interest declared.

References

Practice point
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How?

✓ Go to DKA audit link at http://www.diabetologists-abcd.org.uk/home.htm
✓ Complete institutional data collection form
✓ Complete case forms for the next 5 consecutive DKA patients you see
✓ Return the 6 completed forms to ketan.dhatariya@nhs.net

If you have any questions about the project contact Dr Ketan Dhatariya who is steering the audit as lead author on the upcoming JBDS Guidelines on the management of DKA

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