PEDIATRIC WEIGHT MANAGEMENT: TREATMENT & MOTIVATIONAL INTERVIEWING

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HEALTH DISPARITIES

• HIGHER RATES OF OVERWEIGHT/OBESITY IN CHILDREN FROM DISADVANTAGED BACKGROUND

• RACIAL AND ETHNIC MINORITIES, RURAL AREAS, LOW SES

• DISPROPORTIONATELY IMPACTS HOSPITALS AND HEALTH INSURANCE COMPANIES THAT PROVIDE SERVICES TO CHILDREN/FAMILIES FROM DISADVANTAGED BACKGROUNDS
UNHEALTHY LIFESTYLES

• PHYSICAL ACTIVITY IN YOUTH:

• ~15 MINUTES/DAY IN MODERATE-TO-VIGOROUS PHYSICAL ACTIVITY, OVER 85% TIME IN SEDENTARY ACTIVITIES

• DIETARY INTAKE IN YOUTH:

• FEW CONSUME DIET CONSISTENT WITH DIETARY GUIDELINES, CONSUME LARGE PORTIONS OF HIGH-CALORIE NUTRIENT-POOR FOODS AND SUGAR-SWEETENED BEVERAGES
EXPERT COMMITTEE RECOMMENDATIONS

• STAGED PREVENTION AND TREATMENT:
  
  • PREVENTION COUNSELING
  • STAGE 1: PREVENTION PLUS
  • STAGE 2: STRUCTURED WEIGHT MANAGEMENT
  • STAGE 3: COMPREHENSIVE MULTIDISCIPLINARY INTERVENTION
  • STAGE 4: TERTIARY CARE INTERVENTION

• PATIENT-CENTERED COMMUNICATION:
  • MOTIVATIONAL INTERVIEWING

• (BARLOW AND EXPERT COMMITTEE, 2007)
PREVENTION COUNSELING

• ALL CHILDREN STARTING AT BIRTH

• TARGETS TO MAINTAIN HEALTHY WEIGHT:

• LIMIT SUGAR-SWEETENED BEVERAGES, FRUITS AND VEGETABLES, SCREEN TIME, LIMIT EATING OUT, FAMILY MEALS, DECREASE PORTION SIZES, CALCIUM & FIBER, BALANCED CARBS, FAT AND PROTEIN, EXCLUSIVE BREASTFEEDING FOR 6 MONTHS AND THEN TO 12 MONTHS OR LONGER, MODERATE TO VIGOROUS PHYSICAL ACTIVITY FOR AT LEAST 1 HOUR A DAY, LIMIT HIGH CALORIE FOODS
STAGE 1: PREVENTION PLUS

• YOUTH 2 - 19 YEARS WITH BMI > 85TH PERCENTILE WITH HEALTH RISKS, OR > 95TH PERCENTILE

• PRIMARY CARE PHYSICIANS, ADVANCED PRACTICE NURSES, PA, NP, NURSES

• SPECIFIC TARGETS:
  • 5+ FRUITS AND VEGETABLES, SWEET BEVERAGES, SCREEN TIME, 1H PHYSICAL ACTIVITY, FAMILY MEALS, WHOLE FAMILY, TAILOR TO CULTURAL ENVIRONMENT

• AFTER 3 – 6 MONTHS OF NO IMPROVEMENT MOVE TO STAGE 2
STAGE 1: PREVENTION PLUS

• 5+ FRUITS AND VEGETABLES

• 2 HOURS OF SCREEN TIME → MOST IMPORTANT DETERMINANT BASED ON RESEARCH EVIDENCE

• 1+ HOUR OF PHYSICAL ACTIVITY EACH DAY

• 0 SWEET BEVERAGES, THIS INCLUDES JUICES, SODA, SWEET TEA, CHOCOLATE MILK, ETC

• FAMILY MEALS 5 TO 6 TIMES A WEEK

• AVOID OVERLY RESTRICTIVE FEEDING BEHAVIORS
STAGE 2: STRUCTURED WEIGHT MANAGEMENT

• PRIMARY CARE OFFICES WITH ADDITIONAL SUPPORT/STRUCTURE

• DIETICIAN, COUNSELOR, TRAINING IN MI, PT, MONTHLY VISITS, GROUP SESSIONS

• SPECIFIC TARGETS TO IMPROVE WEIGHT STATUS:

• STRUCTURED EATING PLAN, DECREASE SCREEN TIME TO 1H, PLANNED SUPERVISED 1+ HOUR PHYSICAL ACTIVITY, MONITORING BEHAVIORS, GOAL SETTING

• AFTER 3 – 6 MONTHS NO IMPROVEMENT MOVE TO STAGE 3
STAGE 2: STRUCTURED WEIGHT MANAGEMENT

- PLANNED, BALANCED, DAILY EATING RECOMMENDATIONS (3 MEALS & 1-2 SNACKS, NO CALORIC BEVERAGES)
- FURTHER DECREASE IN SCREEN TIME, TO 1 HOUR OR LESS
- PLANNED SUPERVISED 1+ HOUR OF PHYSICAL ACTIVITY EVERY DAY
- SPECIFIC GOAL SETTING PLANNED REINFORCEMENT FOR ACHIEVING TARGETED GOALS
- SELF-MONITORING, MONITORING BEHAVIORS, KEEP A LOG OF MEAL PLANS, EXERCISE, GOAL SETTING
STAGE 3: COMPREHENSIVE MULTIDISCIPLINARY INTERVENTION

- BMI > 95th percentile, or BMI 85th – 94th with comorbidity (6+ years)
- Pediatric weight management center with behavior counselor, dietician, exercise specialist, pediatrician

- Specific components: behavior modification program, negative energy balance, parent participation, frequent visits, ideally weekly for at least 12 weeks, group sessions

- No improvement in 3 – 6 months move on to stage 4
STAGE 3: COMPREHENSIVE MULTIDISCIPLINARY INTERVENTION

- BEHAVIOR MODIFICATION PROGRAM
- NEGATIVE ENERGY BALANCE
- INTENSIVE PARENT PARTICIPATION
- SYSTEMIC EVALUATION AT BASELINE AND SPECIFIED INTERVALS
- EXPERIENCED MULTIDISCIPLINARY TEAM
- FREQUENT VISITS, IDEALLY WEEKLY, 12-WEEK PROGRAMS
STAGES 2 AND 3 OF TREATMENT

• In children 6 to 12 years of age, family intervention is always preferable to individual intervention, particularly with one recalcitrant parent at home. The fight between patient, mother and father will likely negate attempts at therapy, and possibly worsen obesity by increasing stress.

• Exercise without energy restriction does not lead to weight loss.

• Targeted family intervention yields a mean BMI reduction of 1.5 kg/m² as compared to individual intervention efficacy of 0.4 kg/m².
STAGE 4: TERTIARY CARE INTERVENTION

- BMI > 95<sup>th</sup> PERCENTILE WITH CO-MORBIDITIES OR BMI > 99<sup>th</sup> PERCENTILE

- PEDIATRIC WEIGHT MANAGEMENT CENTERS

- TREATMENTS:
  - INCLUDE MEDICATIONS, VERY LOW-CALORIE DIETS, WEIGHT CONTROL SURGERY
STAGE 3 & 4

• NUTRITION EDUCATION
  • IDENTIFY MAJOR FOOD GROUPS, IMPORTANCE OF PROTEIN
  • TEACH PORTION SIZES
  • MODIFIED “CHOOSE MY PLATE” TO START
  • LEARN CARB COUNTING
  • LABEL READING
  • LOW FAT, HEALTHY FATS
  • FAST FOOD EDUCATION
  • CALORIE COUNTING, CALORIC RESTRICTION BASED ON AGE AND ACTIVITY
  • OLDER CHILDREN: PROTEIN MEAL REPLACEMENTS, MODIFIED INTERMITTENT FASTING FOR 16 AND ABOVE IN STAGE 4, SUPERVISED
STAGE 3 & 4

- EXERCISE/ EXERCISE EDUCATION
  - INDIVIDUALIZED – BASED ON LEVEL OF OBESITY, AGE, INTERESTS
  - LIFESTYLE CHANGES, FAMILY INTERACTION, PARTICIPATION
  - MAINTAIN LEAN BODY MASS WHILE DECREASING BMI
  - IN STAGE 4 INVOLVEMENT OF EXERCISE PHYSIOLOGIST OR PHYSICAL THERAPIST

- EMPHASIZE THE IMPORTANCE OF EXERCISE, BUT DOES NOT WORK WITHOUT ENERGY RESTRICTION!
STAGE 4:

• APPROVED IN PEDIATRICS

  • ORLISTAT: LIPASE INHIBITOR, APPROVED FOR 12 AND UP
  • PHENTERMINE: SYMPATHOMIMETIC AMINE, APPROVED 16 AND UP
  • METFORMIN: NOT APPROVED FOR WEIGHT LOSS, FOR DIABETES AND “PREDIABETES” 10 YEARS AND UP
  • RECENTLY APPROVED FOR DIABETES IN PEDIATRICS, USED IN ADULTS FOR DIABETES, PREDIABETES AND WEIGHT CONTROL: LIRAGLUTIDE, GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST AKA GLP-1 AGONIST
MEDICATIONS ADULTS, CRITERIA

• BMI > 30 KG/M2, OR BMI > 27 KG/M2 WITH COMORBIDITY

• LIRAGLUTIDE: GLP-1 AGONIST

• LORCASERIN: SELECTIVE 5 HT- 2C RECEPTOR AGONIST

• PHENTERMINE - TOPIRAMATE XR

• BUPROPION – NALTREXONE

• ORLISTAT

• CANAGLIFLOZIN AND OTHER SGLT2 INHIBITORS

• LISDEXAMFETAMINE DIMESYLATE: BINGE EATING DISORDER
DRUGS THAT CAUSE WEIGHT GAIN AND SOME ALTERNATIVES

• TYPE 2 DIABETES
  • INSULIN, SULFONYLUREA, GLITAZONES, GLITINIDES
  • ALTERNATIVES: METFORMIN, GLP-1 AGONIST, SGLT2 INHIBITOR

• HYPERTENSION
  • BETA-BLOCKERS
  • ALTERNATIVES: ACE INHIBITORS, ANGIOTENSIN RECEPTOR BLOCKERS, CALCIUM CHANNEL BLOCKERS

• CONTRACEPTION: INJECTABLES
  • ALTERNATIVES: ORAL CONTRACEPTIVES
DRUGS THAT CAUSE WEIGHT GAIN AND SOME ALTERNATIVES

• DEPRESSION: PAROXETINE, AMITRIPTYLINE, AMITRIPTYLINE, MIRTAZAPINE, VENLAFAXINE, DULOXETINE

• ALTERNATIVES: FLUOXETINE, BUPROPION, SERTRALINE, IMIPRAMINE, CITALOPRAM, ESCITALOPRAM?

• PSYCHOSIS: CLOZAPINE, OLanzAPINE, QUETiAPiNE, RISPERIDONE, PERPHENAZINE, ZIPRASIDONE, LITHIUM

• ALTERNATIVES: ARiPRiPAZOLE, AMiSULPRiDE, LURASiDONE

• HYPNOTICS: DIPHENHYDRAMINE

• ALTERNATIVES: BENZODIAZEPINES, TRAZADONE, MELATONERGIC HYPNOTICS
DRUGS THAT CAUSE WEIGHT GAIN AND SOME ALTERNATIVES

• MOOD STABILIZERS: GABAPENTIN, LITHIUM, VALPROATE

• ALTERNATIVES: LAMOTRIGINE, OXCARBAZEPINE, CARBAMAZEPINE?

• MIGRAINE MEDICATIONS: AMITRIPTYLINE, GABAPENTIN, PAROXETINE, VALPROIC ACID, BETA-BLOCKERS

• ALTERNATIVE: TOPIRAMATE

• INFLAMMATORY DISEASES: CORTICOSTEROIDS

• ALTERNATIVES: NSAIDS
STAGE 3 AND 4: PSYCHOLOGY AND THERAPY

- SCREENING FOR UNDERLYING DISORDERS

- BEHAVIOR MODIFICATION:
  - FAMILY INTERVENTION
  - BEHAVIORAL PARENTING STRATEGIES
  - GOAL SETTING
  - POSITIVE ROLE MODELING
  - MONITORING
  - LEARN LIMITS
  - PROBLEM SOLVING
  - CHOOSING ALTERNATIVES
  - RELAPSE PREVENTION
STEP 3 AND 4: PSYCHOLOGY AND THERAPY

- **COMPONENTS OF BEHAVIOR THERAPY:**
  - **1. SELF-MONITORING:** Daily records of food intake, physical activity
  - **2. STIMULUS CONTROL:** Avoidance, narrowing, or use of inhibitory stimuli to reduce triggers that prompt eating
  - **3. PROBLEM-SOLVING:** Define the problem, brainstorm solutions, implement strategy
  - **4. GOAL SETTING:** Establish dietary and weight goals
  - **5. CONTINGENCY MANAGEMENT:** Develop recovery methods from overeating or weight gain
STAGE 3 AND 4: PSYCHOLOGY AND THERAPY

- **Evaluate for Depression:**
  - Overweight children as young as 5 can develop low self-esteem
  - Obese children have been found to have similar QOL as children diagnosed with cancer

- **ADHD**
  - Poor self-control, discipline, compliance - need closer follow up with psychologist

- **Binge Eating Disorder**
  - All patients need to be screened, less common in children than adults (Lisdexamfetamine in adults…), CBT therapy of choice
STAGE 3 AND 4: PSYCHOLOGY AND THERAPY

• BULLYING:
  • AS MANY AS 60% OF OBESE CHILDREN REPORT BULLYING
  • TEACHERS HAVE LOWER EXPECTATIONS FOR OVERWEIGHT CHILDREN
  • KINDERGARTENERS WOULD RATHER SIT NEXT TO A CHILD WITH A PHYSICAL HANDICAP OVER ONE WITH OBESITY

• SCREEN FOR BULIMIA, NIGHT EATING, BINGE EATING
• SCREEN FOR PAST OR ONGOING ABUSE
STAGE 4: BARIATRIC SURGERY

• INDICATIONS IN PEDIATRICS:
  • BMI 40 KG/M² AND 2 CO-MORBIDITIES (DIABETES, HYPERTENSION, ETC) OR BMI 45 KG/M² WITH LESS SEVERE CO-MORBIDITIES
  • REACHED 95% OF GROWTH POTENTIAL (BONE AGE!)
  • SMR 4 TO 5
  • 6 MONTHS IN A STRUCTURED WEIGHT-LOSS PROGRAM
  • PSYCHOSOCIAL EVALUATION INCLUDING DECISIONAL CAPACITY AND ABILITY TO GIVE CONSENT, FAMILY SUPPORT
  • ADHERENCE TO RECOMMENDED BEHAVIORAL CHANGES
  • NEW RECOMMENDATIONS AAP FOR BARIATRIC SURGERY ISSUED IN 2019
## Weight Loss Goals for Children

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>BMI 85th-94th %ile No Risks</th>
<th>BMI 85th-94th %ile with Risks</th>
<th>BMI 95th-99th %ile</th>
<th>BMI &gt; 99th %ile</th>
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<tbody>
<tr>
<td>2-5</td>
<td>Maintain weight velocity</td>
<td>Decrease weight velocity or maintain weight</td>
<td>Maintain weight</td>
<td>Gradual weight loss (up to 1lb/mos if BMI&gt;21)</td>
</tr>
<tr>
<td>6-11</td>
<td>Maintain weight velocity</td>
<td>Maintain weight</td>
<td>Gradual weight loss (1lb/mos)</td>
<td>Weight loss (no more than avg. 2lbs/mos)</td>
</tr>
<tr>
<td>12-18</td>
<td>Maintain weight velocity; Maintain weight once growth complete</td>
<td>Decrease or maintain weight</td>
<td>Weight loss (no more than avg. 2lbs/mos)</td>
<td>Weight loss (no more than avg. 2lbs/mos)</td>
</tr>
</tbody>
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(Barlow and Expert Committee, 2007)
WEIGHT GOALS BASED ON AGE AND BMI

• < 2YRS: NO GOAL-SETTING, PREVENTION PLUS

• 2-5 YRS: 85TH TO 94TH PERCENTILE WEIGHT MAINTENANCE, 95TH PERCENTILE MAXIMUM 1LB/MONTH: STAGE 1

• 6-11 YRS: 85TH TO 94TH WEIGHT MAINTENANCE, 95TH TO 99TH GRADUAL WEIGHT LOSS 1LB/MONTH, ABOVE 99TH 2LB/WEEK MAXIMUM, STAGE 1

• 12-18 YRS: 85TH TO 94TH GRADUAL WEIGHT LOSS, 95TH TO 99TH PERCENTILE WEIGHT LOSS 2LB MAXIMUM/WEEK, > 99TH PERCENTILE WEIGHT LOSS MAXIMUM 2 LB/WEEK UP TO STAGE 2 AND 3 IF FAMILY MOTIVATED IN INITIAL PHASE

• ESCALATE TO STAGE 3 AND 4 DEPENDING ON RESPONSE, CO-MORBIDITIES. EDMONTON STAGING MORE RECENT FOR STAGING OF INTERVENTION, BASED ON ADULT STAGING
EDMONTON OBESITY STAGING FOR PEDIATRICS
EOSS-P

- Not only based on BMI and BMI Z-score
- Adapted from adult EOSS

- Importance of monitoring health risks to determine success
  - Severity of obesity-related co-morbidities
  - Barriers to weight management
  - 4 graded categories – 0 to 3
  - The 4 Ms: Metabolic, Mechanical, Mental Health and Social Milieu

(Hadjiyannakis et al, 2016)
EDMONTON STAGING EOSS

• EOSS ADULTS: 5 GRADED CATEGORIES, 0 TO 4
• INCORPORATES OBESITY-RELATED CO-MORBIDITIES AND FUNCTIONAL STATUS
• STRENGTHS: DETERMINE BOTH HEALTH RISKS AND APPROACH TO MANAGEMENT, OUTLINES METABOLIC, MECHANICAL AND MENTAL HEALTH RISK FACTORS BASED ON CLINICAL GUIDELINES
• EOSS STAGE PREDICTIVE OF MORTALITY, INDEPENDENT OF BMI, (NATIONAL HEALTH AND HUMAN NUTRITION EXAMINATION SURVEYS DATASETS)
• PROVIDES PROGNOSTIC INFORMATION TO TAILOR INTERVENTION TOOLS
• EOSS 0 TO 1 LOW RISK, 2 TO 3 GREATER RESOURCES, INCREASED RISK FOR ALL-CAUSE MORTALITY…
**Stage 0**
- **Metabolic:** No metabolic abnormalities
- **Mechanical:** No functional limitations
- **Mental:** No psychopathology
- **Milieu:** No parental, familial or social environment concerns

**Stage 1**
- **Metabolic:** Mild metabolic abnormalities (i.e. IGT, pre-hypertension, mild lipid abnormalities, mild fatty infiltration of liver/elevation in transaminases)
- **Mechanical:** Mild bio-mechanical complications (i.e. OSA not requiring PAP therapy, mild MSK pain not interfering with ADL, GERD)
- **Mental:** Mild psychopathology, ADHD, LD, mild body image pre-occupation, occasional emotional/binge eating, bullying, mild developmental delay
- **Milieu:** Minor problems in relationships, minor limitations in caregivers ability to support child's needs

**Stage 2**
- **Metabolic:** Moderate metabolic complications requiring pharmacotherapy (i.e. Type 2 Diabetes, Hypertension, lipid abnormalities, PCOS, moderate to severe fatty infiltration of liver)
- **Mechanical:** Moderate bio-mechanical complications (i.e. OSA requiring PAP therapy, GERD, MSK pain limiting activity, moderate limitations in ADLs)
- **Mental:** Moderate mental health issues (i.e. major depression, anxiety, frequent binging, significant body image disturbance, moderate developmental delay)
- **Milieu:** Moderate problems in relationships, significant bullying at home or at school, significant limitations in caregivers ability to support child's needs

**Stage 3**
- **Metabolic:** Uncontrolled metabolic complications (i.e. T2DM (+ complications/ not meeting glycemic targets), uncontrolled hypertension, FSGS, markedly elevated liver enzymes and/or liver dysfunction, symptomatic gall stones, marked lipid abnormalities)
- **Mechanical:** OSA requiring PAP therapy and suppl. oxygen, limited mobility, shortness of breath sitting/sleeping
- **Mental:** Uncontrolled psychopathology, school refusal, daily binge eating, severe body image disturbance
- **Milieu:** Severe problems in relationships, caregivers unable to support child's needs (may include exposure to family violence), dangerous environment (home, neighbourhood or school)
EOSS-P

- Applied in children 2 years and older
- 4MS distinct, independent categories
- Assigned highest stage in which they present with any metabolic, mechanical, mental health or social milieu

- **Stage 0:** Primary health care regular visits
- **Stage 1:** PCP, dietician, mental health care provider depending on individual needs
- **Stage 2:** Referral to multidisciplinary weight management
- **Stage 3:** Referral to tertiary level multidisciplinary weight management
16 YR OLD WITH OSA ON CPAP WITH O2, 5 HOURS SLEEP DUE TO SCREEN TIME, TENSIONS IN THE HOME, BEHAVIOR ISSUES, PROBLEMS IN SCHOOL. BP 137/68, BMI 45.6 (99.8\textsuperscript{TH} PERCENTILE), + ACANTHOSIS NIGRICANS, DEPRESSION SCREENING +, LDL 128 MG/DL. SUGGESTED MANAGEMENT:

- A. SCHOOL GUIDANCE COUNSELOR
- B. DIETICIAN
- C. MULTIDISCIPLINARY TEAM
- D. BARIATRIC SURGEON

STAGE 1 METABOLIC, STAGE 3 SOCIAL MILIEU $\rightarrow$ STAGE 3
8 YR OLD WELL-CHILD, MOTHER CONCERNED ABOUT WEIGHT. KARATE TWICE A WEEK, OTHERWISE PLAYS VIDEO GAMES. NO BULLYING, CHILD NOT CONCERNED. BMI 29.6 (99.2TH PERCENTILE). OTHER PARAMETERS NORMAL, DEPRESSION -, LIPID PROFILE 6 MONTHS AGO WNL. SUGGESTED MANAGEMENT:

- A. FOLLOW UP VISIT WITH YOU
- B. PHYSICAL THERAPY
- C. MULTIDISCIPLINARY TEAM
- D. MENTAL HEALTH PROVIDER

STAGE 0, METABOLIC ABNORMALITIES, FUNCTIONAL LIMITATIONS, NO PSYCHOPATHOLOGY OR SOCIAL CONCERNS
EOSS-P

- The Edmonton Obesity Staging System for Pediatrics uses metabolic, mechanical, and social milieu domains to decipher which children with obesity:
  - A. Need a sleep study
  - B. Require more immediate and intensive therapy
  - C. Are at higher risk for diabetes
  - D. Should be hospitalized for treatment
EOSS-P

• THE EOSS-P IS AN ASSESSMENT TOOL TO HELP CLINICIANS IMPROVE CLINICAL AND ADMINISTRATIVE DECISIONS REGARDING TREATMENT OF CHILDREN WITH OBESITY BY IDENTIFYING AND STRATIFYING WHICH CHILDREN WITH OBESITY HAVE INCREASED RISK OF MORBIDITY AND MAY BENEFIT FROM MORE IMMEDIATE, INTENSIVE THERAPY.

• THE EDMONTON OBESITY STAGING SYSTEM FOR PEDIATRICS: A PROPOSED CLINICAL STAGING SYSTEM FOR PAEDIATRIC OBESITY, (STASIA HADJIYANNAKIS ET AL, 2016) NCBI.NLM.NIH.GOV
MOTIVATIONAL INTERVIEWING

• MOTIVATIONAL INTERVIEWING IS A COLLABORATIVE, GOAL-ORIENTED APPROACH OF COMMUNICATION TO ELICIT BEHAVIOR CHANGE IN PATIENTS

• THE APPROACH IS DESIGNED TO IDENTIFY AND RESOLVE AMBIVALENCE TOWARD A SPECIFIC GOAL BY CONNECTING NECESSARY CHANGES TO INCENTIVES THAT REDUCE BARRIERS FOR CHANGE
MOTIVATIONAL INTERVIEWING

• **EMPHASIZES PERSONAL CHOICE AND CONTROL: THEMES**

• **COLLABORATIVE:** A PARTNERSHIP BETWEEN PATIENT AND CLINICIAN

• **EVOCATIVE:** REASONS FOR CHANGE COME FROM PATIENT RATHER THAN FROM CLINICIAN

• **AUTONOMY SUPPORTING:** ULTIMATELY THE PATIENT DECIDES WHAT TO DO
MOTIVATIONAL INTERVIEWING

• FOUR GUIDING PRINCIPLES: RULE

  • RESIST: THE HELPING REFLEX

  • UNDERSTAND: YOUR PATIENT’S MOTIVATION, THEY SHOULD BE GIVING YOU ARGUMENTS FOR CHANGE

  • LISTEN: TO YOUR PATIENT, DO SO REFLECTIVELY, SUMMARIZE WHAT IS SAID

  • EMPOWER: YOUR PATIENT, PATIENT MAKES OWN DECISIONS ABOUT LIFE
MOTIVATIONAL INTERVIEWING

• GUIDING PRINCIPLES: GRACE

  • GENERATE A GAP, DEVELOP DISCREPANCY
  • ROLL WITH RESISTANCE
  • AVOID ARGUMENTS
  • CAN DO: SUPPORT SELF EFFICACY
  • EXPRESS EMPATHY
MOTIVATIONAL INTERVIEWING

• PSYCHOLOGICAL THEORY

• DRAWS FROM DIFFERENT PSYCHOLOGICAL THEORIES:

  • TTM – EVALUATES READINESS TO CHANGE AND HELPS PEOPLE TO PROGRESS THROUGH STAGES OF CHANGE
  • SDT – DEVELOPING DISCREPANCY TO FOSTER A DIFFERENT VISION OF THE SELF AND DESIRED BEHAVIORS
  • IPT – ROLLING WITH RESISTANCE. A FRIENDLY STYLE ELICITS RECIPROCAL FRIENDLY RESPONSES
MOTIVATIONAL INTERVIEWING

• **MI – KEY PROCESSES**

  • **ENGAGEMENT:** HAVE YOU EVER THOUGHT ABOUT LOSING WEIGHT

  • **FOCUSING:** WHAT PROBLEMS HAVE YOU EXPERIENCED IN TRYING TO LOSE WEIGHT

  • **EVOKING:** WHAT WOULD MAKE YOU WANT TO TRY AGAIN

  • **PLANNING:** LET’S DISCUSS AND FOLLOW UP, I WOULD LIKE TO HELP YOU
MOTIVATIONAL INTERVIEWING

• MI – PRACTITIONER APPROACH

  • EXPRESS EMPATHY: I AM CONCERNED ABOUT YOUR WEIGHT

  • DEVELOP DISCREPANCY: YOU SAY YOU DON’T WANT TO GET DIABETES BUT YOU DON’T SEEM READY TO MAKE CHANGES

  • ROLL WITH RESISTANCE: IT SOUNDS LIKE THIS HAS BEEN BOTHERING YOU FOR A WHILE

  • SUPPORT SELF EFFICACY: I AM HERE FOR YOU TO HELP YOU WHEN YOU ARE READY
MOTIVATIONAL INTERVIEWING

• MI – PRACTITIONER APPROACH: OARS

  • OPEN QUESTIONS: HOW DO YOU FEEL ABOUT TRYING TO CHANGE?

  • AFFIRMATIONS: SO ELIMINATING SWEET DRINKS HAS MADE YOU FEEL BETTER IN THE PAST?

  • REFLEXIONS: IT SOUNDS LIKE YOU WANT TO MAKE CHANGES

  • SUMMARIZE: LET’S START CUTTING OUT THE SWEET DRINKS AND SUGARS AND SCHEDULE A FOLLOW UP SOON
MOTIVATIONAL INTERVIEWING

• MI – PATIENT EXPECTED OUTCOME

• HIGHER ENGAGEMENT: NON – JUDGMENTAL, CURIOUS, PATIENT-CENTERED

• LOWER RESISTANCE

• EVOKE “CHANGE TALK”: DESIRE TO CHANGE, ABILITY TO CHANGE, REASONS TO CHANGE, NEED TO CHANGE – DARN. IMPORTANCE RULER: HOW IMPORTANT ON A SCALE OF 1 TO 10

• IMPROVED OUTCOMES, IN ADULTS AND CHILDREN
MOTIVATIONAL INTERVIEWING

• MI – PLANNING

• EXPLORE BARRIERS TO CHANGE: WHAT KEEPS YOU FROM EXERCISING?
• FACILITATE CHANGE: WHAT TYPE OF EXERCISE DO YOU THINK WOULD BE FUN?
• EXPLORE COMMITMENT/ASSESS CONFIDENCE: SO YOU LIKE DOING DANCING ROUTINES WITH YOUR FRIENDS?
• OARS
MOTIVATIONAL INTERVIEWING

• 5 A APPROACH:
  • **ASK**: ATTEMPT TO ENGAGE: WOULD IT BE OK TO TALK ABOUT YOUR HEALTH AND WEIGHT?
  • **ADVISE** TO ADOPT HEALTHIER LIFESTYLES, “TO STAY HEALTHY, NOT GET DIABETES, ETC”, AVOID “OBESE” AND “OVERWEIGHT”
  • **ASSESS** WILLINGNESS TO CHANGE, INCLUDING FAMILY WITH IMPORTANCE RULER 1 – 10
  • **ASSIST**: HELP THE PATIENT MOVE ALONG THE CONTINUUM OF READINESS TO CHANGE “WHEN YOU ARE READY…”
  • **ARRANGE**: FOLLOW UP CONTACTS, ASK FOR PERMISSION TO CONTINUE HELPING TO MAKE CHANGES
BRIEF MOTIVATIONAL INTERVIEWING FOR PEDIATRIC OBESITY

• NONDIRECTIONAL APPROACH
• OPEN-ENDED QUESTIONS
• REFLECTIVE LISTENING
• COMPARISON OF CURRENT HEALTH BEHAVIORS AND VALUES—LIMIT JUDGMENT BY NORMALIZING CHALLENGES
• PROBLEM-SOLVING TO ADDRESS BARRIERS
• REALISTIC AND GRADUAL GOALS
• FOCUS ON SUCCESSES (NO MATTER HOW SMALL!!)
MOTIVATIONAL INTERVIEWING

• DON’T FORGET THE FAMILY, CARETAKERS...

• EXAMPLE:
  • YOU: ON A SCALE OF 0 TO 10, HOW IMPORTANT IS IT FOR YOU TO CONTROL BETSY’S SCREEN TIME?
  • MOTHER: UM, MAYBE AN 8
  • YOU: HOW CONFIDENT ARE YOU THAT YOU WILL BE ABLE TO CONTROL HER SCREEN TIME?
  • MOTHER: MAYBE A 4...
  • YOU: OK, LET’S TALK ABOUT WHAT FACTORS ARE MAKING YOU FEEL LESS CONFIDENT THAN YOU WANT TO BE, IN OTHER WORDS, WHAT ARE SOME OF THE BARRIERS THAT ARE GOING TO MAKE IT DIFFICULT TO CONTROL BETSY’S SCREEN TIME
MOTIVATIONAL INTERVIEWING

• THIS TECHNIQUE HAS OPENED THE DIALOGUE ABOUT THE VALUE THE FAMILY ASSOCIATES WITH A DESIRED BEHAVIOR AND THEIR CONFIDENCE IN CHANGING. FROM HERE YOU CAN BEGIN A DIALOGUE, SET SPECIFIC, REALISTIC GOALS AND IDENTITY STRATEGIES TO OVERCOME BARRIERS AND BUILD CONFIDENCE.

• THE WAY WE TALK WITH OUR PATIENTS AND THEIR FAMILIES DOES MATTER AND CAN MAKE A BIG DIFFERENCE!
QUESTIONS?
THANK YOU!