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Engaging Families Through Motivational Interviewing

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KEYWORDS

• Motivational interviewing • Health behavior change • Child maltreatment
• Risk factors • Pediatrics

KEY POINTS

- Several risk factors for child maltreatment may be addressed through successful parental behavior change.
- A primary barrier to effective behavior change intervention has been a provider-centered approach to communication about change.
- Motivational interviewing (MI) is a person-centered communication technique that helps address barriers to change.
- MI has been found to be effective in improving outcomes for multiple risk behaviors for child maltreatment.
- Implementing MI includes changing the provider's mind-set to be consistent with the patient-centered spirit of MI, and use of specific communication techniques during the medical visit.

INTRODUCTION

Several risk factors for child maltreatment may be reduced through successful parental behavior change. These risk factors include substance use, partner violence, depression, harsh punishment, and management of children's medical health.[1,2] Because the US Preventive Services Task Force concludes that there is insufficient evidence on the effectiveness of preventing child maltreatment directly among children who do not already have signs of maltreatment,[3] prevention efforts may be best aimed at addressing these risk factors that may lead to maltreatment (**Box 1**). Although health care providers may try to encourage behavior change in parents to reduce risk factors, many providers use ineffective techniques to promote behavior change.[4–7]

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Box 1
Parental factors that increase risk of child maltreatment

- Substance use
- Partner violence
- Depression
- Inadequate parenting skills
  - Harsh punishment
  - Difficulty managing child's health care needs

EXTENT OF THE PROBLEM: HEALTH CARE PROVIDER–CENTERED APPROACH

Health care providers strive to offer the best care possible to their patients, and, in pediatrics, this may include helping parents of their patients to help themselves. This help includes encouraging changes in lifestyle or health behavior in parents, which affect how well parents care for their children, thus improving their children's health. However, it can also be frustrating to health care providers when they discover that parents have not followed through with recommendations. That frustration may grow as the provider spends another appointment telling parents the same information and hoping that they follow through.

One factor affecting the parent's adherence is not what the health care provider says, but how the provider communicates that information. Research has shown that a primary barrier to effective behavior change intervention has been a health care provider–centered, rather than a patient-centered, approach to communication about change. Provider-centered communication is often well intended and fostered by the desire to help patients or prevent suffering.[4,5,7] That is, after assessing for behaviors that can lead to poor outcomes, the health care provider may then focus on what they perceive to be the barriers to health and often elicit little input from the parents of their pediatric patients. Providers then attempt to address the barrier by telling parents that their behavior is problematic and try to persuade parents to change to what the providers see as appropriate, potentially provoking parent defensiveness or resistance.[4–7] When parents become defensive or resistant to change, providers may view them as unmotivated, unwilling, or unable to make behavior changes to improve the health of their child. However, this perception of parents may serve only to exacerbate any potential or existing problems, because it could contribute to providers feeling helpless and frustrated and could prevent providers from taking an active role in assisting parents to change.

More often, parents are not unmotivated, but instead, not yet convinced of the problem or the need for change. For instance, when a parent smokes in a car through an open window, she might believe she is protecting her child and not realize how much secondhand smoke she is exposing her child to, or how much that smoke likely contributed to her child's recent asthma attack. When parents seem unwilling, they are more likely not committed to making a change at that time. For example, a parent may see as many benefits as drawbacks to continuing to feed his diabetic child the sugary foods his child prefers to avoid battles at dinnertime, and thus exploring the pros and cons of this behavior more thoroughly with the father may help. In addition, when parents seem unable, they may need help believing in their ability to change, such as a mother who has recently relapsed who feels discouraged in her efforts to quit drinking and may feel empowered from a discussion of what worked for her the

last time she was successful.[8] If providers set aside their possible assumptions about their patients' parents, and instead try to understand the parents' thoughts and feelings, the providers can both feel personally empowered to influence parents in a positive way and can help empower parents to make difficult changes in their behavior.[4,5]

SEQUELAE OF THE PROBLEM: INCREASING BARRIERS TO CHANGE

Providers may create barriers to their own goals as well as to their patients' families' goals, by failing to use parent-centered communication. Research has shown that taking a more paternalistic approach instead of a collaborative one may both distance the parent from the provider and contribute to worse health outcomes for the pediatric patient.[9,10] When parent and provider agendas or treatment goals do not align or when there is a mismatch between a provider's strategies to address a health behavior and a parent's willingness to change that behavior, the parent's resistance to change is likely to increase.

Another way that providers may be increasing barriers to change for their patients and patients' parents is by taking a more one-dimensional view of behavior change. When providers focus only on certain dimensions of change, such as concentrating solely on the parent's health education (eg, on the link between secondhand smoke and the child's asthma) and ignoring the parent's feelings (eg, she is afraid she cannot cope with stress without smoking) or how ready the parent is to try to change, the intervention is likely going to be unsuccessful.

A more multidimensional view of change is captured in the transtheoretical model, a comprehensive framework that integrates key constructs of several theories of behavior change into one. Intentional behavior change (when people actively monitor and try to modify their behavior) can be thought of as a series of stages that individuals negotiate by engaging in different behaviors and undergoing a variety of cognitive or emotional experiences.[11]

Thus, a parent may not be able to change all at once but instead moves through stages of thinking, planning, and acting to change a behavior. Parents are also at different levels of readiness to change; although they are thinking about changing, they may not be ready to actively make a change yet. Readiness is a dynamic and fluctuating state of motivation. Interacting with readiness is a person's confidence to change, or one's personal evaluation of their ability to exercise control or perform a behavior.[12] A parent may not feel ready to change because they have tried in the past without success and have little confidence in their ability to modify a behavior.

Both readiness and confidence are states that belong to the parents; providers can neither force them to be ready to change nor can providers be confident for them. However, readiness and confidence are modifiable by parents and can be influenced by providers. To influence these states, providers can help change the way parents understand or view particular risk factors or behaviors, they can increase awareness of the impact of these behaviors on their children, and they can empower parents to act. In these ways, providers can promote treatment adherence and engagement in terms of both children's and parents' health.

To decrease resistance and address other problems of provider-centered approaches, providers can learn a person/parent-centered communication technique called motivational interviewing (MI), which has 30 years of research supporting its use in health care settings. MI is not a stand-alone therapy; rather, the provider uses the MI style of interaction to empower the parent to identify their own reasons for change, perceived barriers to change, and strengths to overcome those barriers, as well as to engage the parent in collaborative goal setting. By using MI, the provider

can align with the parent in achieving goals that are in the best interest of the child's health, as well as strengthen the parent-provider relationship.[4,10]

In the example given earlier, it is likely not the case that the parent learns that her smoking exacerbates her child's asthma and then quits the following day. Instead, although the educational piece has given her a reason to quit smoking, she may also need to consider ways to assist her in quitting (eg, telephone counseling, nicotine replacement therapy), what worked and did not work when she tried in the past, and what else she could do other than smoking to help her cope with stressful situations before she makes the quit attempt. Using MI techniques, the provider could help this parent to think about these other aspects of change and support her confidence to change, potentially moving her forward through the stages and increasing her likelihood of successfully quitting smoking.[13]

PREPARING FOR MI

When preparing to incorporate MI into practice, the first step is for providers to learn to approach patient interactions in a manner that encompasses the spirit of MI.[4,6] This spirit is the provider's mind-set, which informs the whole intervention and involves 3 key components: (1) collaboration, or developing a partnership that honors the patient's expertise and perspective; (2) evocation, or exploring a patient's preferences, goals and values in an effort to ignite their motivation for change; and (3) autonomy, which involves affirming a patient's right and capacity for self-direction.[4]

This MI mind-set can be different from the disease model of providing health care, in which providers focus on what they see as going wrong, and then they take actions to try to make things right.[4] For example, the provider may screen for a certain illness, and then give the patient a certain medication to treat that illness. Although this model may be effective for some illnesses, it has been found to be ineffective for behavior change. This finding is partly because the power to take action lies with the parent alone; that is, although the health care provider may affect how the parent thinks about a behavior, only the parent performs the behavior.[4] The spirit of MI focuses on the parent's agency in taking action, rather than the provider's. In pediatrics, when the provider approaches the situation with a true understanding that the parents will make their own decisions about themselves and their children, they are less likely to engage in a power struggle with parents or use techniques that contribute to parents not following through with recommendations. MI allows parents to be the more active participants, rather than providers.[6]

When MI is used effectively, the provider no longer has to shoulder the commonly perceived burden of talking patients into doing something. Instead, the provider notices that people talk themselves into changing based on their own values and goals rather than the provider's and ask for guidance when they do wish the provider to help them make decisions. The provider does not try to convince the parent to change a behavior, or make the parent see the situation from the provider's point of view; instead, the provider tries to understand the parent's thoughts, feelings, and behavior from the parent's point of view.[4] This strategy can help the provider express empathy for the patient's circumstances, emotions, and understanding of behavior and barriers, rather than simply trying to impose their perspective of what the parent needs to do.[4] This strategy also allows parents to bring up their own concerns about their own behaviors and work toward addressing them. For example, a parent may voice concern over their own occasional drunk driving, and may wish to work on ways to ensure that they do not drink and drive with their children in the car, even although they are not ready to stop drinking.

The spirit of MI also focuses on strengths, whereas the disease model focuses on weaknesses.[4] When providers concentrate on telling parents about their weaknesses, or how parents' behaviors are wrong, parents try to defend their actions and may become more resistant to change.[4] Instead, with MI, providers use the interview to help parents identify their own goals, strengths, and skills and then, how to use those strengths to achieve their goals. The parent then owns the plan.

In addition, if providers are using MI, they allow for parents to come up with their own behaviors to change, which may be different than the parental behaviors that the providers would target for change. For example, a mother in a major depressive episode may feel guilty that her depression is not allowing her to be the parent she wants to be. The provider approaches this interaction using the MI spirit and talks with the mother about her goal (ie, to be a better parent), helps her verbalize her motivation to reach that goal, explores the mother's motivations and barriers to change, and helps her identify possible solutions. Although the provider's solution (adhering to an antidepressant medication regimen) does not match the mother's solution (engaging in psychotherapy), the MI-consistent strategy is for the provider to empower the mother to try the solution in which she is motivated to engage (ie, psychotherapy) and, thus, is more likely to move the mother toward her goal of being a better parent.

By using an MI approach, providers can assess parents for risk factors for child maltreatment and build good rapport and set the stage for addressing any problems in a collaborative manner. To remain true to the MI spirit, please see **Table 1** for tips that help establish this rapport and meet parents where they are in their readiness to change their behaviors.

EFFECTIVENESS OF MI

The process to become proficient in MI typically involves rigorous training. However, it is often the case that interventions include components or adaptations of MI, and even trials of less faithful deliveries of the techniques have shown equivalency to other active treatments across health behaviors[14] and particularly positive effects on treatment engagement and retention.[15,16] In a meta-analysis of 72 MI treatment outcome studies,[17] MI was found to have small to medium effect for the improvement of health

Table 1
Tips for initiating MI

Before You Begin the Conversation	Starting the Conversation	During the Conversation
Be aware of your own preconceptions about substance use, mental illness, and chronic health conditions Have a nonjudgmental attitude Avoid using labels (addict, alcoholic) or diagnoses	Ask permission to discuss a topic further Assure parents that you ask everyone these questions so they do not feel singled out Acknowledge that you recognize that some information is difficult to talk about Try to provide as much privacy as possible and ensure confidentiality, but be honest about limitations	Watch for nonverbal cues, such as: Eye contact Fluidity and tone of speech Posture Movements Affect

outcomes regarding alcohol, smoking, human immunodeficiency virus/AIDS, drug abuse, treatment compliance, gambling, partner violence, water purification/safety, eating disorders, and diet and exercise. In particular, MI may be used for multiple risk factors for child maltreatment, such as substance use, partner violence, depression, unbalanced discipline, and parental management of children's medical health conditions. Evidence for the effectiveness of MI when used with these risk factors is reviewed in the next sections.

Substance Use

Addressing parental substance use with MI may reduce the risk of subsequent child maltreatment. Many studies have been conducted that show the effectiveness of MI in modifying risky use or abuse of substances. Regarding the use of alcohol, a meta-analysis of 15 randomized controlled trials (RCTs)[18] concluded that MI was significantly more effective than a no-treatment control, and either as effective as or more effective than standard care or treatment as usual in reducing alcohol consumption at 3-month follow-up. Studies of MI involving abuse of other substances are also promising. Results from 1 RCT[19] for use of MI in combination with cognitive-behavioral therapy with amphetamine or stimulant users showed significantly higher reports of abstinence from participants in treatment than those in the control group. In another RCT, when providers used MI techniques during a routine medical visit with patients who used cocaine, results showed higher rates of abstinence at 6-month follow-ups.[20] Although this is a brief snapshot of the literature, the use of MI with individuals who engage in many types of substance use has been substantiated. Addressing a parent's substance use could make a significant difference, not only in reducing the risk of child maltreatment but in improving the parent's health as well.

Partner Violence

When faced with a parent of a patient who is involved in a violent relationship, health care providers may find it difficult to avoid outright telling the parent what they believe would be best for both the child and the parent. That knee-jerk reaction to be directive is likely fueled in part by the provider's genuine concern as well as in part by the strong social stigma associated with partner violence. However, this same social stigma may increase resistance to change, because the victimized parent may feel a need to defend the relationship, avoid being shamed, or fear that discussing violence may lead to their children being removed from the home or additional violence.[4]

As indicated earlier, MI is a technique that is particularly useful when the topic at hand is more stigmatized or difficult to discuss, such as substance use or partner violence. Parents experiencing partner violence have probably wrestled with many feelings about the relationship, including shame, fear, and worry, before they walk into that appointment. Because they may already be their own harshest critics, they likely assume that health care providers judge them as well, raising their resistance even before the conversation starts. By using MI, providers can meet parents where they are in weighing the pros and cons of their situation and give them a nonjudgmental space to voice their feelings. MI has been found to be effective in addressing the barriers to behavior change when used with both victims and perpetrators of partner violence.[21] Working with victims of abuse by meeting them at their stage of change and incorporating MI techniques has been found to be effective in improving safety outcomes.[22] In addition, use of MI has been proposed as a tool for helping the

nonabusive parent explore their ambivalence when torn between protecting the children and saving the family unit.[23]

Depression

Motivating parents with depressive symptoms to engage in treatment can be difficult, because depressive symptoms can include decreased motivation and energy to engage in treatment. A parent's lack of motivation may be exacerbated by the need to expend energy on child care and their perception that there is little time or energy left over for self-care. Low income and culturally diverse parents may have additional barriers to engaging in treatment, such as transportation, child care, and cultural stigmas about depression or treatment.[24]

Interventions using MI in people with depressive disorders have increased engagement in treatment, increased physical activity,[25] and contributed to fewer reported depressive symptoms.[25,26] MI has also been incorporated into treatments for depression to address medication adherence, completion of therapy homework, and attendance at appointments.[26,27] MI has been effective in increasing medication adherence, especially among cultural groups who have historically had lower adherence rates, such as Latinos.[28] As with addressing parental substance use, when providers address parental depression using MI, they can contribute to parents making positive changes regarding their own physical and mental health, and in turn, may reduce the risk of child maltreatment.

Harsh Punishment

Disciplining children is a necessary part of child rearing, but the type, frequency, or extent of tactics used could modify the risk of child maltreatment. Discipline involves both reinforcing positive behaviors and punishing negative behaviors, and balanced discipline depends on the age and characteristics of the child.[29] There are many tactics that may be used to reinforce or punish children's behavior, and most of these tactics can be beneficial in moderation, but harmful to the child in the extreme.

For example, a parent may give a child a favorite food to reward a behavior; however, the use of food as a motivator can become unbalanced and harmful to the child, such as allowing a child to eat junk food all the time or withholding food for days. Similarly, nonabusive spanking as a punishment has been found to be no more harmful than other forms of discipline and has been linked to several benefits, including increased compliance, decreased fighting, increased parental affection, and enhancement of the effectiveness of other disciplinary methods (such as time-outs).[29,30] However, severe corporal punishment has been found to be harmful,[31] and using only positive forms of parenting has also been found to be problematic.[32]

Parents may be resistant to being told to change their discipline style, and MI has been suggested as a way to reduce resistance that can be exacerbated by professionals, especially when discussing child protection.[33] It has been recommended that MI be used even after other standardized forms of parent training, which include explaining or showing consequences of behaviors, have not been effective.[34] Interventions using MI have been found to be effective in improving balance in discipline, such as increasing parental structure and family management, decreasing parental permissiveness, and subsequently, decreasing problematic behavior in children.[35,36] With regard to physical punishment, MI-based intervention has been found to reduce use of physical punishment in parents who were referred for treatment after children were physically abused or at risk for abuse.[37] In addition, parents who receive MI are more likely to participate in parenting workshops.[38]

Managing Medical Health

Adhering to medical treatments is more strongly related to health outcomes among children than it is for adults,[39] and patient adherence is more than 1.5 times greater for physicians trained in communication skills such as those used in MI.[40] The effect of communication skills on adherence is even stronger among pediatricians.[40] Because nonadherance may result in poor health outcomes or harm to children, use of MI has been recommended to improve parental management of children's medical conditions.[41]

Interventions that have incorporated MI have been found to have long-term benefits for families engaging in and continuing different kinds of treatments for their children.[42] For example, when MI has been used with parents, children with obesity or diabetes have had improved weight-related behaviors, better blood glucose monitoring, and improved hemoglobin A_{1c} levels.[43,44] Similarly, parents who are given options to vaccinate their children have been found to be at different readiness levels to accept vaccination. Pediatricians may increase parents' readiness to vaccinate by using MI and meeting parents at their readiness level when communicating with them.[45]

CLINICAL ASSESSMENT

Although providers may remain in the MI spirit throughout the whole clinical encounter, MI techniques are typically used during the portion of an encounter when the provider wishes to address a specific behavior. After parents have screened positive for a risk factor for child maltreatment, the provider follows up with open-ended questions to gather more information (see section on open-ended questions) and then with more specific questions, particularly when parents provide qualified answers. It is important to pay attention to both the manner in which the parent responds as well as the content. Nonverbal behavior might indicate a positive screen or signify that the parent is holding back information (see **Table 1** for examples of nonverbal behavioral cues). If a provider notices potentially significant nonverbal behavior, acknowledging a parent's discomfort or hesitancy may provide the space for the parent to provide more information and address their feelings around the answer.[4]

Once the parent has given permission to discuss the behavior further, the MI portion of the visit begins. The provider should assess both the parent's readiness and confidence to change their behavior.[4,5] Parents' readiness to change is influenced by how important it is for them to change, or rather, their perceived need for change. Using an importance ruler, on which the numbers 0 (not important at all) to 10 (extremely important) are printed, providers can ask, "On a scale of 0 to 10, how important is it for you to change any aspect of your _____ (behavior)?" If the patient chooses any number greater than 1, the provider could follow up and ask, "What led you to choose that number and not a 0?" to elicit a parent's motivation for changing that behavior. If a parent chooses 0, the provider could ask about the parent's perceived barriers to change.[4]

After a discussion of readiness and importance, the provider should assess a parent's confidence to change, using the same ruler (a confidence ruler, in this case) and format of questioning: "On a scale of 0 to 10, how confident are you that you can change _____ (behavior)?" Once the parent has chosen a number, the provider can follow with questions about why the parent chose that number versus a number higher or lower. These questions are designed to help the provider explore the parent's previous successes, failures, and feelings about past attempts and future change.[4] In this conversation, the provider can bolster a parent's confidence by highlighting a parent's

strengths or steps in the direction of change. Providers can also identify areas of skill deficits for which they could provide resources for treatment or remediation.

APPROACH

There are 4 core skills that are used during the assessment and subsequent discussion that help to make MI effective. These skills can be remembered with the mnemonic OARS: open-ended questions, affirmations, reflections, and summary statements.[4] Each of these skills contributes to a style of communicating that helps the provider elicit information from and collaborate with the parent; a style that contrasts with the provider-centered approach of trying to convince a parent to change a wrong behavior, which may increase resistance.

Open-Ended Questions

Open-ended questions gather more information as well as convey to a parent that the provider values their thoughts and feelings. Open-ended questions are the antithesis of closed-ended questions, which can convey judgment and increase resistance to change. Although providers may believe that close-ended questions are more time efficient, they sacrifice the collaborative relationship and spend more time guessing via closed-ended questions by eliciting specific information or potentially leading the parent in a certain direction. There are several types of closed questions, including multiple choice (the patient is given several options to choose from); dichotomous (question pulls for 1 of 2 answers, such as yes or no), leading (question directs the patient to 1 correct answer), or specific information questions (asking for factual information). In contrast, open-ended questions allow parents to reflect on their own emotions, thoughts, and values and to discuss them.[4] Open-ended questions often start with words like how, what, or tell me and invite the patient to provide a deeper answer and are the key to identifying the parent's perspective. In addition, open-ended questions can be used to invite parents to identify their own strategies for behavior change, which increases the likelihood that the parent tries the new behaviors (**Table 2**).

Affirmations

Affirmations are the contrast to focusing on the negative, which directs attention to the parent's weaknesses, what they need to change, have not accomplished yet, or what

Table 2
Examples of replacing closed-ended with open-ended questions

Avoid	Use Instead
Closed-Ended Questions	**Open-Ended Questions**
Multiple choice	
Will you decrease snacks, sodas, or portion sizes to help your child's weight?	What changes could you make in your child's diet to help your child's weight?
Dichotomous	
Do you want to stay in this relationship?	How do you feel about this relationship?
Leading	
You don't use corporal punishment, do you?	What forms of discipline do you use?
Specific information	
Who takes care of your daughter when you're depressed and in bed?	Tell me how your depression affects your ability to care for your daughter

misinformation the parents have. It is often difficult for providers to mention only the positive without mentioning the change that they are hoping the parent makes or correcting the misinformation. However, pulling attention to changes to be made or weaknesses is deflating rather than motivating. In addition, immediately correcting misinformation is interpreted as judgment or contradiction, rather than support. By providing affirmations, the provider can highlight the parent's strengths and what they have accomplished without drawing attention to what goals have not yet been reached or what they have done wrong.[4] This strategy can help to build the parent's self-efficacy or confidence to move forward with making changes and leaves room for the provider to provide education later (**Table 3**).

Reflections

Reflections are statements that let the parent know what the provider understands about what the parent just said. As the name suggests, reflections should mirror back only the parent's own perspective, without adding in any of the provider's values or ideas. Mirroring back does not mean that the same words need to be used; paraphrasing is sufficient, so long as the provider attempts to make a statement in which the content or meaning of what was said is reflected. Reflections are the key to ensuring that the provider understands the parent's perspective and help the provider communicate their understanding of the parent's perspective back to the parent.[4] This situation is in contrast to making statements that convey the provider's perspective, such as expressing judgment (positive or negative) or suggesting what the parent should do in the situation (**Table 4**).

Summary Statements

Summary statements help to pull together different components of the interview and can help parents develop insight into their own inner conflicts and discrepancies in their goals and actions. Summary statements are not statements that attempt to direct a parent to a specific behavior or statements that highlight only 1 side of the parent's perspective. There are several types of summary statements. They may be collective, reflecting back a list of things that the patient has said. They may form links, connecting various thoughts or experiences from different parts of the conversation, or across different conversations. Summary statements may also help transition to different

Table 3
Examples of replacing nonaffirming statements with affirmations

Avoid	Use Instead
Nonaffirming Statements	**Affirmations**
Even if you smoke outside, your child can still be exposed to smoke	You have been making good efforts to reduce your child's exposure to smoke
Asthma controller medications really need to be taken every day	Even though you have had some challenges, it sounds like you've been trying hard to give your son his medications more regularly
You're really inconsistent with your use of time-outs	You've been using time-outs when you can, and trying hard to use effective disciplining techniques
It's good that you cut down to half a pack per day, so now you can work on quitting completely	It's good that you cut down to half a pack per day. Cutting down is difficult and you've done a great job!

Table 4
Examples of replacing provider's perspective with reflections

Avoid	Use Instead
Provider's Perspective	**Reflections**
It really would be best for you and your kids if you got out of this violent relationship	It sounds like there are still a lot of good parts to this relationship that you don't want to lose
I really think you will only get better if you take medications	Although your depressive symptoms are upsetting and you think medication may help, you are concerned that the side effects of medication will make you feel worse
Even though the insulin shots hurt, it is important to give them to your son to prevent health problems	It is difficult to give your son shots when you know they hurt him, but you also don't want him to have the long-term effects of uncontrolled diabetes
The amount that you're drinking really could affect your children's health	Right now, you feel like the amount you're drinking won't hurt your children's health

parts of the visit, by concluding what has already been discussed and allowing the conversation to move to a different topic (Table 5).[4]

WHEN TO USE MI

MI is particularly effective when used across time (see Fig. 1 for sample structure). Once a behavior that may increase the risk for child maltreatment has been identified, the behavior can be addressed at every visit. MI allows the behavior to be discussed through conversation rather than through pressure to change. The provider can start the conversation with a reflection, followed by an open-ended question.[4,6] This strategy can work well by reflecting back what was said in the summary statement at the previous visit and then asking for an update. For example, a provider may state,

Table 5
Examples of replacing directing with summarizing

Avoid	Use Instead
Directing	**Summarizing**
How about you try using time-outs instead of spanking?	You don't feel that your spanking will get out of control, but you'll consider using time-outs if you get really angry
So it sounds like there are a lot of reasons for you to quit drinking	On 1 hand, alcohol helps you socialize and relieve stress, and you don't want to stop drinking right now. On the other hand, you feel like it can lead to problems
The plan should be take your son to the playground for exercise and replace the processed snacks with options like cut-up vegetables and fruits	It sounds like you're interested in finding ways for your son to get more exercise through play, and you're thinking about trying healthier snacks, but you'd like to brainstorm some ways to accomplish these goals
If you don't take care of yourself, you won't be able to take care of your children	You would like to get treatment for yourself, and you will try, but you're not sure if you'll find the time

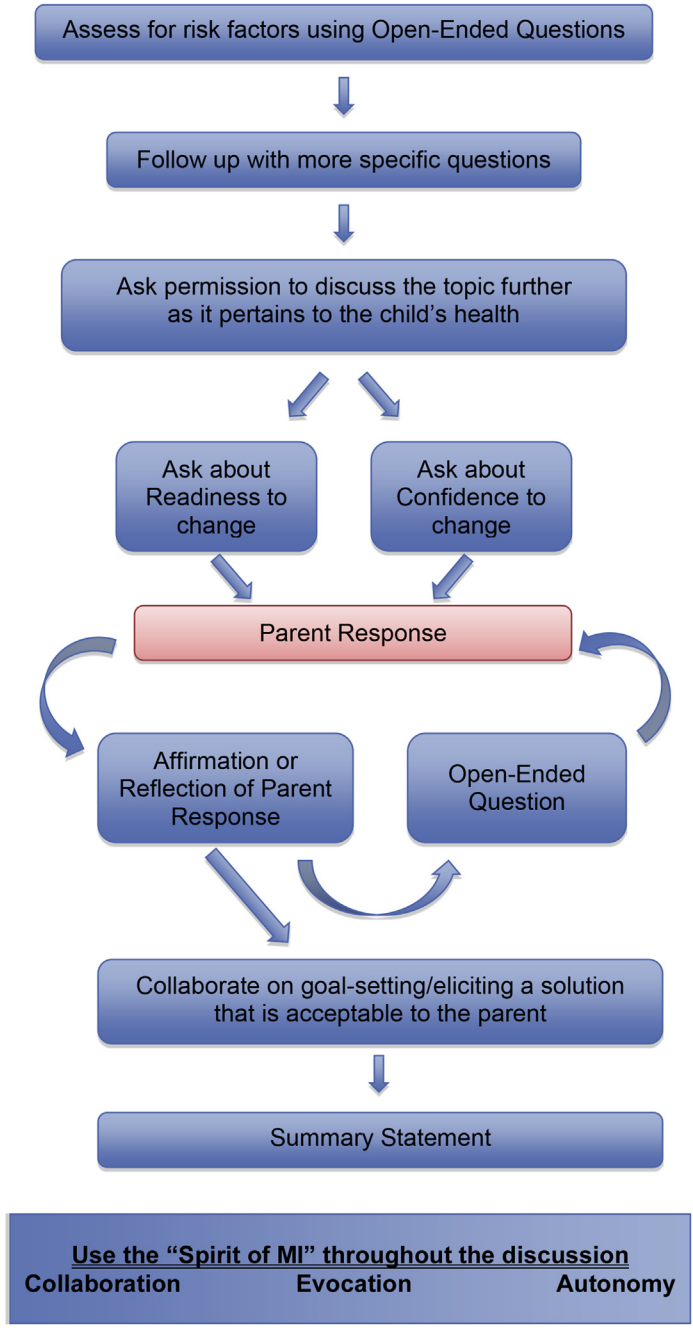

Fig. 1. Sample structure of a discussion with a parent using MI.

"At the last visit, you were telling me how you were concerned about the side effects your daughter might experience on this medication but also were concerned about not treating her condition. What are your thoughts now?"

It can be particularly helpful to make a note in the medical record about the parent's motivation to change a behavior, their primary barrier to change, and where the conversation left off. Because people do not change behaviors all at once, MI helps both the parent and provider by mirroring the process of change.[4,11,46] It allows the parent to rely on strengths and overcome barriers. It aids providers by helping them to relinquish control of a parent's behaviors, decreasing the frustration that is felt when there is a discrepancy between where the parent is in their readiness to change and where the provider wants them to be.

SUMMARY

MI helps providers to reduce the barriers to behavior change that provider-centered techniques may exacerbate. MI has been found to be effective for aiding behavior change for multiple risk factors for child maltreatment. By incorporating MI techniques, providers can collaboratively address parental risk factors, improving adherence to recommendations, decreasing provider and parent frustration, and potentially improving the health of both the parent and their child.

REFERENCES

1. Centers for Disease Control and Prevention (CDC). Child maltreatment: risk and protective factors. In: Centers for Disease Control and prevention: injury prevention & control. 2013. Available at: http://www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html. Accessed November 23, 2013.
2. US Department of Health and Human Services. Administration for Children & Families. In: Child Maltreatment 2011. Children's Bureau; 2012. Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2011. Accessed November 23, 2013.
3. Moyer VA, US Preventive Services Task Force. Primary care interventions to prevent child maltreatment: US Preventive Services Task Force recommendation statement. Ann Intern Med 2013;159(4):289–95.
4. Miller WR, Rollnick S. Motivational interviewing: helping people change. 3rd edition. New York: Guilford Press; 2013.
5. Rollnick S, Miller WR, Butler C. Motivational interviewing in health care: helping patients change behavior. New York: Guilford Press; 2008.
6. Suarez M, Mullins S. Motivational interviewing and pediatric health behavior interventions. J Dev Behav Pediatr 2008;29(5):417–28.
7. Gance-Cleveland B. Motivational interviewing: improving patient education. J Pediatr Health Care 2007;21(2):81–8.
8. DiClemente CC. Addiction and change: how addictions develop and addicted people recover. New York: Guilford Press; 2003.
9. Eisenthal S, Emery R, Lazare A, et al. Adherence and the negotiated approach to patienthood. Arch Gen Psychiatry 1979;36:393–8.
10. Emmons KM, Rollnick S. Motivational interviewing in health care settings: opportunities and limitations. Am J Prev Med 2001;20:68–74.
11. Prochaska JO, DiClemente CC. Transtheoretical therapy: toward a more integrative model of change. Psychotherapy 1982;19(3):276–88.
12. Bandura A. Self-efficacy: toward a unifying theory of behavioral change. Psychol Rev 1977;84(2):191–215.

13. Miller W. Motivation for treatment: a review with special emphasis on alcoholism. Psychol Bull 1985;98(1):84.
14. Burke BL, Arkowitz H, Menchola M. The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. J Consult Clin Psychol 2003;71:843–61.
15. Carroll KM, Ball SA, Nich C, et al. Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: a multisite effectiveness study. Drug Alcohol Depend 2006;81:301–12.
16. Miller WR, Yahne CE, Tonigan JS. Motivational interviewing in drug abuse services: a randomized trial. J Consult Clin Psychol 2003;71:754–63.
17. Hettema J, Steele J, Miller WR. Motivational interviewing. Annu Rev Clin Psychol 2005;1:91–111.
18. Vasilaki EI, Hosier SG, Cox WM. The efficacy of motivational interviewing as a brief intervention for excessive drinking: a meta-analytic review. Alcohol Alcohol 2006;41:328–35.
19. Baker A, Lee NK, Claire M, et al. Brief cognitive behavioural interventions for regular amphetamine users: a step in the right direction. Addiction 2005;100:367–78.
20. Bernstein J, Bernstein E, Tassiopoulos K, et al. Brief motivational intervention at a clinic visit reduces cocaine and heroin use. Drug Alcohol Depend 2005;77:49–59.
21. Murphy CM, Maiuro RD. Motivational interviewing and stages of change in intimate partner violence. New York: Springer; 2009.
22. Reisenhofer S, Taft A. Women's journey to safety–the transtheoretical model in clinical practice when working with women experiencing intimate partner violence: a scientific review and clinical guidance. Patient Educ Couns 2013; 93(3):536–48.
23. Corcoran J. The transtheoretical stages of change model and motivational interviewing for building maternal supportiveness in cases of sexual abuse. J Child Sex Abus 2002;11(3):1–17.
24. Sampson M, Zayas LH, Seifert SB. Treatment engagement using motivational interviewing for low-income, ethnically diverse mothers with postpartum depression. Clin Soc Work J 2013;41(4):387–94.
25. Bombardier CH, Ehde DM, Gibbons LE, et al. Telephone-based physical activity counseling for major depression in people with multiple sclerosis. J Consult Clin Psychol 2013;81(1):89–99.
26. Westra HA, Aviram A, Doell FK. Extending motivational interviewing to the treatment of major mental health problems: current directions and evidence. Can J Psychiatry 2011;56(11):643–50.
27. Hides L, Carroll S, Lubman DI, et al. Brief motivational interviewing for depression and anxiety. In: Bennett-Levy J, Richards DA, Farrand P, et al, editors. Oxford guide to low intensity CBT interventions. New York: Oxford University Press; 2010. p. 177–85.
28. Interian A, Lewis-Fernández R, Gara MA, et al. A randomized-controlled trial of an intervention to improve antidepressant adherence among Latinos with depression. Depress Anxiety 2013;30(7):688–96.
29. Larzelere RE. Child outcomes of nonabusive and customary physical punishment by parents: an updated literature review. Clin Child Fam Psychol Rev 2000;3(4): 199–221.
30. Bernal ME, Duryee JS, Pruett HL. Behavior modification and the brat syndrome. J Consult Clin Psychol 1968;32(4):447–55.
31. Hicks-Pass S. Corporal punishment in America today: spare the rod, spoil the child? A systematic review of the literature. Best Pract Ment Health 2009;5(2): 71–88.

32. Reece H. The pitfalls of positive parenting. Ethics Educ 2013;8(1):42–54.
33. Forrester D, Westlake D, Glynn G. Parental resistance and social worker skills: towards a theory of motivational social work. Child Fam Soc Work 2012;17(2):118–29.
34. Scott S, Dadds MR. Practitioner review: when parent training doesn't work: theory-driven clinical strategies. J Child Psychol Psychiatry 2009;50(12):1441–50.
35. O'Leary CC. The early childhood family check-up: a brief intervention for at-risk families with preschool-aged children. Diss Abstr Int 2001;62(6-B):2992.
36. Rao SA. The short-term impact of the family check-up: a brief motivational intervention for at-risk families. Diss Abstr Int 1999;59(7-B):3710.
37. Runyon MK, Deblinger E, Schroeder CM. Pilot evaluation of outcomes of combined parent-child cognitive-behavioral group therapy for families at risk for child physical abuse. Cogn Behav Pract 2009;16(1):101–18.
38. Sterrett E, Jones DJ, Zalot A, et al. A pilot study of a brief motivational intervention to enhance parental engagement: a brief report. J Child Fam Stud 2010;19(6):697–701.
39. DiMatteo MR, Giordani PJ, Lepper HS, et al. Patient adherence and medical treatment outcomes: a meta-analysis. Med Care 2002;40(9):794–811.
40. Zolnierek KB, Dimatteo MR. Physician communication and patient adherence to treatment: a meta-analysis. Med Care 2009;47(8):826–34.
41. Gance-Cleveland B. Motivational interviewing as a strategy to increase families' adherence to treatment regimens. J Spec Pediatr Nurs 2005;10(3):151–5.
42. Ingoldsby EM. Review of interventions to improve family engagement and retention in parent and child mental health programs. J Child Fam Stud 2010;19(5):629–45.
43. Chin CN. The impact of an obesity intervention including motivational interviewing on outcomes for children and adolescents. Diss Abstr Int 2012;73(1-B):659.
44. Stanger C, Ryan SR, Delhey LM, et al. Multicomponent motivational intervention to improve adherence among adolescents with poorly controlled type 1 diabetes: a pilot study. J Pediatr Psychol 2013;38(6):629–37.
45. Leask J, Kinnersley P, Jackson C, et al. Communicating with parents about vaccination: a framework for health professionals. BMC Pediatr 2012;12:154–65.
46. Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: toward an integrative model of change. J Consult Clin Psychol 1983;51:390–5.