

Motivational interviewing: a key approach for supporting the transition to parenthood including breastfeeding?

Lauren Copeland and Shantini Paranjothy, researchers at the Institute of Primary Care and Public Health, Cardiff University, explore the effectiveness of Motivational Interviewing (MI), an increasingly popular form of counselling.



This review looks at evidence from recent studies on how Motivational Interviewing (MI) has the potential to increase self-efficacy in a variety of health settings, and in particular, considers opportunities for using MI to support breastfeeding.

What is motivational interviewing?

MI is a style of counselling that supports behaviour change through enhancing a person's motivation for change and increasing self-efficacy (a person's belief in their ability to achieve a desired outcome). The MI practitioner is trained to encourage reflection, and to show empathy and acceptance, and to support the person's sense of autonomy, to help them explore their own reasons and build the motivation for behaviour change. It was developed initially by psychologists Miller and Rollnick to help people with addictions, and was intended to be less confrontational, authoritarian and directing than other approaches in the 1980s.³ MI has since found application in many settings including medication adherence, weight

loss and dental health care,^{4,5} and in areas around the transition to parenthood such as smoking cessation and breastfeeding.

MI is not based on any theory but some researchers have linked it to Self-Determination Theory (SDT). SDT is a theory about a person's self-motivation to change behaviour. It shares a common principle with MI that 'people have an innate organisational tendency toward growth, integration of the self and the resolution of psychological inconsistency'.⁶ SDT seeks to explain what drives human behavior, and places motivation on a continuum of autonomy ranging from external regulation (no autonomy) to intrinsic regulation (full autonomy). By examining people's different motivations for achieving goals, for example, pleasure versus obligation,⁷ SDT identifies three psychological needs that must be met in order to help people shift the sense of autonomy from external to intrinsic: the need to believe that they can achieve something successfully, the need to manage themselves, and the need to establish close, stable, nurturing, and

Key points

- Motivational interviewing (MI) has shown some effectiveness in supporting behaviour change in a wide range of educational and health settings including during pregnancy, childhood and adolescence.
- There is only limited evidence available on the use of MI to support breastfeeding.
- Providing midwives and other health workers with training in MI may help to increase breastfeeding initiation and continuation.
- Further research is needed on the effectiveness of MI, with interventions delivered in accordance to the latest MI Treatment Integrity scale guidelines¹ and to see how MI can be incorporated into the work of National Health Service professionals and allied practitioners.²

protective relationships. MI supports the same psychological needs as SDT.

MI counselling involves four key processes: engaging (establishing a 'mutually trusting and respectful helping relationship to collaborate toward agreed-upon goals'),⁸ evoking (eliciting 'the client's own motivation for a particular change'), focusing ('clarifying a particular goal or direction for change'),⁸ and planning (developing a specific change plan that the client is willing to implement).³ These are not sequential and can be used at any time during a session. They help make complex behaviour changes seem more achievable by allowing the client to decide which changes they feel they can make. Qualified, skillful MI practitioners employ several techniques to support or guide behaviour change:

- 'Asking open questions
- Affirming (recognising and commenting on the patient's strengths and abilities)

- Reflective listening (summarising what the patient has told you in your own words, in the form of a statement rather than a question that encourages them to continue talking)
- Summarising (giving a collection of reflections, allowing you to indicate what you think were the most important headlines of what the patient has said)
- Informing and advising (giving information and advice where appropriate, for example when the patient asks, or more spontaneously, when there is good engagement).⁹

In the case of breastfeeding, these techniques can be used to support initiation and continuation. However, as MI is essentially a conversation style, the techniques are not specific to any one type of behaviour change. Rather they are used in response to whether the client is considering change or not.

Qualified MI practitioners will have been trained by the Motivational Interviewing Network of Trainers (MINT) and will further develop their skills and competencies with experience. In order to verifiably practice MI, they will need to have been rated as at least 'beginning proficiency' or 'competent' on the Motivational Interviewing Treatment Integrity scale (MITI 3.1.1),¹ which serves as a measure of fidelity to the original design of MI. They must use more open than closed questions, more complex than simple reflections, and more reflections than questions.

Interventions described as 'MI-based' will use only some but not all of these techniques. It is important to distinguish between these and interventions with at least a 'beginning proficiency' level of MI fidelity. This review covers both MI-proficient and MI-based studies. Some studies used MI as the sole intervention while others included MI as part of a complex set of interventions.

How has motivational interviewing been used to promote healthy behaviours and outcomes?

MI has been used successfully for a range of health outcomes, such as for treating addictions and reducing cholesterol, body weight and HIV viral load.^{4,10,11,12,13} A systematic review¹⁴ found 31 MI studies for smoking cessation, targeting adolescents, adults with chronic physical or mental illness, pregnant/postpartum women, and other adult groups. Compared to controls, MI interventions increased the likelihood of smoking cessation. A Cochrane review¹⁵ examined 59 randomised controlled trials (RCTs) that included MI for people who were dependant on, or who were abusing

substances. Compared to controls, MI had a statistically significant effect on reducing substance use. MI has also been used during the transition to parenthood.

MI and the transition to parenthood

Studies on the use of MI during the transition to parenthood include a meta-analysis on children's behaviour and health outcomes², an RCT examining the impact of MI training on nurses' self-efficacy,¹⁶ a summary of three RCTs from the Nurse-Family Partnership in the USA,¹⁷ and preliminary results from the UK Family Nurse Partnership.^{18,19,20}

Children's behaviour and health outcomes

The use of MI interventions to influence health-related behaviours and undesirable health outcomes in children include ones aimed at tackling obesity^{16,21} and dental problems.^{2,22} These interventions were delivered by various health professionals either during pregnancy or to children up to the age of six.

The meta-analysis² investigated the overall effectiveness of MI for child and adolescent health problems such as obesity, asthma, HIV/AIDS, type 1 diabetes, infant accident prevention, targeted dental health, accident prevention, infant sleep, and targeted calcium intake. It covered 37 studies, with sample sizes ranging from 20 to over 4,000 participants (either aged under 18, or the parent of a child aged under 18), with an average follow up of five months (some up to two years).

In 95% of the studies, MI produced a small but statistically significant positive effect compared with a pooled group of controls and alternative active treatment, but the size of the effect varied by health outcome. The largest effects were observed for type 1 diabetes, calcium intake, and asthma. There were some drawbacks in that close fidelity to the original MI design was only mentioned in 15 out of the 37 of studies, and only five out of the 37 measured fidelity according to the MITI scale (reporting a generally high fidelity - see above). It was therefore not possible to distinguish between the effects of interventions with or without clear MI fidelity. However, a clear take-home message for practitioners is stated in the summary of the meta-analysis, that 'MI seems to be most effective when both parent and child participate in sessions and when the cultural background of the practitioner matches the family.'¹⁴ There do not yet appear to be any qualitative studies on the experiences of the parent and child after receiving MI.

Training for nurses

An RCT¹⁶ evaluated the effects of training a group of 22 nurses with a combination of knowledge and advice on diet and physical activity, and using MI techniques, to prevent childhood obesity. The nurses were given 3.5 days of training in MI and had their performance compared with that of a control group of 38 nurses who received no training. The nurses' self-efficacy in delivering training was significantly increased in the intervention group: MI training appeared to have increased the nurses' confidence in delivering interventions on obesity, but their increased knowledge about diet and physical activity may also have played a role.

Support for first-time mothers

The original Nurse-Family Partnership in the USA used MI to provide support to young, first-time mothers and their babies as part of a psycho-educational approach. Three studies have revealed the positive effects of the support, from pregnancy through to children aged 15. For mothers there were improvements in health during pregnancy, fewer pregnancies, longer intervals between births, higher rates of maternal employment, and decreased use of welfare.¹⁷ The intervention has been adapted for implementation in the UK (Family Nurse Partnership), through trained nurses or health visitors, providing sensitive structured home visits for women from early pregnancy to the child's second birthday. Trials so far indicate that it can be delivered in Wales, England and Scotland and is acceptable to practitioners, mothers and fathers.^{18,19,20}

Can MI be used to enhance self-efficacy and motivation for breastfeeding?

Although 81% of mothers in the UK initiate breastfeeding, rates fall steeply in the first few weeks: around two-thirds of women stop before six weeks, which is earlier than planned for most,²³ and only 1% of UK mothers exclusively breastfeed for the six months duration recommended by WHO. There are also marked inequalities in breastfeeding rates: younger mothers (aged 20 or less), of white British ethnicity and of lower socio-economic status, are less likely to start or continue breastfeeding beyond six weeks.²³

Women choose to breastfeed for many different reasons, as described in a narrative review of women's experience of breastfeeding.²⁴ For many, breastfeeding is a symbol of motherhood, as it helps to nurture and nourish the baby, and to establish a physical and emotional connection. The provision of support and

Motivational Interviewing: an approach for NCT practitioners?

When it comes to infant feeding, NCT practitioners, including breastfeeding counsellors, don't seek to convince or persuade – our message framework is clear on this (see the NCT Message Framework for Infant Feeding, available from: bit.ly/NCT_FeedingSupport)

Instead, we're aware that in order to enable women to make decisions about feeding we avoid being directive, authoritarian or judgemental. The empathy and unconditional positive regard of our counselling approach appear to echo the 'atmosphere of acceptance and compassion' of MI.

Considering further points of similarity with MI can enhance our practice and understanding of our aims when engaging with parents:

- Breastfeeding counsellors also employ the techniques such as using open questions and reflective listening, as well as the emphasis on client-led dialogue.
- The focus on self-efficacy is helpful to all NCT practitioners. Supporting mothers to feel confident makes them more likely to achieve their aims.
- Our own self-efficacy – our belief that we are effective in our work as practitioners may also be crucial. Our CPD, supervision, and everyday reflections all play a role.

Although the words 'motivational interviewing' sound unlike us, as we don't 'interview' and we don't seek to increase motivation, in practice, it seems we do share with MI the person-centred approach. Clearly, there is more to learn, and the results of the Cardiff pilot³¹ should be of great interest to us.

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reassurance can also enhance the mother's experience of breastfeeding. Various factors are associated with initiation and continuation of breastfeeding, such as motivation, self-efficacy, affective attitudes and social norms.^{25,26,27,28} There is a statistically significant relationship between high breastfeeding self-efficacy and duration of breastfeeding at four months,²⁹ and between intrinsic motivation and breastfeeding for six months or beyond.³⁰ Mothers with strong inner motivation are more likely to breastfeed because they know and believe it is good for their infant and for themselves. Mothers who are motivated more by external influences are less likely to initiate or maintain breastfeeding.³⁰ In this respect, simply giving women breastfeeding information is not sufficient to change their breastfeeding behaviour.³⁰

MI-based interventions could help to enhance women's self-efficacy and motivation to breastfeed. Although there have been many interventions designed to support continued breastfeeding, few have proven successful in the UK setting, and of these, none involved MI. Of two MI-related studies conducted in the USA, one³¹ was a pilot RCT designed more broadly to improve nutrition and physical activity in postpartum mothers and their infants. The intervention consisted of a brief focused negotiation by paediatric primary care-givers, individualised coaching and motivational counselling based on MI techniques, and an

invitation to group-based parenting skills training. The intervention did not have a statistically significant effect on exclusive breastfeeding at six months. However, the intervention significantly delayed the introduction of solid food compared to the control group. Among the study's limitations was the lack of a fidelity check on the MI intervention, and so it is not easy to determine retrospectively the impact of MI. In addition, the intervention was delivered by a single individual, making it difficult to disentangle the effect of MI from the individual's personal style of delivery.

The second RCT conducted in the USA was small (sample size, 73) and underpowered for detecting statistically significant outcomes.³² The third study was a larger RCT (sample size, 330) which examined whether MI could improve exclusive breastfeeding rates in Australia.³³ The intervention nurse practitioners were trained to follow a 'conversation tool' flowchart, using MI techniques such as affirming autonomy or acknowledging ambivalence. They tailored the intervention to the participant's response to the question, 'How would that work for you?' in relation to the idea of breastfeeding exclusively for six months, which meant that the participant may only have received the affirming autonomy technique rather than full MI. At two months and four months after giving birth, the intervention group were more likely to have exclusively or predominantly breastfed in the last 24 hours, compared to the control group.

However, at 6 months there was no significant difference between groups in relation to either any form of breastfeeding or exclusive breastfeeding.

In the UK, MI may have a role in helping women to continue breastfeeding by increasing their intrinsic motivation to breastfeed, but its inclusion in interventions will need to be evaluated to determine its effectiveness. Researchers at Cardiff University are developing a new MI-based peer-support intervention aimed at promoting breastfeeding maintenance by training peer-supporters in using MI to provide responsive mother-centred support. The results will help to inform the development of a future trial on the effectiveness of an MI-based intervention for breastfeeding maintenance.³⁴

Conclusions

MI has shown at least some effectiveness in supporting behaviour change in a wide range of educational and health settings, including for tackling obesity, smoking cessation and health during pregnancy, childhood and adolescence. The term 'motivational interviewing' is widely used in healthcare settings, but does not always refer to MI delivered by fully qualified MI practitioners. Many different practitioners may use communication skills that draw on the MI approach. However, in order to fully assess the effectiveness of MI, there needs to be research on MI interventions delivered in accordance to the latest MITI guidelines¹ with high fidelity to the original MI design. Adequate training and support should be provided to help ensure fidelity. Training can be accessed through the Motivational Interviewing Network of Trainers (MINT).

It is also important to understand how MI works in order to inform practice most usefully and improve outcomes. Future research should therefore address the role of individual aspects of the MI process: self-efficacy, motivation, MI practitioner skills and 'change talk' (when a client discusses their desire or intention to change behaviour). Furthermore, it is important to conduct research on how MI could be incorporated into work by National Health Service professionals and allied practitioners.

There is only limited evidence available on the use of MI to support breastfeeding. By providing midwives and other health professionals with training in motivational interviewing it may be possible to help increase breastfeeding initiation and continuation. However, such initiatives should be accompanied by robust evaluation in order to provide evidence for their effectiveness.

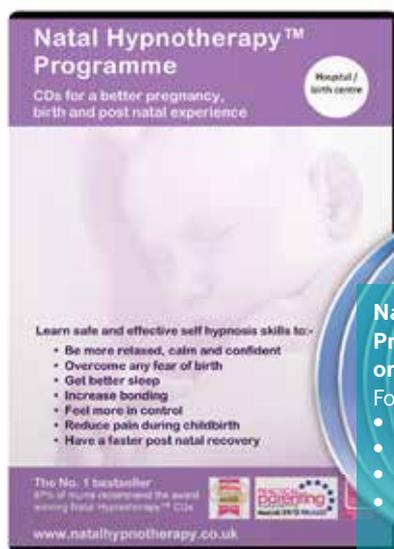
References

- Moyers TB, Martin T, Manuel JK, et al. Motivational Interviewing treatment integrity 3.1.1 (MITI 3.1.1) University of New Mexico Center on Alcoholism, Substance Abuse and Addictions (CASAA) Draft manuscript. Available from: casaa.unm.edu/download/MITI3_1.pdf Accessed 16.4.15
- Gayes LA, Steele RG. A meta-analysis of motivational interviewing interventions for pediatric health behavior change. *J Consult Clin Psychol* 2014;82(3):521-35.
- Miller WR, Rollnick S. *Motivational interviewing: helping people change*. 3rd edition New York: Guilford Press; 2012.
- Lundahl B, Moleni T, Burke BL, et al. Motivational interviewing in medical care settings: a systematic review and meta-analysis of randomized controlled trials. *Patient Educ Couns* 2015;93(2):157-68.
- Martins RK, McNeil DW. Review of Motivational Interviewing in promoting health behaviors. *Clin Psychol Rev* 2009;29(4):283-93.
- Ryan RM. Psychological needs and the facilitation of integrative processes. *J Pers*. 1995;63(3):397-427.
- Teixeira PJ, Carraca EV, Markland D, et al. Exercise, physical activity, and self-determination theory: a systematic review. *Int J Behav Nutr Phys Act*. 2012;9(1):78.
- Miller WR, Rollnick S. Glossary of Motivational Interviewing terms updated July 2012. Available from: www.feard.org.uk/docs/Glossary_MI_Terms.pdf
- Rollnick S, Gobat N, Batson J. Motivational interviewing in brief consultations. Available from: learning.bmj.com/learning/module-intro/.html?moduleId=10051582
- Knight KM, McGowan L, Dickens C, et al. A systematic review of motivational interviewing in physical health care settings. *Br J Health Psychol* 2006;11(Pt 2):319-32.
- Britt E, Hudson SM, Blampied NM. Motivational interviewing in health settings: a review. *Patient Educ Couns* 2004;53(2):147-55.
- Dunn C, Deroo L, Rivara FP. The use of brief interventions adapted from motivational interviewing across behavioral domains: a systematic review. *Addiction* 2001;96(12):1725-42.
- Armstrong MJ, Mottershead TA, Ronksley PE, et al. Motivational interviewing to improve weight loss in overweight and/or obese patients: a systematic review and meta-analysis of randomized controlled trials. *Obes Rev* 2011;12(9):709-23.
- Heckman CJ, Egleston BL, Hofmann MT. Efficacy of motivational interviewing for smoking cessation: a systematic review and meta-analysis. *Tob Control* 2010;19(5):410-6.
- Smedslund G, Berg RC, Hammerstrom KT, et al. Motivational interviewing for substance abuse. *Cochrane Database of Systematic Reviews* 2011, Issue 5. Available from: onlinelibrary.wiley.com/doi/10.1002/14651858.CD008063.pub2/abstract
- Bohman B, Ghaderi A, Rasmussen F. Training in methods of preventing childhood obesity increases self-efficacy in nurses in child health services: a randomized, controlled trial. *J Nutr Educ Behav* 2014;46(3):215-8.
- Dawley K, Loch J, Bindrich I. The nurse-family partnership. *Am J Nurs* 2007;107(11):60-7.
- Barnes J, Ball M, Meadows P, et al. *Nurse-family partnership programme: first year pilot sites implementation in England. Pregnancy and the post-partum period*. London: Department for Children, Schools and Families; 2008. Available from: www.education.gov.uk/rsgateway/DB/RRP/u015497/index.shtml
- Barnes J, Ball M, Meadows P, et al. *The Family-Nurse Partnership Programme in England: Wave 1 implementation in toddlerhood & a comparison between Waves 1 and 2a of implementation in pregnancy and infancy*. London: Institute for the Study of Children, Families and Social Issues Birkbeck, University of London; 2011. Available from: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123366.pdf
- Martin C, Marray L, Miller M, et al. The evaluation of the Family Nurse Partnership Programme in Scotland: phase 1 report - intake and early pregnancy. Edinburgh: Scottish Government Social Research; 2011. Available from: www.scotland.gov.uk/socialresearch
- Taveras EM, Gortmaker SL, Hohman KH, et al. Randomized controlled trial to improve primary care to prevent and manage childhood obesity: the High Five for Kids study. *Arch Pediatr Adolesc Med* 2011;165(8):714-22.
- Freudenthal JJ, Bowen DM. Motivational interviewing to decrease parental risk-related behaviors for early childhood caries. *J Dent Hyg*. 2010;84(1):29-34.
- McAndrew F, Thompson J, Fellows L, et al. *Infant feeding survey 2010*. Leeds: Health and Social Care Information Centre (IC); 2012. Available from: bit.ly/1bkhHjn
- Afoakwa G, Smyth R, Lavender T. Women's experiences of breastfeeding: a narrative review of qualitative studies. *Afr J Midwifery Womens Health* 2013;7(2):71-7.
- Bai Y, Middlesteadt SE, Peng CY, et al. Predictors of continuation of exclusive breastfeeding for the first six months of life. *J Hum Lact* 2010;26(1):26-34.
- Brown A, Lee M. An exploration of the attitudes and experiences of mothers in the United Kingdom who chose to breastfeed exclusively for 6 months postpartum. *Breastfeed Med* 2011;6(4):197-204.
- Dyson L, Green JM, Renfrew MJ, et al. Factors influencing the infant feeding decision for socioeconomically deprived pregnant teenagers: the moral dimension. *Birth* 2010;37(2):141-9.
- Lawton R, Ashley L, Dawson S, et al. Employing an extended Theory of Planned Behaviour to predict breastfeeding intention, initiation, and maintenance in White British and South-Asian mothers living in Bradford. *Br J Health Psychol* 2012;17(4):854-71.
- Forster DA, McLachlan HL, Lumley J. Factors associated with breastfeeding at six months postpartum in a group of Australian women. *Int Breastfeed J* 2006;1:doi:10.1186/1746-4358-1-18.
- Racine EF, Frick KD, Strobino D, et al. How motivation influences breastfeeding duration among low-income women. *J Hum Lact*. 2009;25(2):173-81.
- Taveras EM, Blackburn K, Gillman MW, et al. First steps for mommy and me: a pilot intervention to improve nutrition and physical activity behaviors of postpartum mothers and their infants. *Matern Child Health J* 2011;15(8):1217-27.
- Wilhelm SL, Stepan MB, Hertzog M, et al. Motivational interviewing to promote sustained breastfeeding. *J Obstet Gynecol Neonatal Nurs* 2006;35(3):340-8.
- Elliott-Rudder M, Pilotto L, McIntyre E, et al. Motivational interviewing improves exclusive breastfeeding in an Australian randomised controlled trial. *Acta Paediatr* 2014;103(1):e11-e16.
- Health Technology Assessment. HTA - 13/18/05: A novel peer-support intervention using Motivational Interviewing for breastfeeding maintenance: a UK feasibility study. 2014. Available from: www.nets.nihr.ac.uk/projects/hta/131805

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