Motivacijski intervju s djecom i adolescentima: Razvojni pristup i prikaz bolesnika

/ Motivational Interviewing with Children and Adolescents: Developmental Perspective and a Case Report

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Motivacijski intervju (MI) je na dokazima temeljena, prema klijentu usmjerena, kolaborativna terapijska tehnika za povećanje motivacije za promjenu razrješenjem ambivalencije. MI je razvijen u području ovisnosti i prerastao je u široko korištenu bihevioralnu intervenciju. MI naglašava autonomiju, empatiju te uvažavanje vjerovanja i misli o promjeni pacijenta. Iako može biti samostalna intervencija, MI se koristi i za povećanje motivacije prije početka ili kod gubitka motivacije tijekom zdravstvenog tretmana. Istraživanja MI su primarno bila usmjerena na odraslu populaciju te studije učinkovitosti za mlađu populaciju fokusirane na adolescente i preadolescente, a ne djecu predškolske i školske dobi. Izostanak direktnih istraživanja na djeci mlađe dobi nastao je zbog zahtjeva za određenim stupnjem apstraktnog mišljenja za provođenje MI. Međutim, novija istraživanja pokazuju da je moguće prilagoditi MI teoriju i primjenu na jezik razumljiv i svrsishodan djeci. Korištenje MI materijala specifičnih za mlade s prikladnim i fleksibilnim adaptacijama aktivnosti omogućuje postizanje pozitivnih ishoda kod djece. Cilj je ovog rada prikazati glavne principe MI te suvremene spoznaje o razvojnoj primjerenosti i učinkovitosti MI u djece i adolescenata.

/ Motivational interviewing (MI) is an evidenced-based, client-centered collaborative therapeutic method of enhancing motivation for change through the resolution of ambivalence. MI was developed in the field of addictions and has grown into a widely applied behavioural intervention. While it can be a stand-alone intervention, MI may also be used as a springboard for motivation before starting health treatment or to address dips in motivation throughout treatment. MI research have primarily centered on the study of adults, with studies of its effectiveness for youth and children focusing on adolescent and pre-adolescent youth rather than preschool or elementary aged children. The lack of direct study with young children was due to the requirement for some degree of abstract reasoning to conduct MI. However, recent evidence shows that it is possible to translate MI theory and practice into childfriendly language which is understandable and meaningful to younger children. Using MI-based materials specifically aimed at young people and making appropriate and flexible adaptations to the activities help to enable positive outcomes for the children. The purpose of this paper was to provide core principles of MI and the current knowledge on its developmental appropriateness and effectiveness for children and adolescents.

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UVOD

Motivacijski intervju (MI) je na dokazima temeljena, prema klijentu usmjerena, suradna terapijska tehnika za povećanje motivacije za promjenu kroz razrješenje ambivalencije (1). Ambivalencija podrazumijeva nesigurnost ili nemogućnost donošenja odluke zbog istodobne ili promjenljive želje za ostvarenjem dviju suprotnih ili različitih aktivnosti. Ambivalencija često ima ključnu ulogu u psihološkim poteškoćama. Umjesto interpretiranja ambivalencije kao patološke ili kao naznake nečije moralne ili ponašajne slabosti MI tumači ambivalenciju kao rješiv problem koji jednom razrješen pokreće osobu prema promjeni (2).

MI je prvi opisao Miller koji je ujedinio i prilagodio elemente Rogerove prema klijentu usmjerene terapije (4), Festingerove teorije kognitivne disonancije (5) i Bemove teorije samo-percepcije (6). MI naglašava autonomiju, empatiju, uvažavanje pacijentovih vlastitih vjerovanja i misli o promjeni. Prisutan je također i direktivni element različitim izazivanjem i potkrepljenjem razgovora o promjeni (1).

Početni cilj MI je olakšati povećanje klijentove intrinzičke motivacije, opredjeljenja (Faza 1) i potom pripreme za promjenu (Faza 2) (8). Ponajprije, terapijski odnos je partnerstvo u kojem se poštuje pacijentova autonomija (8).

INTRODUCTION

Motivational interviewing (MI) is an evidenced-based, client-centred collaborative therapeutic method of enhancing motivation for change through the resolution of ambivalence (1). Ambivalence refers to an uncertainty or inability to make a choice because of the simultaneous or fluctuating desires to engage in two opposite or conflicting activities. Ambivalence frequently plays a key role in psychological difficulties. Rather than interpreting ambivalence as pathological or an indication of someone's moral or behavioural weakness, MI construes ambivalence as a resolvable issue that, once resolved, will move a person toward change (2).

MI was first described by Miller (3) who combined and adapted elements of Rogers' client-centred therapy (4), Festinger's (5) theory of cognitive dissonance and Bem's (6) self-perception theory. MI emphasises autonomy, empathy, and respect for the patient's own beliefs and thoughts about change. There is also a directive element guided by differentially eliciting and reinforcing change talk (1).

The initial goal of MI is to facilitate an increase in the client's intrinsic motivation, commitment (Phase 1) and then preparation for change (Phase 2) (8). Primarily, the therapeutic relationship is a partnership where the patient's autonomy is re-

Poticanje promjene se osniva na suptilnom, nježnom i osjetljivom vođenju, procesu koji je gotovo neprimjetan promatraču (1). U početku terapeut pomaže pacijentu razviti diskrepanciju između sadašnje situacije i njegovih željenih ciljeva. Suptilne metode koje se koriste kako bi pokrenule diskrepanciju su različite od otvoreno direktivnih i konfrontirajućih metoda koje su se ranije koristile. Poticanje samo-motivirajućeg govora (govora o promjeni) omogućuje pacijentu sagledati vlastite prednosti i nedostatke promjene. Iako može biti samostalna intervencija, MI se može također koristiti za poticanje motivacije prije početka zdravstvenog liječenja ili kako bi se poradilo na zastojima u motivaciji tijekom tretmana (9).

MI je prvotno razvijen za osobe sa zloporabom i ovisnostima. Tijekom godina MI je modificiran i prilagođen za korištenje u različitim kliničkim područjima, uključujući ovisnosti, mentalno zdravlje i zdravstvenu skrb (10). Većina istraživanja u posljednjih 30 godina ispitivala su korištenje MI u odraslih i veliki je broj pozitivnih rezultata. Atkinson i Woods (11) ističu potencijalnu korist MI u radu s djecom i mladima kod kojih je poticaj za upućivanje obično od treće strane.

Cilj je ovog rada prikazati osnovne principe MI i sadašnje spoznaje o razvojnoj primjerenosti za djecu školske dobi i adolescente. Posebno će biti prikazani kognitivni procesi u okviru neurorazvoja i kognitivnog razvoja djece i adolescenata uključeni u MI te implikacije za korištenje MI u djece i adolescenata od stane stručnjaka za mentalno zdravlje i preporuke za daljnja istraživanja.

MOTIVACIJSKI INTERVJU KAO INTERVENCIJA

Za podršku MI često je korišten je Transteorijski model (TTM) (12) koji se također naziva Model stadija promjene. Prema ovom modelu, koji je prikazan na sl. 1., osoba prolazi kroz

spected (8). The facilitation of change is based on subtle, gentle and responsive guiding, a process almost undetectable to an observer (1). Initially the therapist helps the patient develop discrepancy between their present situation and their desired goal. The subtle methods used to initiate the discrepancy are a far cry from the overtly directive and confrontational methods once employed. The evocation of self-motivating speech (change talk) allows the patient to develop their own advantages and disadvantages of change. While it can be a stand-alone intervention, MI may also be used as a springboard for motivation before starting health treatment or to address dips in motivation throughout treatment (9).

MI was originally developed for people with substance abuse disorders. Over the years, MI has been modified and adapted for use in many clinical areas, including addictive behaviours, mental health and medical management (10). The majority of research over the last 30 years has investigated the use of MI with adults and a considerable volume has yielded positive results. Atkinson and Woods (11) highlight its potential usefulness in work with children and young people, where the impetus for referral is typically from a third party.

The purpose of this paper was to provide core principles of MI and the current knowledge on its developmental appropriateness for school-aged children and adolescents. Specifically, we present cognitive processes involved in MI in terms of child and adolescent cognitive development and neurodevelopment, and implications for using MI with children and adolescents, considerations for school-based mental health professionals and suggestions for future research.

MOTIVATIONAL INTERVIEWING AS AN INTERVENTION

The framework frequently used to support MI has been the Transtheoretical Model (TTM) (12), also referred to as the Model of Stages

pet stadija promjene: prekontemplacija (još ne razmatra promjenu), kontemplacija (razmatra promjenu), priprema (planiranje i posvećenost promjeni), akcija (promjene u ponašanju) i održavanje (održavanje i podržavanje dugoročne promjene).

MI i TTM su se često koristili zajedno u kliničkim i obrazovnim ustanovama. Međutim, Miller i Rollnick u zadnje vrijeme jasno naglašavaju razliku između MI i TTM (13).

Miller i Rollnick (1,8) opisuju tri principa koji čine osnovu MI (suradnja, poticanje i autonomija) te četiri praktična principa koja određuju ulogu terapeuta (empatija, razvijanje diskrepancije, rad na otporu i podržavanje samo-učinkovitosti). Navedeni principi MI su prikazani u Prikazu 1 i 2.

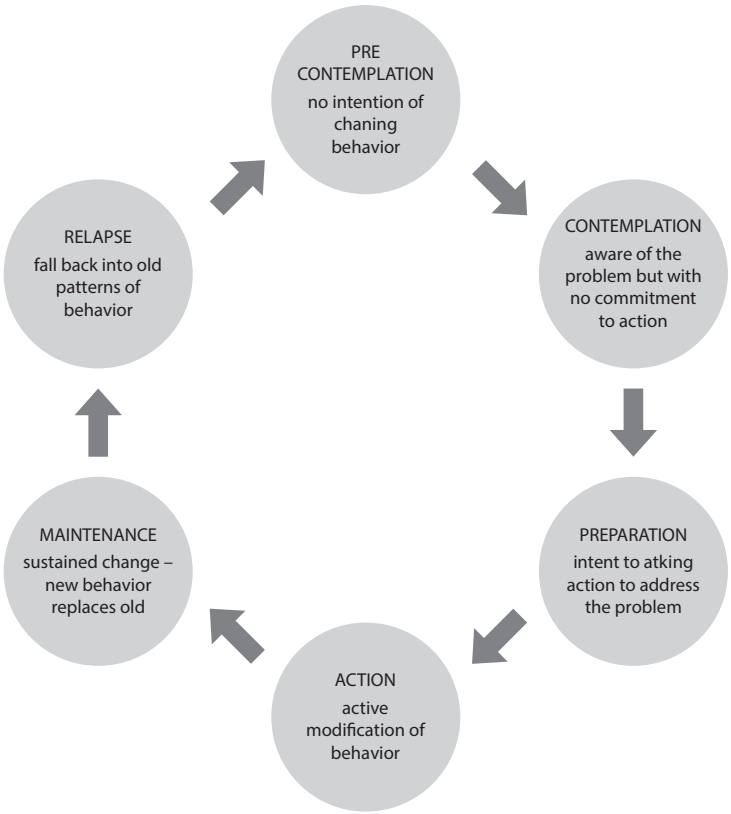
Pojam aktivno slušanje je temeljno za MI i karakterizira ga mnemonički izraz „OPRS“ koji označava otvorena pitanja, afirmacije, refleksije i sažetke (1,8).

of Change. In this model shown in Picture 1, it is posited that a person progresses through 5 stages of change: precontemplation (not yet considering change), contemplation (considering change), preparation (planning and committing to change), action (making the behaviour change) and maintenance (maintaining and sustaining long-term change).

MI and the TTM have frequently been used in conjunction in both clinical and educational settings. In recent times, Miller and Rollnick have increasingly distanced MI from TTM (13).

Miller and Rollnick (1,8) describe three fundamental principles that encapsulate the spirit of MI (collaboration, evocation and autonomy), and four practical principles defining the practitioner role (empathy, develop discrepancy, roll with resistance and support self-efficacy). These are paraphrased in Figures 1 and 2.

The notion of active listening is fundamental to MI and characterised by the mnemonic "*OARS*",



PICTURE 1. Transtheoretical Model of Stages of Change by DiClemente and Prochaska (12)

Prikaz 1. Osnovni postulati motivacijskog intervjua (Miller i Rollnick, 2002)

1. ***Suradnja*** podrazumijeva odnos između klijenta i terapeuta u kojem su obje strane aktivni sudionici u procesu rješavanja problema koji uključuje identificiranje problema, sakupljanje i analiziranje informacija vezanih uz problem, planiranje intervencija i evaluaciju ishoda.
2. ***Poticanje*** se osniva na činjenici da je želja za promjenom u klijentu. Terapeut djeluje kao voditelj koristeći klijentovo vlastito znanje, iskustva, vrijednosti i ciljeve kako bi poticao motivaciju za procjenu za razliku od edukacije ili pružanje znanja ili nagovora za promjenu.
3. ***Autonomija*** se odnosi na klijentovu slobodu za ili protiv promjene. Važno je da terapeut prepozna i prihvati klijentovu autonomiju. Terapeut potiče promjenu pomažući klijentu napraviti izbor temeljen na informacijama i prihvatiti odgovornost za svoj izbor. To je u suprotnosti s raspravljanjem ili davanjem savjeta koji izazivaju otpor što povećava vjerojatnost promjene ponašanja u smjeru suprotnom od onog kojem terapeut pokušava usmjeriti klijenta.

Prikaz 2. Principi motivacijskog intervjua (Miller i Rollnick, 2002)

1. ***Izražavanje empatije*** se odnosi na sposobnost terapeuta da pokaže klijentu da razumije njegove osjećaje i situaciju na neosuđujući način.
2. ***Razvijanje diskrepancije*** se osniva na pomaganju klijentu da uvidi diskrepanciju između sadašnjeg stanja i željenih ciljeva.
3. ***Rad na otporu*** se odnosi na činjenicu da se terapeut nikada ne smije prepirati s klijentom kako bi potaknuo klijenta na promjenu, jer to povećava otpor klijenta prema promjeni.
4. ***Podržavanje samo-učinkovitosti*** uključuje povećanje klijentovog vjerovanja u vlastitu sposobnost za promjenu.

Otvorena pitanja otvaraju mogućnost za pacijenta da govori nasuprot tzv. zatvorenim pitanjima koja izazivaju jednolične odgovore. Sveukupno pitanja trebaju biti ograničena (nikad više od tri u slijedu). Preporuča se koristiti refleksije umjesto pitanja.

Figure 1. The spirit of MI (Miller and Rollnick, 2002)

1. ***Collaboration*** refers to a relationship between the client and the counsellor in which both parties are active participants in the problem-solving process, which includes identifying the problem, gathering and analysing information related to the problem, designing interventions and evaluating outcomes.
2. ***Evocation*** is based on the notion that the desire to change is within the client. The therapist acts as a guide using the client's own knowledge, experiences, values and goals to elicit the motivation to change as opposed to educating or providing knowledge or incentives for change.
3. ***Autonomy*** refers to the client's freedom to change or not. It is important for the counsellor to recognize and accept the client's autonomy. The counsellor promotes change by helping the client make informed choices and accept responsibility for their choices. It is opposed to arguing and giving advice that can increase reactance, which has been shown to increase the likelihood of behaviour change in the direction opposite of that in which the therapist is attempting to steer the client.

Figure 2. The principles of MI (Miller and Rollnick, 2002)

1. ***Expressing empathy*** refers to the counsellor's ability to show the client that she understands the client's feelings and situation in a non-judgemental manner.
2. ***Developing discrepancy*** is based on helping the client develop discrepancy between the present state of affairs and their desired goal.
3. ***Rolling with resistance*** refers to the notion that the counsellor should never argue with the client in order to get the client to change because this increases the client's resistance to change.
4. ***Supporting self-efficacy*** involves enhancing the client's belief in their own ability to change.

which stands for Open-ended questions, Affirmations, Reflections and Summaries (1,8).

Open questions open the opportunity for the patient to speak as opposed to closed questions which elicit monosyllabic answers. Questions

Afirmacije. Terapeut ima suosjećajan stav prihvaćanja i reflektira snage i pozitivne pomake prema korisnijim ponašanjima.

Refleksije su implicitni znak slušanja koje mogu ohrabriti pacijenta da se zaustavi na misli, jer je u stanju čuti ono što on sam razmišlja. Ovo može voditi daljnjoj eleboraciji. Refleksije odražavaju empatiju. Komplekne refleksije pokreću konverzaciju i usmjeravaju je prema promjeni oslanjanjem na emocionalnu energiju, poticanjem samo-učinkovitosti i naglašavanjem učinkovitih strategija promjene. Koristi se nekoliko načina refleksije koje smanjuju otpor: na primjer, dvostrana refleksija suprotstavlja i približava razloge za i protiv promjene.

Sažetci. Kratko ponavljanje koje sadrži srž rasprave, posebno ideja, namjera i ponašanja za promjenu, može koristiti u određenim intervalima kako bi pacijent mogao čuti što on/ona misli i govori.

Frey i sur. (14) opisuju važnost *govora o promjeni*, koji se događa nakon nakon što su definirani klijentovi motivi za promjenu (1). Potiče ga terapeut koji naglašava prednosti promjene i nedostatke sadašnje situacije zadržavajući ulogu „ne-eksperta“ što omogućava da klijent počinje odvagivati prednosti i nedostatke sadašnjeg i budućeg ponašanja.

MOTIVACIJSKI INTERVJU S DJECOM I ADOLESCENTIMA – RAZVOJNA PERSPEKTIVA

Istraživanja MI su primarno bila usmjerena na odrasle, a studije učinkovitosti za mlade bile su fokusirane na adolescente i preadolescente za razliku od djece predškolske i školske dobi. Lundahl i sur. (15) su objasnili nedostatak direktnih istraživanja na mlađoj djeci zahtjevom za određenim stupnjem apstraktnog mišljenja s obzirom da se MI provodi u kognitivnoj sferi

should be limited overall (never more than three in a row). Reflections should be used in preference to questions.

Affirmations. The therapist has a compassionate accepting stance and reflects upon strengths and positive moves towards more helpful behaviours.

Reflections are an implicit mark of listening, which may encourage the patient to pause for thought as they are able to hear what they themselves are thinking. This in turn may lead to further elaboration. Reflections convey empathy. Complex reflections move the conversation forward and direct it towards change by drawing upon emotional energy, enhancing self-efficacy, or emphasizing effective change strategies. Several forms of reflections are used to side step resistance: for example, a double sided reflection contrasts and joins reasons for and against change.

Summaries. Short précis that encapsulate the gist of the argument, particularly of the pro change ideas, intentions or behaviours, can be used at intervals to enable the patient to hear what he/she is thinking and saying.

Frey et al. (14) describe the importance of *change talk*, which occurs after the client's motives for change have been established (1). It is elicited by the practitioner, who highlights the advantages of the change and the disadvantages of the current situation, while retaining a "non-expert" role, which allows the client to begin to weigh up the advantages and disadvantages of current and future behaviour.

MI WITH CHILDREN AND ADOLESCENTS – DEVELOPMENTAL CONSIDERATIONS

MI investigations have primarily centred on the study of adults, with studies of its effectiveness for youth and children focusing on adolescent and pre-adolescent youth rather than preschool or elementary aged children. Lundahl et

(16). Stoga autori zaključuju da MI ne može biti od pomoći u mlađe djece.

Smatra se da učinkovitost MI ovisi o klijentovom odgovoru na ključna ponašanja terapeuta koja potiču osjećaj suradnje, samo-evaluaciju i razvoj osjećaja autonomije (1). Nadalje, pretpostavlja se da odgovor klijenta ovisi i o razvoju niza kognitivnih procesa (kontrola pažnje, moralno prosuđivanje, odlučivanje, osjećaj selfa, samoprocjena, samokontrola, planiranje, teorija uma i postavljanje ciljeva).

Istraživanja pokazuju da su funkcije uočavanja (pažnja i perceptualna sposobnost) i afektivnosti (moralna prosudba i emocionalno procesiranje držanja, vrijednosti i ponašanja vršnjaka i odraslih) u potpunosti razvijene do dobi od 12 godina (17,18). Razvoj kognitivnih regulatornih funkcija je dugotrajan tijekom djetinjstva i adolescencije (18). U adolescenciji dolazi do povećanja impulzivnog ponašanja što znači da adolescenti mogu imati probleme samokontrole kao rezultat odgođenog sazrijevanja prefrontalnog korteksa (19). Međutim, istraživanja izvršnog funkcioniranja (odlučivanje, planiranje, postavljanje ciljeva, samokontrola, osobno upravljanje, teorija uma, samosvjesnost i samoprocjena) pokazuju da su mnogi procesi povezani s kognitivnim regulatornim funkcijama relativno sazreli i funkcionalni do dobi od 12 godina (20). S obzirom da je većina kognitivnih procesa razvijena ili doseže punu maturaciju do dobi od 12 godina, opravdano je smatrati MI kao zdravstvenu intervenciju za preadolescente i adolescente (18).

Prve studije koje su uključivale predškolsku i osnovnoškolsku djecu su ukazivale da se MI može koristiti s roditeljima i učiteljima koji imaju značajnu ulogu u životu djeteta (21,22) te kontroliraju kućno i školsko okruženje. U kontekstu mentalnog zdravlja u školi, MI predstavlja način promjene ponašanja odraslih kao medijatora promjene ponašanja djeteta. Frey i sur. (14) tvrde da principi MI trebaju činiti

al. (15) explained the lack of direct study with young children with the requirement for some degree of abstract reasoning that should be present as MI is conducted within a cognitive medium (16); thus, he concluded that MI may not be helpful in preteen children.

The efficacy of MI is thought to be contingent on the client's responsiveness to key therapist behaviours that promote a sense of collaboration, evoke self-evaluative statements and develop a sense of autonomy (1). In addition, client responsiveness is hypothesized to be contingent on the development of an array of cognitive processes (e.g. attentional control, moral judgement, decision making, sense of self, self-appraisal, self-control, evaluation, planning, theory of mind and goal setting).

Research indicates that the detection function (basic attentional and perceptual capacity) and affective functions (moral judgement and emotional processing of peer and adult attitudes, values and behaviours) are fully developed by the age of 12 (17,18). Development of the cognitive regulatory functions is protracted throughout childhood and adolescence (18). There are increases in impulsive behaviour which means that adolescents may have difficulty in self-control as a result of the delay of prefrontal cortex maturation (19). However, research on executive (decision making, planning, goal setting, self-control, personal agency, theory of mind and self-awareness and self-appraisal) functioning indicates that many of the processes related to the cognitive regulatory functions are relatively mature and functional by the age of 12 (20). Given the vast majority of cognitive processes are developed or are reaching full maturation by the age of 12, it is reasonable to consider MI a potential health intervention for middle and high school students (18).

The first studies that involved preschool and elementary aged children suggested that MI can be used with parents and teachers, who play a significant role in the life of the child (21,22)

osnovu konverzacije s učenicima, roditeljima i nastavnicima.

Istraživanja MI u mlađe djece su tek u začetku. Vrlo je vjerojatno da se MI može koristiti s određenom učinkovitošću u mlađe djece (23). Daljnja istraživanja u ovom području pokazat će spektar potrebnih MI vještina koje su prikladne za određeni razvojni stupanj.

KORIŠTENJE TEHNIKA MOTIVACIJSKOG INTERVJUA S DJECOM I ADOLESCENTIMA

Istraživanja pokazuju da spremnost djece, mladih i obitelji za liječenje može utjecati na terapijski proces i uspjeh tretmana (24). Drugim riječima, važno je za klijente da se osjećaju spremnima za promjenu kako bi tretman u području mentalnog zdravlja bio učinkovit. Osim spremnosti za početak tretmana, posvećenost terapijskim ciljevima tijekom tretmana je imperativ za postizanje tih ciljeva. Stoga je ključno za terapeute uključiti i motivirati mlade i obitelji prije i tijekom tretmana kako bi se povećala učinkovitost (24). Izgradnja snažnog terapijskog saveza s mladima i obiteljima je prvi i najvažniji čimbenik u poticanju uključenosti i povećanju motivacije (25).

Po svojoj prirodi MI nije direktivan i autoritaran te je kao takav prikladan za mlade osobe koje zahtijevaju više suradnički i nekonfrontirajući pristup (8). MI može biti posebno privlačan djeci i mladima zbog svoje specifične karakteristike da ne pretpostavlja klijentovu spremnost za promjenu. Ovo je posebno važno kada osoba koja je zabrinuta nije dijete, jer dopušta razmatranje različitih čimbenika koji mogu uzrokovati da je dijete ambivalentno ili u otporu prema promjeni.

Većina istraživanja provedena na mladim osobama bila su usmjerena na ovisnosti uključujući puštenje (26), alkohol (27) i kanabis (28). U posljednje vrijeme tehnike MI su korištene za

and control home and school environments. In the context of school mental health, MI is promising as a vehicle to change adult behaviour, while mediating changes in the child's behaviour. Frey et al. (14) claim that MI principles should form the basis of conversations with students, parents and teachers.

The direct study of MI with young children is only just beginning. It may be plausible that MI could be utilized with young children with some effectiveness (23). More likely, continued research in this area could reveal a continuum of MI requisite skills that are appropriate for certain developmental levels.

THE USE OF MI TECHNIQUES WITH CHILDREN AND ADOLESCENTS

Research shows that the treatment readiness of children, youth and families can influence the therapeutic process and treatment success (24). In other words, it is important for clients to feel ready for change in order for mental health treatment to be effective. In addition to feeling ready at the start of treatment, staying committed to treatment goals throughout the course of treatment is imperative to reaching those goals. Consequently, it is crucial for practitioners to engage and motivate youth and families both before and throughout treatment to maximize its effectiveness (24). Building a strong working alliance with youth and families is thought to be the first and most important ingredient for enhancing engagement and fuelling motivation (25).

MI is by its nature not directive or authoritarian and, as such, it is suited for young people who require a more collaborative and non-confrontational approach (8). MI may be particularly appealing to children and youth because of its distinctive feature of not assuming client readiness for change. This is important when the concern holder is typically not the child, as it allows consideration of different factors which can cause the child to be ambivalent about, or even resistant to change.

mlade osobe s depresijom (29) i samoozljeđivanjem (30). Intervencije MI su poboljšale uzimanje antidepresiva i stabilizatora raspoloženja u adolescenata s depresijom (31). MI također pomaže uključivanju obitelji adolescenata s ADHD u tretman i poboljšava simptome i oštećenja (32). Istraživanja su pokazala pozitivne rezultate u mladih s poremećajima hranjenja, opsesivno-kompulzivnim poremećajem, HIV-om i drugim kroničnim somatskim stanjima (20), kao i poboljšanje akademskog uspjeha i ponašanja srednjoškolaca (33). Korištenje tehnika MI u pretile djece je pokazalo pozitivne kratkoročne rezultate (34,35), no potrebno je još ispitati i dugoročnu učinkovitost.

MI se koristi s mladima u obrazovnom sustavu s rastućim interesom i ohrabrujućim rezultatima (36,37). Frey i sur. (14) su istaknuli da će MI biti sve više korišten u obrazovanju zbog fleksibilnosti i utemeljenosti na dokazima. Woods, McArdle i Tabassum (38) u svom sistematskom pregledu literature o korištenju MI s djecom i mladima u školama ukazuju vjerojatnu učinkovitost prilagodbom dobi djece. Međutim, uporaba tehnika MI u osnovnoškolske djece je trenutno još uvijek slabo istraženo područje.

McNamara (37) navodi da su bihevioralne intervencije s mlađom djecom koja imaju socijalne, emocionalne i ponašajne probleme ograničene u svojoj mogućnosti promjene ponašanja, jer pretpostavljaju da se ponašanje mijenja ekstrinzički. Autor predlaže promjenu intervencija za mlađu djecu prema onima koje su usmjerene na misli, osjećaje, intrinzičku motivaciju i suradnju, što su sve principi uključeni u MI. McNamara (37) također predlaže da se teorija i praksa MI prevedu na jezik prihvatljiv za djecu koji im je razumljiv i smislen. Materijali MI koji su specifično usmjereni na mlade ljude te odgovarajuće i fleksibilne prilagodbe aktivnosti pomažu u ostvarivanju pozitivnih ishoda za mlađu djecu. Nedavne meta-analize primjene MI s mlađom djecom pokazuju da su

The majority of research with young people has focused on substance related behaviours, including smoking (26), drinking (27) and marijuana use (28).

More recently, MI techniques have been used to support young people suffering from depression (29) and self-injurious behaviour (30). MI intervention improved antidepressants and mood stabilizers adherence in adolescents with depression (31). MI helped engage families in treatment and improve the symptoms and impairments of adolescents with ADHD (32). Research has also shown positive results with youth with eating disorders, obsessive-compulsive disorder and HIV or other chronic medical conditions (20) as well as middle school students' academic performance and behaviour (33). The use of MI techniques with overweight children showed positive results in the short term (34,35), but long-term efficacy still needs to be evaluated.

MI has also been utilised with young people in the educational sectors with growing interest and encouraging results (36,37). Frey et al. (14) proposed that MI will be used increasingly within educational settings because of its flexibility and the encouraging evidence-base it is producing. Woods, McArdle and Tabassum (38) have undertaken a systematic review of literature relating to the use of MI with children and young people in schools and suggest its possible effectiveness through age-appropriate adaptations. However, the use of MI techniques with primary school children is currently an under-researched area.

McNamara (37) proposes that behavioural interventions for younger children with social, emotional and behavioural difficulties are limited in their capacity because they assume that behaviour is changed extrinsically. He proposes that interventions for younger children should be shifting towards those that focus on thoughts, feelings, intrinsic motivation and collaboration, which are properties incorporated in MI.

McNamara (37) suggests that MI theory and practice need to be translated into child-friend-

adaptacije tipične (39,40). Međutim, bitno je da intervencije sadrže osnovne postavke i principe MI.

PRIKAZ BOLESNIKA

Petar (star 9 godina) živi s majkom, očuhom i mlađim bratom (star 6 mjeseci). Dječak nikada nije upoznao biološkog oca. Upućen je dječjem psihijatru zbog značajnih promjena u ponašanju koje traju zadnjih 6 mjeseci. Školski psiholog je opisao ponašanje dječaka: izgleda umorno većinu dana, rijetko uspostavlja kontakt pogledom i smije se, uopće nije motiviran u razredu, treba mu dugo da započne i često ne završi zadatke, uznemiri se kada mu se postavi pitanje, ocjene su se značajno snizile, izbjegava drugu djecu tijekom odmora, sjedi sam u klupi.

Procjena multidisciplinskog tima (dječji psihijatar, klinički psiholog, logoped, EEG i neuropedijatar) pokazala je da su dječakove intelektualno sposobnosti prosječne te da su prisutni klinički značajni anksiozno-depresivni simptomi uz vjerojatnost da je rođenje brata i osjećaj gubitka ranije pozicije u obiteljskom okruženju doprinijelo gubitku školske i socijalne uključenosti. Preporučena je psihoterapija, no dječak se nije htio uključiti. Dječakovoj majci pružena je podrška da dovede dječaka na terapiju te je najprije primijenjen MI.

Provedene su četiri seanse MI, 45 minuta svaka. Tablica 1 prikazuje aktivnosti koje su se koristile i detalje svake seanse s dječakom. Specifične prilagodbe kako bi aktivnosti MI bile dostupne djetetu su uključivale crteže, radne listiće i flomastere, različite boje za različito ponašanje, igranje uloga za istraživanje ponašanja i osjećaja i potkrepljivače (nagrade) za izvršene aktivnosti (naljepnice u boji). Dječak je uživao u aktivnostima te je uspješno mogao razviti samosvijesnost tijekom praktičnih vježbi.

ly language which is understandable and meaningful to the child. MI-based materials specifically aimed at young people and making appropriate and flexible adaptations to the activities help enable positive outcomes for younger children. Recent meta-analyses of MI in younger children report adaptations to be typical (39,40). However, it is vital that the MI intervention embodies its spirit and principles.

CASE REPORT

Peter (aged 9) lived with his mother, stepfather and young brother (aged 6 months). He has never met his biological father. He was referred to child and adolescent psychiatrist for a significant change in his behaviour that has lasted for the past 6 months. Peter's school psychologist described his behaviours as: looks tired most days, rarely makes eye contact, smiles or laughs, generally unmotivated within the classroom, takes a long time to initiate a task and often does not finish his work, looks annoyed if asked a question, his grades had dropped significantly, withdraws from other children during schoolbreakes, sits by himself.

Multidisciplinary team assessment (child psychiatrist, clinical psychologist, speech therapist, EEG and neuropediatrician) showed that the boy's intellectual abilities were average and that clinically significant anxious-depressive symptoms were present with the possibility that his brother's birth and his resultant feelings of loss of his previous position within the family environment may have contributed to his lack of school and social engagement. Psychotherapy was recommended, but the boy was reluctant to engage. His mother was encouraged to bring him to the sessions and it was decided that MI will be done first.

Four sessions of MI, 45 minutes each, were conducted. Table 1 presents the activities used and details about each session with Peter. Specific adaptations to make the MI activities ac-

TABLE 1. Motivational Interviewing (MI) activities with an elementary school aged child

Session	Activities	Description
Session one	Words that describe me	Allows child to consider his skills and assets, but also his shortages
	My life	Helps child to develop an understanding of the different aspects of his life (family, school, friends, hobbies, etc.)
	Self-evaluation	Allows child to evaluate his satisfaction with different aspects of his life.
Session two	Me and my feelings	Addressing feeling fear, anxiety, sadness or worry because of the problematic behaviour
	Me and others	Helps child to understand how his problematic behaviour affects himself and others
	The good things and less good things about my behaviour	Helps child to understand advantages and disadvantages of his problematic behaviour
Session three	Weighing it up Thinking about change	Considers motivation and ability to change, reflects on the child's skills and how these might support change
	Looking into the future	Considers child's future life and helps child set goals for different aspects of his life and create a new self-image
Session four	Using my skills to change	Reflects on child's skills and how these might support change
	Get support	Finding people who can help with making the change
	New skills	Helps child to develop an understanding that some new skills (social skills, problem solving, self-control, assertiveness, good thinking) need to be learned and practiced to make the change and reach the goals
	More encouragement	Using reminders and cues that encourage positive behaviour

Petar se doimao uzbuđen govoriti o hobijima (igranje nogometa) i bio je spreman iznijeti detalje o tome. Ova tema je predstavljala pozitivan aspekt Petrovog života. Aktivnosti MI su tražile da Petar razmatra i ostale aspekte svog života koji nisu bili tako pozitivni. Aktivnosti su omogućavale da razmotri razloge zašto voli, odnosno ne voli neke aspekte škole, prijatelja, obiteljskog života, te svoje ponašanje koje je povezano s osjećajima. Daljnje MI aktivnosti su bile usmjerene na razgovor o budućim željama i povećanju unutarnje motivacije za ostvarenje ciljeva. Petar je uspio odrediti specifične buduće ciljeve, na primjer, obiteljske odnose (bolji odnos sa svojom majkom, zajedničke aktivnosti, pomaganje u kući), školska postignuća (redovito izvršavanje zadaće, 2 sata dnevno učenje, dodatna pomoć za teže predmete) i odnose s prijateljima (aktivnosti s dva najbolja prijatelja u školi i tijekom vikenda).

Pohvale i nagrade (naljepnice u boji) su povećavale motivaciju za sudjelovanje u MI aktivnostima tijekom seansi. U prve dvije seanse Petar je postavljao brojna pitanja i bila su potrebna pojašnjenja. Neke od aktivnosti su bile Petru zahtjevnije, na primjer, otvorena pitanja. Kada su povećani praktični i konkretni elementi u tehnikama, dječak je bolje razumio i mogao je

cessible to the child included using drawings, worksheets and coloured felt tip pens, different colours for opposite behaviours, role-plays to explore behaviours and emotions and reinforcement (rewards) for completed activities (coloured stickers). The boy enjoyed practical elements and was able to develop his self-awareness most effectively during the practical activities.

Peter appeared excited to speak about his hobbies (playing football) and he was eager to share details about it. This theme reflects a positive aspect of Peter's life. The MI activities required Peter to consider other aspects of his life that were not so positive. The activities allowed him to reflect on the reasons why he liked and did not like some aspects of school, friends and family life and on his behaviour related to his feelings. Further MI-based activities aimed to elicit conversations about future aspirations with a view to building internal motivation to achieve goals. Peter was able to consider specific future elements and goals, for example, family relationships (a better relationship with his mother, joint activities, helping in the household), school achievements (doing homework regularly, 2 hours of studying per day, extra help for difficult subjects), and engagement with friends (activities with 2 best friends in school and during weekends).

razmotriti kompleksnije misli. Radni listići i aktivnosti koje su se koristile u seansama MI omogućavale su da Petar raspravlja o različitim aspektima svoje osobe i poveća znanje i razumijevanje o svojoj trenutnoj situaciji, vještinama i sposobnostima. Ovo upućuje da korištenje MI pristupa na praktičan način može biti prikladno za školsku djecu. „Suradnja" kao osnovna postavka MI se pokazala vrlo važnom te je tijekom seansi dječak uspostavio suradnički odnos i poštivanje terapeuta. Dječakova se samostalnost povećala kako je dolazio na sve više seansi te se također povećalo i njegovo vjerovanje u vlastite sposobnosti i znanje o vlastitim vještinama. Petar je razvio razumijevanje da će u postizanju svojih ciljeva trebati podršku drugih te je također naučio nove vještine. Dječak je nastavio s kognitivno-bihevioralnom terapijom.

Ovaj prikaz bolesnika pruža primjer kako se tehnike MI mogu koristiti s djetetom osnovnoškolske dobi. Intervencija je bila adaptacija MI prilagođena djeci koja sadrži osnovne postavke i principe MI (1,8). Iako su rezultati pozitivni i u skladu s ranijim meta-analizama MI koje navode da su prilagodbe tipične (39, 40), potrebna su daljnja istraživanja i praksa kako bi se istražili dokazi za učinkovitost MI za mentalno zdravlje i ishode djece.

ZAKLJUČCI

Istraživanja su dokazala učinkovitost MI kod ovisnosti u adolescenata, i rastući broj istraživanja ukazuje na kliničku korisnost MI za poboljšanje mentalnog i tjelesnog zdravlja preadolescenata i adolescenata. Rezultati također pokazuju da prilagođene intervencije mogu imati značajan učinak na motivaciju i ponašanje mlađe djece. MI se može uključiti u kliničke intervencije za djecu i adolescente na različite načine, od samo kratkog MI do MI kao platforme nakon koje se mogu primijeniti druge terapijske intervencije.

Praise and reward (coloured stickers) increased motivation to engage in MI activities throughout sessions. In the first two sessions, Peter asked many questions and needed clarifications. Some aspects of the MI activities Peter found more challenging, for example, open-ended questions. When the practical and more concrete elements of the techniques were increased, Peter was better able to reflect and consider more complex thoughts. The work sheets and activities used in the MI sessions provided Peter with opportunities to discuss aspects of his self and increase knowledge and understanding of his current status, skills and abilities. This suggests that using MI approaches in a practical manner might appeal to school children. "Collaboration" from the MI spirit appeared to be important, and over the sessions Peter build up a collaborative and respectful relationship with the therapist. Peter's autonomy increased as he attended more MI sessions and his belief in his own ability and knowledge of his individual skills also increased. Peter also developed understanding that in reaching his goals he will need support from others and also to learn some new skills. He continued cognitive-behavioural treatment.

This case study provides an example of how MI techniques might be used with an elementary-school child. The intervention was a child-friendly adaptation of MI that embodied its spirit and principles (1,8). Although the results were positive and consistent with previous meta-analyses of MI which report the adaptations to be typical (39,40), further research and practice are needed to provide the evidence-base for the effectiveness of MI on mental health outcomes of children.

CONCLUSIONS

Research has shown the efficacy of MI in substance use in adolescents, and emerging research suggests the clinical utility of MI to improve mental and physical health in adolescents and pread-

Daljnja istraživanja mehanizama djelovanja MI i kako oni utječu na razvoj će povećati teorijsko i praktično znanje koje se može koristiti za poboljšanje motivacije i dobrobiti adolescenata i vjerojatno mlađe djece. Također, potrebna je provjera učinaka MI s djecom i adolescenata u grupnom radu i puna integracija MI u druge terapijske pristupe za adolescente. Konačno, istraživanje prepreka za intervencije MI je važno, npr. jezične poteškoće i kako intervencije MI mogu biti dostupne djeci s ovim teškoćama, bilo osnovnoškolske ili srednjoškolske dobi.

olescents. Results also indicate that an adapted intervention can have a significant impact on motivation and behaviour in younger children. MI can be included in clinical interventions for children and adolescents in several ways, ranging from MI in brief settings to using MI as a platform from which all other treatments are offered.

Further research on the mechanisms of action of MI and how these are impacted by development could yield significant practical and theoretical knowledge that can be used to improve the motivation and well-being of adolescents and, possibly, some pre-teens. Furthermore, testing the effects of MI in children and adolescent group settings and the full integration of MI into other adolescent treatment approaches is needed. Finally, exploring barriers to MI interventions is important i.e. language difficulties and how MI interventions might be made more accessible to pupils with these difficulties, whether of primary or secondary school age.

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