



# Diet Link

OFFICIAL NEWSLETTER OF THE MALAYSIAN DIETITIANS' ASSOCIATION

First Issue 2019

## Content

|                             |        |
|-----------------------------|--------|
| From the Editorial Desk     |        |
| What's New In The Field     | Pg 1-3 |
| Healthy Recipe              | Pg 3   |
| Contribution from Members   | Pg 4   |
| Feature practice            | Pg 4   |
| Feature MDA Member          | Pg 5   |
| A case study with NCP tips  | Pg 5-6 |
| Research Methodology Corner | Pg 7   |
| Counselling Skill           | Pg 8-9 |
| Upcoming events/ Diet Joke  | Pg 10  |

## FROM THE EDITORIAL DESK

Welcome to the revived issue of DIET LINK – the official newsletter of MDA! I am reminiscence of the first issue of DIET LINK in 1994 when MDA was formed, and we created the name as it was a newsletter that will link MDA members together discussing matters related to the closest subject to dietitians i.e., about diets. I am incredibly happy that now as we celebrated our 25th anniversary of MDA in 2019, we have DIET LINK revived and members now can again be connected intellectually!

Now is the best time ever to be a dietitian- in an era where lifestyle-related diseases are on the rise. Dietitians play essential roles in the preventive, curative and rehabilitative aspects of our patients and clients in chronic diseases. In the past decade or so, we have seen an expulsion of clinical and scientific interest in nutrition and dietetics. Hence, dietitians need to ensure that we keep updated and enhance our competencies to demonstrate we are indeed an important member of the multidisciplinary team in patient care.

Hence, we share with you the latest scientific news in the nutrition and dietetics frontier, tips to improve our MNT, research and counselling skills. We also feature fun articles such as recipes we can try out for ourselves or share with our clients and even diet jokes! Best of all,

each issue will feature one of our members who has contributed significantly to

the field of nutrition & dietetics. We will also provide opportunities for members who have attended conferences also to share their expertise and work with MDA members. We hope this fresh uplift of the DIET LINK newsletter will have enough offerings for everyone to enjoy!

I cannot thank enough the 13th MDA Council for this idea that we revitalise DIET LINK and especially to Lee Zheng Yii who has volunteered with such enthusiasm and dedication to make it happen! It is our aspiration that MDA members will enjoy more benefits and we also invite you to contribute and showcase your expertise and talent to enhance our profession in DIET LINK. Happy reading!



Prof Winnie Chee, PhD, FMDA, FNSM  
President  
13<sup>th</sup> MDA Council

### EDITORIAL MEMBER

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Ng Kar Foo



**Primary care-led weight management for remission of type 2 diabetes (DiRECT):  
an open-label, cluster-randomised trial**Lancet 2018; 391(10120):541-551.  
DOI:10.1016/S0140-6736(17)33102-1

This open-label cluster randomized trial in 49 primary care centres (n=306) in Scotland and England among overweight and obese patients (age 20-65 years, BMI 27-45) who were diagnosed with type 2 diabetes within the previous 6 years (mean: 3 years) and were not receiving insulin shown that almost half (46%) of diabetes achieved remission (HbA1c < 6.5%) after 12 months of structured and supervised intensive weight management, compared with 4% in the control group (Intention-to-treat analysis: odds ratio 19.7, 95% confidence interval 7.8-49.8). Weight loss of 15 kg or more was achieved in 24% participants in the intervention group and none in the control group.

The intervention comprised withdrawal of antidiabetic and antihypertensive drugs, total diet replacement (825–853 kcal/day formula diet for 3–5 months), stepped food reintroduction (2–8 weeks), and structured support for long-term weight loss maintenance.

Although this result may not be generalizable to the Asian population, and longer-term follow-up is needed to establish the long-term outcome, this study shows a promising result for patients who wish to attain diabetes remission, especially for those who were diagnosed recently.

**Effect of Low-Fat vs Low-Carbohydrate Diet on 12-Month Weight Loss in Overweight Adults and the Association With Genotype Pattern or Insulin Secretion. The DIETFITS Randomized Clinical Trial**

JAMA. 2018;319(7):667-679. DOI:10.1001/jama.2018.0245



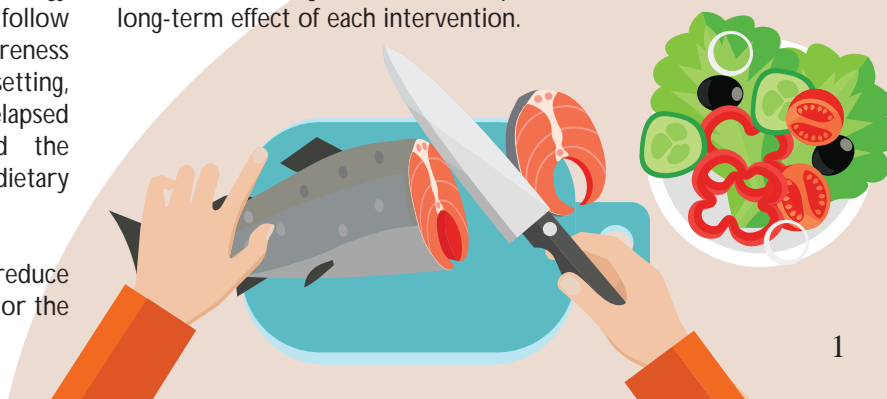
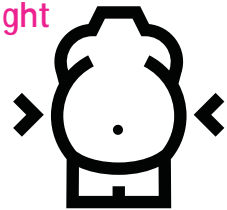
This single-center RCT in the US randomized 609 healthy adults aged 18-50 years (mean: 40) with a BMI of 28 to 40 (mean:33) to healthy low fat and healthy low-carbohydrate diet for 12 months.

All participants received 22 instructional sessions held over 12 months in diet-specific groups of approximately 17 participants per class. Session were held weekly for 8 weeks, then every 2 weeks for 2 months, then every 3 weeks until the sixth month, and monthly thereafter. Both groups were instructed to: (1) maximize vegetables intake; (2) minimize intake of added sugars, refined flours, and trans fats; and (3) focus on whole food that were minimally processed, nutrient dense, and prepared at home whenever possible. No explicit instructions for energy restriction were given. Participants were encouraged to follow current physical activity recommendation. Emotional awareness and behavioural modification strategies such as goal setting, self-efficacy building, supportive environment, and relapsed prevention based on social cognitive theory and the transtheoretical model were emphasized to support dietary adherence and weight loss.

During the first 8 weeks, participants were instructed to reduce intake of total fat or digestible carbohydrates to 20 g/d. For the

healthy low-fat group, reduction of edible oils, fatty meals, whole-fat dairy, and nuts were prioritized. For the healthy low-carbohydrate group, reduction of cereals, grains, rice, starchy vegetables, and legumes were prioritized. Then, participants slowly add fats or carbohydrates back to their diets in increment of 5 to 15 g/d per week until they reached the lowest level of intake they believed could be maintained indefinitely.

At 12-month, no significant difference in weight change between a low-fat diet vs a low-carbohydrate diet, and neither genotype pattern (low-fat genotype, low-carbohydrate genotype or neither genotype) nor baseline insulin secretion was associated with the dietary effects on weight loss. The generalizability of this study may be limited as the study population had relatively high education levels and have personal resources and high accessibility to high-quality food options. Furthermore, longer-term follow-up is needed to elucidate the long-term effect of each intervention.



## Dietary carbohydrate intake and mortality: a prospective cohort study and meta-analysis

Lancet Public Health 2018;3: e419–28.

DOI: 10.1016/S2468-2667(18)30135-X

This prospective cohort study and updated meta-analysis investigated the association between carbohydrate intake and mortality, and whether replacement of dietary carbohydrate by plant-based or animal-based fat and protein will modified this association.

The result of the meta-analysis was summarized.

The meta-analysis included 432,179 participants from 8 cohort studies from the Eastern and Western populations (mean or median follow-up time: 4.9-25 years). Among the 8 included studies, 6 are from North American or European countries (n=287,644), 1 represent the Asian population (Japan; n=9200), 1 is multinational study across 5 continents (n=135,335) including Malaysia.

As North American and European consumed significantly lower carbohydrate (~50 % of energy from carbohydrates) than the Asian and multinational studies (~61% of energy from carbohydrate), the meta-analysis was divided into two categories. The North American and European studies compared low (<40%) with moderate (~50%) carbohydrate consumption, while the Asian and multinational studies compared high (>70%) vs moderate (~60%) carbohydrate consumption.

The result showed a significant increased risk of all-cause mortality among participants with low vs moderate carbohydrate consumption (pooled HR 1.20, 95% CI 1.09-1.32,  $p<0.0001$ ). Similarly, all-cause mortality was also higher in high vs moderate carbohydrate consumption (HR 1.23, 95% CI 1.11-1.36,  $p<0.0001$ ).

Mortality was increased with animal-derived fat and protein were substituted for carbohydrate (HR 1.18, 95% CI 1.08-1.29,  $p<0.0001$ ) and decreased when these substitutions were plant-based (HR 0.82, 95% CI 0.78-0.87,  $p<0.0001$ ).

Plausible explanation of why moderate carbohydrate (~50-55% of energy) has the lowest risk of mortality: Low carbohydrate diets have tended to result in lower intake of vegetable, fruits, and grains, and increased intake of protein from animal sources. While high carbohydrate diets, which are common in Asian and less economically advantages nation, tend to be high in refined carbohydrates; these types of diets might reflect poor food quality.

The result of this study must be interpreted in the light of its limitations. Firstly, the data are observational, therefore causal inference cannot be made; however, randomized trials of low carbohydrate diets on mortality are not practical because of the long duration of study required. The findings about animal fat and protein might have less generalizability to Asian cultures, which often feature very high carbohydrate consumption but with a primary meat source that is often from fish. Furthermore, this study focused on general carbohydrate intake, which represents a heterogeneous group of dietary components. Any number and combination of dietary components could have been considered and adjusted for in this analysis; therefore, some confounders might have been unadjusted for.



### More Frequent Nutrition Counseling Limits Weight Loss and Improves Energy Intake During Oncology Management: A Longitudinal Inpatient Study in Taiwan

Nutrition and Cancer. 2018; 21:1-9.  
DOI: 10.1080/01635581.2018.1516791

This single-center longitudinal study was conducted in Taiwan from April 2010 to July 2015 among 3221 inpatients with head and neck, esophageal, stomach, colorectal, hepatobiliary, lung, breast, or gynecological cancer (mean age: 58 years, female 46.9%, mean BMI: 23.4, stage IV cancer: 31%). Patients who received at least 2 nutrition consultations during the study period were included. Approximately 60.7% of the patients had a follow-up duration of up to 6 months.

For a follow-up period of up to 6 months, patients with head and neck cancer exhibited the highest rate of weight loss (-1.16 kg/mo), followed by those with upper gastrointestinal (-0.92 kg/mo) and gynecological (-0.38 kg/mo) cancers. However, patients with breast cancer gained 0.08 kg/mo.

Dietitian consultation was associated with a 0.03-kg weight gain per month at every visit in the whole sample. Among patients with a follow-up duration of ≤6 mo, a 0.09-kg weight gain per month rate was observed at every visit (P=0.008). Compared to first consultation, the average energy consumption percentages at the second, third, fourth, fifth to seventh, eighth, and subsequent consultations increased significantly (P<0.05). However, after controlling for potential covariates, the significant difference between the first and second consultations disappeared. This implied that at least 3 visits were required to yield a significant effect.

The major limitation of this study is that energy intake was only assessed by a 1-day 24-h dietary recall.



## Spicy Tomato Chicken



| Nutrition Info Per Serving |      |
|----------------------------|------|
| Calories                   | 227  |
| Protein                    | 23.8 |
| Carbs                      | 19.0 |
| Fat                        | 6.2  |
| Fiber                      | 3.8  |
| Sodium                     | 485  |
| Cholesterol                | 0    |



### Ingredients

| A                             | B                     |
|-------------------------------|-----------------------|
| 5 skinless chicken drumsticks | 6 cloves garlic       |
| 1 tsp turmeric powder         | Galangal (thumb size) |
| 4 medium tomatoes             | 2 medium onion        |
| 2 stalks lemongrass           | 6 shallots            |
| 2 kaffir lime leaves          | 3 red chili           |
| 5 lady's fingers              | 1 cili padi           |
| ½ cup pineapple chunk         | 1 bunga kantan        |
| Lime juice (2 lime)           | 3 Tbsp cili boh       |
| 1/2 tsp salt                  |                       |



### Methods

1. Marinate drumstick with turmeric powder for at least 15 mins.
2. Sear the drumsticks in a pot with 1 Tbsp of oil for 2-3 mins then set aside.
3. Blend B in a food processor with ½ cup of water until smooth.
4. Transfer mixture into the same pot and bring to a boil.
5. Add in the remaining ingredients, season with salt and simmer for 15 minutes over small heat.
6. It's ready to serve!



### Good to know

Adding lady's finger hypes up the fiber content of the dish which helps to better regulate the blood glucose and cholesterol too!

## HEALTHY RECIPE

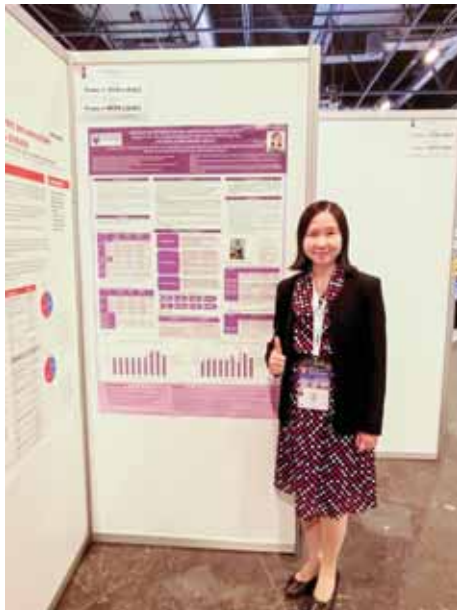
Contributed by Georgen Thye  
Holmusk  
Founder of Georgen Cooking  
MDA Council Member

Hello, dear MDA members! I am Georgen, It is a great honour to share my recipe with all of you in this issue of MDA Diet Link! During my time as a dietetics student, I used to get this advice very frequently - "As a dietitian, you must learn how to cook!". I guess this is also why I started to take cooking a little bit more seriously (apart from me being a foodie too!), my passion for healthy cooking has never stopped growing since then! Now, I share healthy recipes and eating tips on my Facebook Page (<https://www.facebook.com/georgencooking/>) and Youtube Channel (<http://www.youtube.com/c/GeorgenThye>) with the mission to debunk people common perception that healthy eating is difficult and boring!

The recipe that I am sharing this time is called Spicy Tomato Chicken, a recipe inspired by the Ayam Masak Merah, but with a Nyonya twist by incorporating lime juice and kefir lime leaves. This recipe is suitable for busy working adults, they can cook this in a big batch on the weekend and have it over a few meals in the weekdays. Its gravy goes very well with rice, pasta or even bread :) Enjoy! To view the recipe video, click here <https://youtu.be/h1JITUvK34k>

**My Experience in 40th ESPEN Congress in Madrid, Spain from 1st – 4th September 2018**

Contributed by Tah Pei Chien, University of Malaya Medical Centre



First and foremost, I would like to thank the Malaysian Dietitians' Association (MDA) for giving me the opportunity to experience in MDA Diet Link. I would also like to express my gratitude to MDA for the continuous support and providing me with the MDA Education Grant to present the poster presentation with the title "Association Between Energy And Protein Adequacy With Quality of Life In Mechanically Ventilated Critically Ill Patients: A Preliminary Result" in the international ESPEN Congress. My abstract had published in the Official Journal of ESPEN – Clinical Nutrition (DOI: 10.1016/j.clnu.2018.06.2053). This is my great honour to share my experience in 40th ESPEN Congress 2018 on Clinical Nutrition and Metabolism with the theme "Nutrition Without Borders". With the theme, I had explored new topics in clinical nutrition and different clinical settings in conjunction of the introduction of new ESPEN Guidelines such as Clinical Nutrition and Hydration in Geriatrics and Nutrition in the ICU, besides the multidisciplinary and worldwide environment of the Congress.

During the Congress in IFEMA – Feria de Madrid, I had visited many exhibition booths from Europe companies and discussed research and clinical experiences with active participants and nutrition experts in different clinical settings in the symposium and poster session that aims to continue ESPEN's effort to improve Nutritional Care and Education. With the

occasion of celebrating the 40th anniversary of ESPEN Congress and to remember the main achievements of the Society during this long trajectory, ESPEN had "season" the schedule with some special events such as opening session; welcome reception served with delicious Spanish foods, Sir David Cuthbertson Lecture, etc. I had the opportunity to visit the ESPEN Timeline that was displayed at IFEMA for the duration of the Congress and located in the Avenida in front of Halls 8 & 10 along the escalators and allowed me to walk through the past 40 years on ESPEN Congresses.

The program of ESPEN 2018 offered an excellent opportunity for physicians, dietitians, pharmacists, nutritionists, scientists and nurse involved in the field of nutrition and metabolism to meet and discussed cutting-edge science in an informal atmosphere, strengthening old and sparkling new collaborations

FEATURE PRACTICE

Contributed by Teong Lee Fang, Hospital Selayang

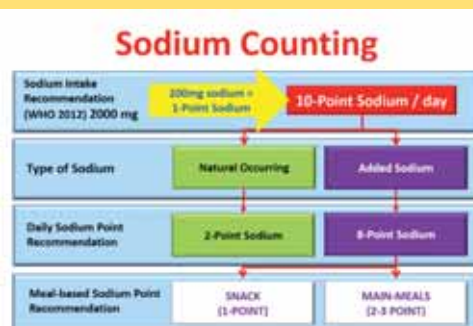


Team MYSTARS (Malaysia Strategy to Reduce Salt)  
 From Left Standing: Viola Michael (NCD), Zuwariah Abd Rahman (NCI) Jumiatiin Othman (NCD), Muhammad Muzzammil Razali (SH), Siti Farrah Zaidah Mohd Yazid (NCD), Norasimah Kassim (FHD)  
 From Left Below: Nurul Huda Ibrahim (FHD), Teong Lee Fang (SH)

The MYSTARS Team consists of six dietitians and two healthcare staffs from various divisions of the Ministry of Health (Non-Communicable Disease Division, Selayang Hospital, Family Health Development Division, and the National Cancer Institute). Team MYSTARS had presented a novel concept of Sodium Counting and won first place for hybrid category during Ministry of Health Innovation Competition 2018 National Level.

The highlight for this innovation is the introduction of new sodium conceptual dietary assessment and education using the sodium-point system. This sodium-point quantification concept is based on 1-point sodium equivalency to 200mg sodium. This concept can be implemented in clinical practice via S.M.A.R.T (Specific, Measurable, Attainable, Realistic, Time) approach to assist dietitians during nutrition assessment and nutrition education.

The soft copy for this education material is available for free at the Ministry of Health Official Website ([www.moh.gov.my/index.php/pages/view/1937](http://www.moh.gov.my/index.php/pages/view/1937)).



2 slices of bread = 221mg SODIUM (1-POINT SODIUM)

Contributed by Jazlina binti Syahrul, Universiti Putra Malaysia



**1** What is your role as Clinical Instructor?

A clinical Instructor is a person who is responsible in assisting/supervising students during the clinical year. In UPM, Clinical Instructors not only involve in teaching internship students, but we begin the clinical teaching in the wards or the clinics since the second year of Bachelor of Science in Dietetics.

**2** What do you think is/are the successful factors(s) that allow you to get the MDA Best CI Award?

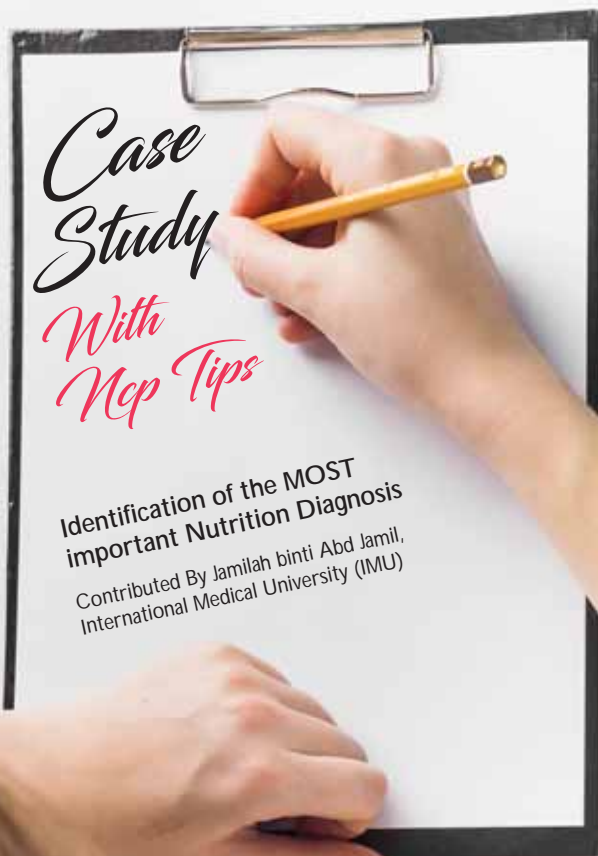
Student's enthusiasm and good team spirit are the factors that push me to do better as a Clinical Instructor. As we treat patients individually, so do the students during clinical attachment by providing the platform and chances for them to practice and train them to think as an undergraduate student. Besides, teamwork from the colleagues and lecturers is the most critical support system for me. They are my inspiration to improve myself every day and excel in whatever I do.

**3** What is your advice to all current dietetics' students?

The internship is an important and challenging phase where students need to translate theoretical knowledge into practice. Being a student, this is the phase where your critical thinking will be tested, in addition to improving your clinical judgment. Perseverance is the crucial part during this year. Be persevered in updating your knowledge as every day you will learn new things. Be persevered in finishing your task and avoiding procrastination. There will be a lot of ups and downs but stay positive in what you are doing. If you get tired, learn to rest but not to quit. Stay humble wherever you go and do not stop helping other people with the dietetics knowledge that you have.

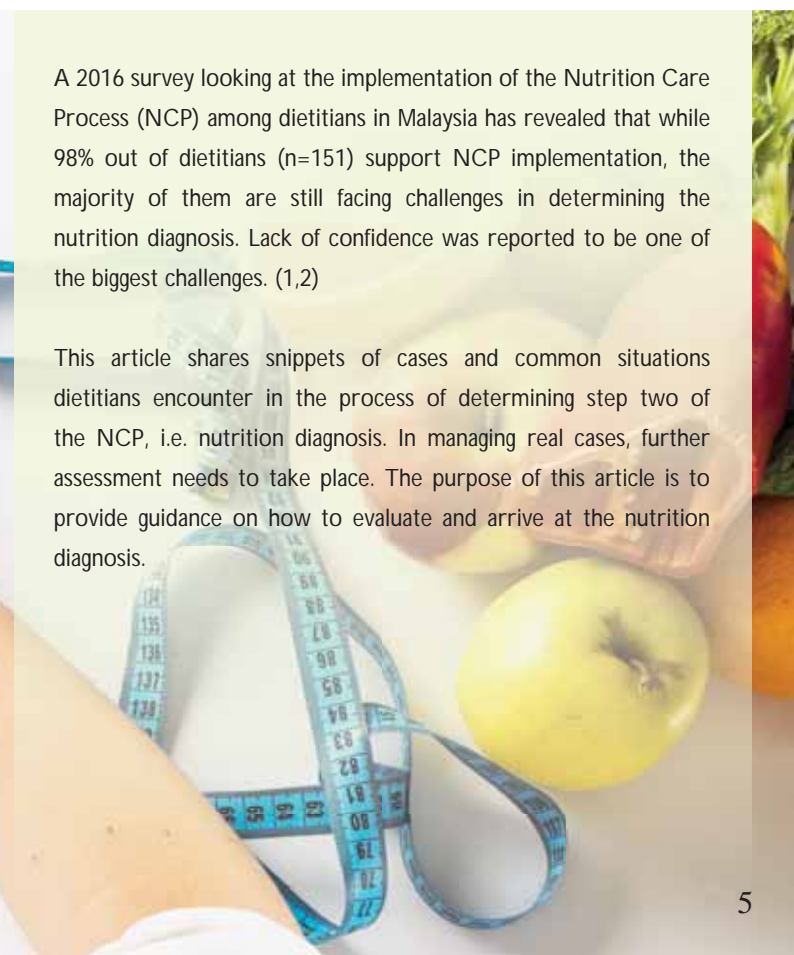
**4** Any words of encouragement for other CIs?

Being a clinical instructor is not an easy task/job as most of the time we need to be very flexible and to multitask while assisting our students. One of my teachers told me that to be able to teach/assist others; you will not only be rewarded instantly for what you are doing now but also in the future. You are one of the persons who helps our future generation and makes this profession grow. Feel the satisfaction in spreading the knowledge and not to forget to persevere in your passion into this field. Let's continue being an inspiration for our students!



A 2016 survey looking at the implementation of the Nutrition Care Process (NCP) among dietitians in Malaysia has revealed that while 98% out of dietitians (n=151) support NCP implementation, the majority of them are still facing challenges in determining the nutrition diagnosis. Lack of confidence was reported to be one of the biggest challenges. (1,2)

This article shares snippets of cases and common situations dietitians encounter in the process of determining step two of the NCP, i.e. nutrition diagnosis. In managing real cases, further assessment needs to take place. The purpose of this article is to provide guidance on how to evaluate and arrive at the nutrition diagnosis.



CASE  
1



A ten-month-old baby was referred to the dietitian due to faltering growth with weight for age below -1 Z score. Food and nutrition-related history reveal that her mother insists on breastfeeding the baby exclusively until the age of one year. She has practiced the same with her first daughter and verbalised that the first daughter is growing up well.

The dietitian arrives at the following nutrition diagnosis: Limited access to food related to current exclusive breastfeeding provided at ten months old as evidenced by mother's statement that she prefers exclusive breastfeeding.

**Nutrition diagnosis inquiry and reflections**

1. Can a PES statement be derived from the caretaker's perspective?
2. In this case, there is a great potential that the patient is not getting sufficient iron. Complementary feeding should be introduced at the age of six months old to close the nutrient (iron) gap.

Yes, the ND could be addressed from the child's perspective as well as the caregiver's. The existing nutrition diagnosis is acceptable.

Another potential nutrition diagnosis is - Potential inadequate mineral intake – iron related to mother's preference and belief for exclusive breastfeeding until the age of one-year AEB child being exclusively breastfed, and mothers stated preference for exclusive breastfeeding (nutrition focused)

In both of these PES statements, the nutrition problem label is the problem/s that the patient is experiencing, but etiology is the mother's preferences, attitudes, and beliefs. The nutrition intervention would most likely be nutrition counselling combined with nutrition education but focusing on the mother's beliefs first.

CASE  
2



A 79-year-old female was admitted to the geriatric ward due to chronic obstructive pulmonary disease. Before admission, the patient had a fall, and the daughter verbalised that patient has lost her appetite since a month ago. High calorie and high protein diet were indented. The doctor referred the case to the dietitian, in view of her poor oral intake. Patient consumes less than half of the meals provided in the ward. She does not take any snacks. She complains of having difficulty in chewing the vegetables due to dental problems and breathing difficulty. The dietitian observes some protrusion on the clavicle and mild depression on the inner thigh. Patient's current weight is 49kg, and her BMI is 18.9 kg/m<sup>2</sup>. She experiences 7% of weight loss for the past three months.

Estimated energy intake is < 500 kcal/day and the estimated requirement is 1400 kcal/day.

**Nutrition diagnoses:**  
Inadequate oral intake related to loss of appetite due to decreased ability to eat as evidenced by energy intake of <500 kcal/day as compared to the estimated energy requirement of 1400 kcal/day.

**Nutrition diagnosis inquiry and reflections**

1. Could any other nutrition diagnoses have been considered?
2. How does a dietitian prioritise the nutrition diagnosis?

Other nutrition problem label that could be considered (but may not be the most important) are unintentional weight loss, inadequate energy intake, and underweight. The inadequate oral intake would be the best problem statement as it reflects the condition in which the patient is experiencing, whereby the patient is taking a very small amount of food and beverages and nutrients are very much lacking. Inadequate energy is not the only issue in this case. The dietitian could derive to three nutrition diagnoses, however having a short note can also increase the likelihood of other healthcare providers to read our notes.

Four factors could be considered when prioritising the nutrition diagnosis. They are the reason for referral, impact on medical condition and health status, the strength of evidence and patient preference. In this case, the patient was referred due to her poor oral intake.

**References:**

1. Foo LL. Nutrition care process: survey of implementation and perceptions on enablers and barriers among dietitians in private hospitals and clinics, Malaysia [BSc thesis]. International Medical University; 2016.
2. Low SY. Nutrition care process: survey of implementation and perceptions on enablers and barriers among dietitians in government hospitals and clinics, Malaysia BSc thesis]. International Medical University; 2016.
3. Esther Myers & Ylva Orrevall. Using the Nutrition Care Process: Critical Thinking Vignettes from Eight Clinical Cases. Esther Myers and Ylva Orrevall: 2016.

## Association vs. Causation

Contributed By Lee Zheng Yii, University of Malaya

A man was on a long flight that encountered several episodes of air turbulence. After the plane landed, he was asked to fill an evaluation form. He wrote: "Tell the captains of your airplanes to stop turning on the Fasten Seat Belt sign. Every time they did that, the ride got bumpy".

An old grandmother encountered a solar eclipse and was frightened. She asked her grandchildren to take out some cooking utensils from the kitchen and make loud noises to scare away the "monster" that is eating the sun! From her previous experience, the "monster" will be scared away after the loud noises, and the sun will reappear.

From a scientific perspective, the man and the old grandmother observed (although they may have incorrectly analysed) an association of 2 factors (e.g., A and B). The man observed an association between the appearance of the seat belt sign and turbulence in the air, while the grandmother observed an association between making loud noises and the reappearance of the sun.

In the above relatively simple situations, it is probably clear to you that both of them have made an incorrect conclusion regarding causation. The lesson learned is that the presence of association cannot prove causation.

Epidemiologists look for associations to develop hypotheses regarding disease causation. Factors A and B can be associated in one of several ways.

- 1) A cause B
- 2) B cause A
- 3) Some other factor(s), C, cause(s) both A and B
- 4) On occasion, the association may be spurious (Type I error: demonstrating a 'statistically significant' p-value when no true difference exists)

To establish a causative relationship of a particular factor (usually an intervention that is being used to achieve a desirable outcome), a situation has to be created in which that factor is the only difference between the groups. This is the value of the randomized controlled trial, as it eliminates the issue of 'confounding' (having other factors separate the two groups besides the intervention of interest). Therefore, a well-conducted randomized controlled trial has the highest quality of evidence because it is the design that is least prone to bias and the result is most likely to prove causation.

However, in particular situation, a randomized trial may not be feasible or cannot be conducted (e.g., due to ethical issues). Other study designs may be employed to investigate such questions. We will talk about various study designs and their associated level of evidence in the next issue.



### Reference

- 1) Koretz. JPEN Journal Club. Association vs Causation. JPEN J Parenter Enteral Nutr 2014 38: 269. DOI: 10.1177/0148607113504591







## MOTIVATIONAL INTERVIEWING (PART 1)

The definition of Motivational Interviewing (2009) is:

“ . . . a collaborative, person--centered form of guiding to elicit and strengthen motivation for change. ”

### The Motivational Interviewing Approach

Motivational Interviewing is grounded in a respectful stance with a focus on building rapport in the initial stages of the counselling relationship. A central concept of MI is the identification, examination, and resolution of ambivalence about changing behaviour.

Ambivalence, feeling two ways about behaviour change, is seen as a natural part of the change process. The skilful MI practitioner is attuned to client ambivalence and “readiness for change” and thoughtfully utilizes techniques and strategies that are responsive to the client. Recent descriptions of Motivational Interviewing include three essential elements:

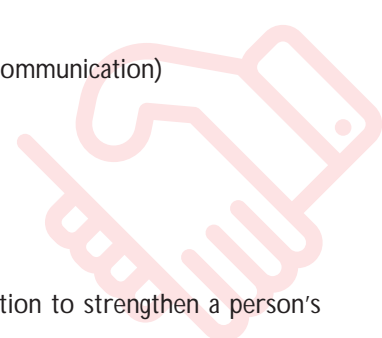
1. MI is a particular kind of conversation about change (counselling, therapy, consultation, a method of communication)
2. MI is a collaborative (person-centered, partnership, honours autonomy, not the expert-recipient)
3. MI is evocative (seeks to call forth the person's own motivation and commitment)

These core elements are included in three increasingly detailed levels of definition:

Lay person's definition (What's it for?): Motivational Interviewing is a collaborative conversation to strengthen a person's own motivation for and commitment to change.

A pragmatic practitioner's definition (Why would I use it?): Motivational Interviewing is a person-centered counselling method for addressing the common problem of ambivalence about change

A technical therapeutic definition (How does it work?): Motivational Interviewing is a collaborative, goal-oriented method of communication with particular attention to the language of change. It is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own arguments for change.



### The “Spirit” of Motivational Interviewing

MI is more than the use of a set of technical interventions. It is characterized by a particular “spirit” or clinical “way of being” which is the context or interpersonal relationship within which the techniques are employed.

The spirit of MI is based on three key elements: collaboration between the therapist and the client; evoking or drawing out the client's ideas about change, and emphasizing the autonomy of the client.

#### Collaboration (vs. Confrontation)

Collaboration is a partnership between the therapist and the client, grounded in the point of view and experiences of the client.

This contrasts with some other approaches to substance use disorders treatment, which are based on the therapist assuming an “expert” role, at times confronting the client and imposing their perspective on the client's substance use behaviour and the appropriate course of treatment and outcome.

Collaboration builds rapport and facilitates trust in the helping relationship, which can be challenging in a more hierarchical relationship. This does not mean that the therapist automatically agrees with the client about the nature of the problem or the changes that may be most appropriate. Although they may see things differently, the therapeutic process is focused on mutual understanding, not the therapist is right.

#### Evocation (Drawing Out, Rather Than Imposing Ideas)

The MI approach is one of the therapist's drawing out the individual's own thoughts and ideas, rather than imposing their opinions as motivation and commitment to change is most powerful and durable when it comes from the client. No matter what reasons the therapist might offer to convince the client of the need to change their behaviour or how much they might want the person to do so, lasting change is more likely to occur when the client discovers their own reasons and determination to change. The therapist's job is to “draw out” the person's own motivations and skills for change, not to tell them what to do or why they should do it.

#### Autonomy (vs. Authority)

Unlike some other treatment models that emphasize the clinician as an authority figure, Motivational Interviewing recognizes that the true power for change rests within the client. Ultimately, it is up to the individual to follow through with making changes happen. This is empowering to the individual, but also gives them responsibility for their actions.

Counsellors reinforce that there is no single “right way” to change and that there are multiple ways that change can occur. In addition to deciding whether they will make a change, clients are encouraged to take the lead in developing a “menu of options” as to how to achieve the desired change.

## The Principles of Motivational Interviewing

Building on and bringing to life the elements of the MI “style”, there are four distinct principles that guide the practice of MI. The therapist employing MI will hold true to these principles throughout treatment.

### Express Empathy

Empathy involves seeing the world through the client's eyes, thinking about things as the client thinks about them, feeling things as the client feels them, sharing in the client's experiences. This approach provides the basis for clients to be heard and understood, and in turn, clients are more likely to share their experiences in depth honestly. The process of expressing empathy relies on the client's experiencing the counsellor as able to see the world as they (the client) sees it.

### Support Self-Efficacy

MI is a strength-based approach that believes that clients have within themselves the capabilities to change successfully. A client's belief that change is possible (self-efficacy) is needed to instil hope about making those difficult changes. Clients often have previously tried and been unable to achieve or maintain the desired change, creating doubt about their ability to succeed. In Motivational Interviewing, counsellors support self-efficacy by focusing on previous successes and highlighting skills and strengths that the client already has.

### Roll with Resistance

From an MI perspective, resistance in treatment occurs when then the client experiences a conflict between their view of the “problem” or the “solution” and that of the clinician or when the client experiences their freedom or autonomy being impinged upon. These experiences are often based in the client's ambivalence about change. In MI, counsellors avoid eliciting resistance by not confronting the client and when resistance occurs, they work to de-escalate and avoid a negative interaction, instead “rolling with it.” Actions and statements that demonstrate resistance remain unchallenged especially early in the counselling relationship. By rolling with resistance, it disrupts any “struggle” that may occur, and the session does not resemble an argument or the client's playing “devil's advocate” or “yes, but” to the counsellor's suggestions. The MI value on having the client define the problem and develop their own solutions leaves little for the client to resist. A frequently used metaphor is “dancing” rather than “wrestling” with the client. In exploring client concerns, counsellors invite clients to examine new points of view, and are careful not to impose their own ways of thinking. A key concept is that counsellors avoid the “righting reflex”, a tendency born from concern, to ensure that the client understands and agrees with the need to change and to solve the problem for the client.



### Develop Discrepancy

Motivation for change occurs when people perceive a mismatch between “where they are and where they want to be”, and a counsellor practicing Motivational Interviewing works to develop this by helping clients examine the discrepancies between their current circumstances/behaviour and their values and future goals. When clients recognize that their current behaviours place them in conflict with their values or interfere with accomplishment of self-identified goals, they are more likely to experience increased motivation to make important life changes. It is important that the counsellor using MI does not use strategies to develop discrepancy at the expense of the other principles, yet gradually help clients to become aware of how current behaviours may lead them away from, rather than toward, their important goals.

This article is adapted from:

[https://www.umass.edu/studentlife/sites/default/files/documents/pdf/Motivational\\_Interviewing\\_Definition\\_Principles\\_Approach.pdf](https://www.umass.edu/studentlife/sites/default/files/documents/pdf/Motivational_Interviewing_Definition_Principles_Approach.pdf) (Accessed 8<sup>th</sup> Dec, 2018)

Stay tuned for next issues  
on Motivational Skills and  
Strategies



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# BOOK YOUR CALENDAR - UPCOMING EVENTS

## 1. MDA Evening Symposium and Dinner

Date : 1<sup>ST</sup> March 2019 (Friday)

Time : 6pm to 10pm

Venue : Hilton Kuala Lumpur

Speaker : Professor Daren Heyland

(Clinical Evaluation Research Unit, Kingston General Hospital,  
Queens University, Kingston, Ontario, Canada)

Topics : Current Controversies in Critical Care Nutrition



## 2. Medical Nutrition Therapy for the Adult Critically Ill Patients Workshop in East Malaysia

Date : 23<sup>rd</sup> - 24<sup>th</sup> March 2019 (Saturday and Sunday)

Time : 12pm to 9pm (Sat) and 7.30 am to 2pm (Sun)

Venue : Mecure Hotel, Kota Kinabalu (Tentative)



## 3. Malaysian Dietitians' Association 25th Annual Conference

Theme : IR 4.0: Digital Dietetics to Combat Diseases

Date : 23<sup>th</sup> - 24<sup>th</sup> June 2019

Venue : Hotel Istana, Kuala Lumpur



1. Q: Why shouldn't you fall in love with a pastry chef?  
A: He'll dessert you.
2. I tell people I'm on a low-carb diet. But in reality, I just eat pasta while lying on the floor.
3. Q: Why go to the paint store when you're on a diet?  
A: You can get thinner there.
4. Q: How did Native Americans say vegetarian?  
A: "Bad hunter!"
5. The only difference in my life when I'm on a diet is instead of saying, "I ate chocolate," I say, "I accidentally ate chocolate."

Source:  
<https://www.rd.com/jokes/diet-jokes/> (Accessed 8<sup>th</sup> Dec 2018)