What is MI?

<table>
<thead>
<tr>
<th>Key Processes of MI</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaging</td>
<td></td>
</tr>
<tr>
<td>Focusing</td>
<td></td>
</tr>
<tr>
<td>Evoking</td>
<td></td>
</tr>
<tr>
<td>Planning</td>
<td></td>
</tr>
</tbody>
</table>

**Engaging: Fundamental Communication Skills**

<table>
<thead>
<tr>
<th>Skills</th>
<th>OARS Characteristics and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open-ended Questions</td>
<td></td>
</tr>
<tr>
<td>Affirmations</td>
<td></td>
</tr>
<tr>
<td>Reflective Listening</td>
<td></td>
</tr>
<tr>
<td>Summarizing</td>
<td></td>
</tr>
</tbody>
</table>

**Focusing**

<table>
<thead>
<tr>
<th>Sources</th>
<th>Characteristics and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td></td>
</tr>
<tr>
<td>Setting</td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td></td>
</tr>
</tbody>
</table>

**Evoking: Mobilizing Change Talk**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Characteristics and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire</td>
<td></td>
</tr>
<tr>
<td>Ability</td>
<td></td>
</tr>
<tr>
<td>Reasons</td>
<td></td>
</tr>
<tr>
<td>Need</td>
<td></td>
</tr>
</tbody>
</table>

Planning Strategies: List examples
<table>
<thead>
<tr>
<th>Steps</th>
<th>Characteristics, Examples, Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment</td>
<td></td>
</tr>
<tr>
<td>Activation</td>
<td></td>
</tr>
<tr>
<td>Taking Steps</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Characteristics and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance/Confidence</td>
<td></td>
</tr>
<tr>
<td>Rulers</td>
<td></td>
</tr>
<tr>
<td>Exploring Values, Goals</td>
<td></td>
</tr>
<tr>
<td>Forward, Backward, Extremes</td>
<td></td>
</tr>
</tbody>
</table>

**Evoking: Negotiating Treatment Plan - SOARS**

<table>
<thead>
<tr>
<th>Key Processes</th>
<th>Characteristics, Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set Goals</td>
<td></td>
</tr>
<tr>
<td>Sort Options</td>
<td></td>
</tr>
<tr>
<td>Arrive at Plan</td>
<td></td>
</tr>
<tr>
<td>Reaffirm Commitment</td>
<td></td>
</tr>
</tbody>
</table>

**Acceptance and Commitment Therapy**

```
+-------------------+-------------------+
| Experiential Avoidance | Committed Action  |
| Unwanted Internal Experiences | Values |
+-------------------+-------------------+
Motivational Interviewing

Thomas P. Guck, Ph.D.
Professor and Director of Behavioral Sciences
Department of Family Medicine

Objectives

- Demonstrate how SOC and MI can be used to promote behavior change.
- Describe the theory and philosophy behind Motivational Interviewing.
- Describe the spirit of the client/provider relationship required to do effective behavior change.
- Demonstrate fundamental communication skills required to bring about behavior change.
- Demonstrate how to elicit "change talk."
- Describe Acceptance and Commitment Approach to behavior change.

Changing for Good, Prochaska, Norcross, & Diclemente
Characteristics, Tasks and Goals for Each Stage of Change

**PRECONTEMPLATION**

- Little or no desire to change the current pattern of behavior in the foreseeable future.
- It's not that they can't see the solution, they can't see the problem
- No intention of changing -- Others see need
- "Get people off my back"
- They resist change
- Denial is characteristic
- Often are demoralized or hopeless

**TASKS:**
- Increase awareness of need for change and concern about the current pattern of behavior;
- Envision possibility of change

**GOALS:**
- Serious consideration of change for this behavior;
- Movement toward contemplation;
- Move patient from "NO!" to "I will think about it."

**Contemplation**

- Acknowledge problem, begin to think about solving it
- Struggle to understand problem - its causes and possible solutions
- Indefinite plans to take action w/in 6 months.
- May stay in this stage for a long time
- Smokers typically stay here for up to 2 years.
- Ambivalence about change is common
Tasks and Goals for Contemplation

- **TASKS:**
  - Analysis of the pros and cons of the current behavior pattern and of the costs and benefits of change.
  - Decision-making.
- **GOAL:**
  - A considered evaluation that leads to a decision to change.

Decisional Balance Worksheet

<table>
<thead>
<tr>
<th>NO CHANGE</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROS (Status Quo Behavior)</td>
<td>CONS (Status Quo Behavior)</td>
</tr>
<tr>
<td>PROS (Change)</td>
<td>CONS (Change)</td>
</tr>
</tbody>
</table>

Transition to Preparation

- Begin to focus on solution rather than the problem
- Begin to think more about the future than the past
Preparation

- Plan to take action w/in the very next month
- Make final adjustments
- Make public intended changes
- While committed to change, ambivalence is not yet resolved
- May have initiated small changes
- Failure to do preparation, lowers ultimate chances of success

Action Stage

- Patient overtly changes behavior & environment
- Most busy period
- Greatest commitment of time & energy
- Most visible stage to others
- **Remember:** Only 20% are ready for this stage at any time; While 90% of our change strategies are designed for this stage

Tasks and Goals of Action Stage

**TASKS:**
- Implementing strategies for change;
- Revising plan as needed;
- Sustaining commitment in face of difficulties

**GOALS:**
- Successful action to change current pattern.
- New pattern established for a significant period of time (3 to 6 months).
Maintenance Stage

- Work to consolidate gains
- Prevent relapse; if relapse, usually go back to precontemplation or contemplation
- "Easy Change Programs" fail because they don’t take maintenance into account
- Only 5% make to Termination w/out some setback

Tasks and Goals of the Maintenance Stage

- **TASKS:**
  - Sustaining change over time and across a wide range of different situations.
  - Avoiding slips and relapse back to the old pattern of behavior.
  - Increase Self-Efficacy
- **GOALS:**
  - Long-term sustained change of the old pattern
  - Establishment of a new pattern of behavior.

Stages of Change and Importance/Confidence: Conceptual Overlap

<table>
<thead>
<tr>
<th>Stages</th>
<th>Importance more of an Issue</th>
<th>Confidence more of an Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contemplation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Motivational Interviewing) (Self-Efficacy)
Processes of Change

Processes are broad strategies that may employ any number of techniques. For each process there are dozens even hundreds of techniques. Give Patient choice of technique to get at process.

Processes of Change: Experiential

1. Consciousness Raising [Increasing Awareness]
   - I recall information people had given me on how to stop smoking.
2. Dramatic Relief [Emotional Arousal]
   - I react emotionally to warnings about smoking cigarettes.
3. Environmental Reevaluation [Social Reappraisal]
   - I consider the view that smoking can be harmful to the people around me.
4. Social Liberation [Environmental Opportunities]
   - I find society changing in ways that make it easier for the nonsmoker.
5. Self Reevaluation [Self Reappraisal]
   - My dependency on cigarettes makes me feel disappointed in myself.

Processes of Change: Behavioral

1. Stimulus Control [Re-Engineering]
   - I remove things from my home that remind me of smoking.
2. Helping Relationships [Supporting]
   - I have someone who listens to me when I need to talk about my smoking.
3. Counter Conditioning [Substituting]
   - I find that doing other things with my hands is a good substitute for smoking.
4. Reinforcement Management [Rewarding]
   - I reward myself when I don't smoke.
5. Self liberation [Committing]
   - I make commitments not to smoke.
Stages, Processes, and Techniques of Behavior Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

Consciousness Raising
Dramatic Relief
Environmental Reevaluation
Social Liberation
Self-Reevaluation

Pros of changing increasing
Cons of changing decreasing
Self-Efficacy Increasing

Match Stages of Change with Processes of Change

Motivational Interviewing
Miller and Rollnick, 3rd edition, 2013
Miller and Rollnick, MI in Healthcare, 2008

- A patient-centered, directive intervention focused on resolving ambivalence in the direction of change.

“… not a series of techniques … but a way of being with patients.”
Foundations of Motivational Interviewing

- The Spirit of MI
- The Four Key Processes in MI
  - Engaging – The Relational Foundation
    - Fundamental Communication Skills – OARS
    - Three Styles of Focusing
      - Following, Directing, Guiding
      - A word about Ambivalence
      - Guiding as Facilitator of Behavior Change Talk
      - DARN – Pre-Commitment Change Talk
    - Planning – The Bridge to Change
      - Mobilizing Change Talk (CAT)
      - Commitment-Activation-Taking Steps
  - Focusing – The Strategic Direction
    - Three Styles of Focusing
      - Following, Directing, Guiding
      - A word about Ambivalence
      - Guiding as Facilitator of Behavior Change Talk
      - DARN – Pre-Commitment Change Talk
  - Evoking – Preparation for Change
    - A word about Ambivalence
    - Guiding as Facilitator of Behavior Change Talk
    - DARN – Pre-Commitment Change Talk
  - Planning – The Bridge to Change
    - Mobilizing Change Talk (CAT)
    - Commitment-Activation-Taking Steps
  - Planning – The Bridge to Change
    - Mobilizing Change Talk (CAT)
    - Commitment-Activation-Taking Steps

The Spirit

<table>
<thead>
<tr>
<th>Fundamental Approach of MI</th>
<th>Mirror-Image Opposite Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration: Involves a partnership that honors the patient’s expertise and perspectives. The MD provides an atmosphere that is conducive rather than coercive to change.</td>
<td>Confrontation: Involves overriding the client’s impaired perspectives by imposing awareness and acceptance of “reality” that the client cannot see or will not admit.</td>
</tr>
<tr>
<td>Evocation: Resources/ motivation for change are presumed to reside within the patient. Intrinsic motivation for change is enhanced by drawing on the patient’s own perceptions, goals and values.</td>
<td>Education: The patient is presumed to lack key knowledge, insight and or skills that are necessary for change to occur. MD seeks to address these deficits by providing the requisite enlightenment.</td>
</tr>
<tr>
<td>Autonomy: The MD affirms the patient’s right and capacity for self-direction and facilitates informed choice.</td>
<td>Authority: The MD tells the patient what he or she must do.</td>
</tr>
</tbody>
</table>

Four Key Processes in Motivational Interviewing

- Engaging – process of establishing a helpful connection and working relationship.
- Focusing – process by which you develop and maintain a specific direction in the conversation about change.
- Evoking – involves eliciting the client’s own motivations for change and lies at the heart of MI.
- Planning – encompasses both developing commitment to change and formulating a concrete plan of action.
Engaging
is the process of establishing a helpful connection and working relationship
➤ How comfortable is this person in talking with me?
➤ How supportive and helpful am I being?
➤ Do I understand this person’s perspective and concerns?
➤ How comfortable do I feel in this conversation?
➤ Does this feel like a collaborative partnership?

Avoid First Encounter Traps
➤ The Question - Answer Trap
  ➤ MD asks closed questions – Pt. gives short answers
➤ The Confrontation – Denial Trap
  ➤ MD states problem – Pt. denies or minimizes
➤ The Expert Trap
  ➤ MD’s desire to help leads to premature prescription
➤ The Labeling Trap
  ➤ MD thinks Pt must accept diagnostic label
➤ The Premature - Focus Trap
  ➤ MD/Pt Mismatch on perception of problem
➤ The Blaming Trap
  ➤ MD/Pt want to assign blame – when that is not necessary

Fundamental Communication Skills (OARS)
➤ Open-Ended Questions
➤ Affirmations
➤ Effective Listening
➤ Summarizing
OARS: Open-Ended Questions

- Are difficult to answer with brief replies or simple "yes" or "no" answers
- Early on use more open-ended questions
- Begin new topic with open-ended question
- Content may require more closed questions (e.g., suicidal ideation; sexual history)
- To elicit change talk – Open-ended are better.
- Rule of thumb: 3:1 ratio – open to closed

A good question is worth a hundred commands

OARS: Affirmations: Catching Someone Doing Something Right

- Recognition of Effort
- Appreciation of Strengths
- Use of Positive Reframes

OARS: Affirmations: Recognition of Effort

- Parent of Patient: I really tried to get our son to bed by 8 PM. We did it for two days, then my husband was out of town, and I was too stressed to battle our son, so now we are right back where we started.
- MD: Wow. I give you a lot of credit for making a good start. It often takes more than one attempt to make changes.
Patient: I don’t like my weight the way it is now. Even with my busy school schedule, I have to figure out how to get more exercise.

MD: Your health is important to you. You seem pretty determined to make exercising a priority.

Patient: I’ve avoided getting the results. My Dad died due to Diabetes. My older brother and sister have diabetes. If my A1C levels are high, I may just give up. I don’t want to throw away my efforts to eat better, but I’m worried I won’t be able to handle it.

MD: You know what it means to have Diabetes based on your experiences with your family. You want to prepare yourself for getting the results. So in a way that protects your recent efforts.

OARS: Affirmations: Use of Positive Reframes

Simple Reflection – simply repeating one or more aspects of what is said
Rephrasing – changing one or more of the words used in a statement (no meaning is added)
Paraphrasing – reflecting the inferred meaning of a statement (meaning is added onto what is said)
Reflection of Feeling – paraphrasing that focuses on the emotional aspect of the statement
OARS: Reflective Listening
Active Listening

Patient

What the Patient Says

Encoding

What the Patient Means

What the Clinician Understands

Clinician

Hearing

What the Clinician Hears

Decoding

Reflection

OARS: Summary Statements

- Reasons for Summary Statements
  - Collection – Organize and repeat a collection of change talk statements. This demonstrates empathy and clarifies.
  - Linkage – Used to link two discrepant statements that summarize patient’s ambivalence
    - On one hand …… then on the other hand
    - A part of you wants to …….. Then another part of you doesn’t
  - Transition – Summary before moving to another content area.

Fact or Crap

- After summarizing one content area, it would be best to open a new content area with a closed ended question.
  - A. Fact
  - B. Crap

Answer: Crap: It is best to start a new content area with another open-ended question.
Focusing
process by which you develop and maintain a specific direction in the conversation about change.
- What goals for change does this person really have?
- Do I have different aspirations for change for this person?
- Are we working together with a common purpose?
- Does it feel like we are moving together, not in different directions?
- Do I have a clear sense of where we are going?
- Does this feel more like dancing or wrestling?

Three Sources of Focus
- The Patient
  - Most common source of direction and focus
  - Presenting problem or complaint
  - Can be straightforward
    - "I think my child has an ear infection and think he needs an antibiotic."
    - "I've been feeling really depressed lately."
    - "Our son struggles with math, we think tutoring could help him."
  - Provider feels comfortable and competent to help.
  - Natural match of guide and traveler.

Three Sources of Focus
- The Setting
  - Direction of service can be focused by setting
    - An eating disorders clinic
    - A suicide hotline
    - A mandated program
    - Person may be seeking targeted services
    - Or could seek services at someone else’s behest.
    - Focus of service can be predetermined or limited by the context.
Three Sources of Focus

- Clinical Expertise or Clinician
  - Clinician perceives that another kind of change is needed in addition to that expressed by patient.
  - Challenge: How to raise the subject and explore willingness to make this additional change.
  - New change may help or be essential to patient’s stated goal.
    - Mother brings child to MD for Asthma and yet another URI. MD wants to talk about parents smoking.
    - Depressed teen wants to have more friends. Provider perceives appearance and hygiene to be significant obstacles to making friends.

Three Focusing Scenarios

- Scenario 1. “I know where we are going; the focus is clear.”
  - Patient is in Action Stage of Change
  - Motivation and Commitment for change has been reached – move on to planning.
- Scenario 2. “There are several options, and we need to decide.” May be in contemplation or preparation stage.
  - Focusing is process of enumerating and sorting options and deciding where to start first.
- Scenario 3. “The focus is unclear and we need to explore.” May be in precontemplation or contemplation stage.
  - Most common for use of MI.

Three Styles of Focusing

- Directing – Provider determines the focus
  - Certain circumstances when this is appropriate
  - Serious limitation for promoting behavior change
- Following – Focus is on patient or client priorities
  - Necessary for establishing relationship
  - Not sufficient for promoting behavior change
- Guiding – Midway between Directing and Following
  - Promotes a collaborative search for direction
  - Best for promoting behavior change
- All 3 are used in everyday life.
  - They are suited to different types of circumstances and relationships.
  - A mismatch can cause problems
Guiding and Behavior Change

- In health care the balance of communication often shifts toward directing rather than following and guiding.
- In discussion of patient's lifestyle and behavior change it is crucial to engage the patient's own motivation, energy, and commitment.
- Guiding is well suited to help patients solve behavior change problems.

Evoking

Involves eliciting the patient's own motivations for change and lies at the heart of MI.

- What are the person's own reasons for change?
- Is the reluctance to change more about importance or confidence?
- What change talk am I hearing?
- Am I steering too far or too fast in a particular direction?
- Is the righting reflex pulling me to be the one arguing for change?

A Word About Ambivalence

- Ambivalence is normal
- Conflict: Person both wants and does not want to change.
- Telltale sign of ambivalence is the but in the middle.
  - "I need to lose weight, but I hate exercise"
  - "I want to get up, but it hurts"
  - "I know I shouldn't hit other kids, but I just get so frustrated"
  - "I mean to take my medicine, but I keep forgetting"
- Provider interpretation of ambivalence:
  - Patient is noncompliant
Common Frustration in Health Care. You explain over and over why they should change, and yet nothing happens.

Do patients know evil of smoking? High sugar diet? No exercise?

Careful of the "Righting Reflex"
- Desire to fix people and to set them on a better course.
- Directing style with an ambivalent person:
  - You are taking the pro-change side.
  - Common patient response to pro-change arguments is to fill the other side of the ambivalence, to say "Yes, but…….
- Your task is to elicit "change talk" from your patients not resistance.

Preparatory and Mobilizing Change Talk

Desire
Commitment
Ability
Activation
Reasons
Behavior Change
Need
Taking Steps

Miller and Rollnick, 2013

Facilitating Change Talk

- Attune your ears to change talk, recognize it, affirm it.
- DARN language informs you about deeply held values.
- Values can be a powerful motivation for change.
- Help patients talk about how behavior change is (in)consistent with values.
- When you hear change talk, you are doing it right.
- When you argue for change and the patient is defending status quo, you know you are off course.
- Are you working harder than the patient?
Change Talk (DARN)

› Desire: Verbs include want, like, and wish

› These tell you what the person wants and about the person’s preference to maintain or change the status quo.
  - “I wish my child could lose some weight”
  - “I want to get rid of these headaches”
  - “I like the idea of getting more exercise”
  - “I want my child to listen to me”
  - “I want to fit in”

Change Talk (DARN)

› Ability: Verbs include able, can and its conditional form could

› These reveal what the person perceives as within his or her ability.
  - “I might be able to get her in bed by 8”
  - “I think I can check my homework before bed”
  - “I can definitely take a walk before supper”
› Ability-related change talk also signals motivational strength:
  - “I definitely can” vs “I might be able”

Change Talk (DARN)

› Reasons: There are no particular verbs here, although reasons can occur along with desire verbs.
  - “I’m sure I’d feel better if I exercised regularly”
  - “I want my child to grow up to be a responsible adult”
  - “These headaches keep me from playing in the band”
  - “Quitting smoking would make my teeth look brighter”
Change Talk (DARN)

› Need: Verbs include need, have to, got to, should, ought, and must. Imperative language indicates a need or necessity.
  - “I must get some sleep”
  - “I’ve got to get back some energy”
  - “I really need to get my mother off my back”

› Ability-related change talk also signals motivational strength:
  - “I definitely can” vs “I might be able”

Evocative Questions

DARN

› Desire  “What might you hope for if you make this change?”
› Ability  “If you decide to make this change, how would you do it?”
› Reasons  “What are the three most important benefits in making this change?”
› Need    “How important is it to you to make this change?”

Practice evoking change talk

› 5 year old child with asthma, needs daily preventive “controller” treatment in the form of inhaler treatments twice a day in addition to oral medication once a day.
› Medication is prescribed with refills and the important of adherence to the treatment regimen is explained to the parents and the child.
› Patient is admitted to the hospital 3 times in the span of a year with “asthma exacerbation”, or worsening of his asthma symptoms. One of these admissions he ends up in the Intensive Care Unit and intubated.
› Parents always maintain that they give the medications regularly, however when we check with the pharmacy we find they have not refilled the medications since the initial prescription months ago.
› Patient lives with his mother and 3 younger siblings, 2 of his siblings also have asthma although not as bad as his.
› Mother works a minimum wage job and pays for day care for the 2 other children
Develop Discrepancy

- Develop a discrepancy between individual’s current behaviors and his/her stated values and interests.
- Let patient present arguments for change.
- Acknowledge both the positives and negatives of behavioral change.

Planning

Planning encompasses both developing commitment to change and formulating a concrete plan of action

- What would be a reasonable next step toward change?
- What would help this person move forward?
- Am I remembering to evoke rather than prescribe a plan?
- Am I offering needed information or advice with permission?
- Am I retaining a sense of quiet curiosity about what will work best for this person?

Planning Strategies

- Mobilizing Change Talk, CAT, and Evocative Questions
- Use of Importance and Confidence Rulers
- Exploring Values and Goals
- Looking Forward, Backward, Extremes
- Support Self-Efficacy
- Negotiating a Treatment Plan (SOARS)
- Giving Advice
DARN are Pre-Commitment Forms of Change Talk

- Necessary, but not sufficient for behavior change.

- What is missing from the following?
  - “I would like to [Desire].”
  - “I could [Ability].”
  - “It would help you if I did [Reason].”
  - “I should [Need].”

- None of these is sufficient.
- What is missing is? Mobilizing Change Talk: CAT

Mobilizing Change Talk (CAT) Commitment-Activation-Taking Steps

- **Commitment**
  - The quintessential verb is *will*, but commitment comes in many forms
  - Lower level, but important
  - “I will think about it.” ; “I’ll consider it.” ; “I plan to.”

- **Activation**
  - Stronger commitment
  - “I am willing…” ; “I am ready to…” ; “I am prepared to…”
  - Meaningful statements to be Reinforced by Physician

- **Taking Steps**
  - Already done something in the direction of change
  - “I bought some walking shoes.”
  - “Even though I was tired, I checked by daughter’s homework.”

Evocative Questions CAT

- Commitment – “What do you think you will do?”
- Activation – “What are you prepared to do?”
- Taking Steps – “What are you already doing to be healthy?”
Importance and Confidence Rulers

- Importance
  - How important on a scale of 0 (not at all important) to 10 (extremely important) would you say it is for you to ______?
  - Help me understand why your importance score is 6 and not 2?
  - What would need to change for your importance score to move from 5 to 9?
  - What would have to happen for taking your ADHD medication to become more important to you?

- Confidence
  - Ask similar questions with confidence

Importance and Confidence Rulers

- Get patients to state Values or Goals
  - Who is important to you
  - What is important to you
  - Will explore more with Acceptance and Commitment Therapy

- Then ask:
  - “How does your current behavior affect your value or goal?” Creates discrepancy
  - “How does the new behavior affect your value or goal?”

- The Values Card Sort Activity (download at http://casaa.unm.edu/inst.html)
Looking Forward, Backward, Extremes

- **Forward**
  - What do things look like for you by the end of the semester?
  - If you changed – How does the end of the semester look?
- **Backward**
  - Do you remember a time when things were going well for you? What has changed?
  - What are the differences between how you were last year and the person you are today?
- **Extremes**
  - What concerns you most as you continue as you have been, without changing?
  - What do you think could be the best results if you make this change?
- **Essential**
  - Ask in a genuine way; not as a way of thinking you are clever.
  - Don’t be a smarty pants.

Support Self-Efficacy

- Communicate that patient is capable of change
- Reinforce successive approximations of positive statements and behaviors.
- Patient is responsible for achieving goal
- Physician supports them in their ability to achieve goal
- Promote confidence that patient can execute new behavior when required.

Negotiating a Treatment Plan: SOARS

- **Set Goals**: How would you like your life to be different? What would you like to see change? If things were better, what would change?
- **Sort Options**: Brainstorm options – sometimes have to go with LCO.
- **Arrive at a Plan**: What will you do first? What specific steps will need to be done?
- **Reaffirm Commitment**
Giving Advice:
More likely heeded if you have permission to give it

Three Forms of Permission

1. The patient offers it (e.g., asks for advice)

2. You ask permission to give it
   - Something worries me here. Would it be all right if I . . .
   - Would you like to know . . .
   - Do you want to know what I would do, if I were in your situation?
   - I could tell you some things other parents have done that worked . . .

3. You preface your advice with permission to disagree/disregard
   - This may or may not be important to you . . .
   - I don’t know if this will make sense to you . . .
   - You may not agree . . .
   - I don’t know how you’ll feel about this . . .
   - Tell me what you think of this . . .

   - It’s often better to offer several options, rather than only one.

In Summary
In Simple Terms MI Posits:

- 1. MI will increase patient change talk
- 2. MI will diminish patient resistance
- 3. Degree to which status quo (resistance) is defended will be inversely related to behavior change
- 4. Extent to which patients argue for change (change talk) will be directly related to behavior change

Are these propositions supported by data?

Mean Combined Effect Size by Problem Area (N=72 Clinical Trials)

Source: www.motivationalinterview.org/library/biblio.html
Practice evoking commitment talk

14 year old patient with Type 1 diabetes, multiple daily injections of insulin and multiple daily glucose checks. She also requires dietary management and carb counts to determine the daily dose of short acting insulin.

Family received intensive hands on training when patient was initially diagnosed.

Treatment is also reviewed with the patient and parents with every outpatient visit. Patient ends up in the ED almost every other month with “diabetic ketoacidosis” because of poor control of diabetes, which can be life threatening if not treated promptly.

Additionally, her HgA1c blood test is very high indicating poor long term control of her blood glucose.

Acceptance and Commitment Therapy (ACT)

- Assumption: Healthy normality is core of traditional physical medicine now adopted by behavioral and mental health community
- Assume that humans are inherently happy, connected to others, altruistic, and at peace with themselves
- But the state can be disturbed by particular emotions, thoughts, memories, historical events, states of the brain, or physical symptoms.
- Treatment is designed to return us to healthy normality
- As a result we pathologize normal human suffering
  - (DSM – ICD – often for billing purposes)
  - Big Pharma – Advertising campaigns
- Leads to overemphasis on symptom reduction.
Acceptance and Commitment Therapy (ACT)

- ACT is based on functional contextualism and relational frame theory (RFT), a comprehensive theory of language and cognition.
- The core conception of ACT is that psychological suffering is usually caused by experiential avoidance, cognitive entanglement, and resulting psychological rigidity that leads to a failure to take needed behavioral steps in accord with core values.

Acceptance and Commitment Therapy (ACT)  Steven Hayes, Ph.D.

- Unwanted internal experiences and suffering are normal and universal.
- You cannot deliberately get rid of your unwanted internal experiences or suffering, but you can take steps to avoid increasing them artificially.
- You can learn to direct your behavior toward values-based activities, even in the presence of unwanted internal experiences and suffering.
- Lessons from:
  - 1. Evolution and Fight/Flight Response
    - Unchecked F/F is anxiety
    - Inclusion is basic human need: “A lone monkey is a dead monkey.” Harry Harlow
  - 2. Development of Language

Acceptance and Commitment Therapy (ACT)
1. Determine Your Values

"Bulls Eye" Exercise

- Who is most important to you?
- What is most important to you?
- Self-Care - Often difficult to make a value for healthcare professionals
- Others

- Place a mark on this target that reflects the degree to which you are living your values.
- A mark in the center means you are participating in your life to the fullest extent possible.
- A mark away from the center means you living your values sometimes or maybe not at all.

2. Identify Unwanted Inner Experiences

"Your Geese"

- What gets in the way of moving toward your values?
  - Pain, Illness, Symptoms
  - Negative Thoughts
  - Negative Emotions
  - Suffering associated with or mislabeled as pain

They flock,
They come in bunches,
They crap all over everything.

Acceptance and Commitment Therapy (ACT)
3. Eliminate: Things Done (or not Done) to Ease Unwanted Inner Experiences

- Maladaptive Coping Strategies
  - Avoidance
  - Escape
- Not Consistent with Values
  - Opioids
  - Inactivity
  - Drink too much
  - Eat too much
  - Smoke
  - Numb out with TV or Videogames
  - Pokémon
  - Don’t go to the Party
  - Isolate
  - Etc, Etc, Etc………..

Avoid Avoidance

Rationale for Exposure Patterns of Anxiety Response

Acceptance and Commitment Therapy (ACT)
4. Committed Action: Small Things Matter

- What small behavior would you be willing to do consistent with your values even in the presence of your “Geese?”
  - Something Kind
  - Something Active
  - Something Brave
  - Something that would be a 2nd or 3rd Chance
  - Something Bold
  - Something Valued

If you wait to act until your “Geese” are quiet, you may never act!

Behavioral Activation

- Key to changing how people feel is help them change what they do
- Structure and schedule activities that follow a plan not mood
- Change will be easier when starting small
- Emphasize activities that are naturally reinforcing
- Act as a coach
- Emphasize a problem-solving empirical approach
- Don’t just talk. Do!
- Troubleshoot possible and actual barriers to activation

Core Principles of Behavioral Activation

Patient with Social Anxiety Disorder

- 12 year-old white female with social anxiety and depression
- Does not want to go to school due to her sense that other students are talking about her in negative manner
- Patient has restricted activity to staying at home on couch and watching TV or surfing the web
- She will take short walks around yard with dog and an occasional trip away from home with parents, but she experiences significant distress
- She does not want to be on medication
What would be your next step in helping this young girl?

- A. Tell her to get off the couch and go to school.
- B. Refer her to a psychologist.
- C. Ask who is important to her?
- D. Give her a prescription for an antidepressant.