WEBINAR VIDEO TRANSCRIPT

Opioid Addiction Treatment ECHO

Introduction to Motivational Interviewing

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- [Angela] This presentation is on Introduction to Motivational Interviewing. And after hearing everyone's introductions it seems that my guess would be a lot of you have experience with Motivational Interviewing. Can I have another thumbs up if you currently use or have been trained in Motivational Interviewing. Okay great. So I've got a lot of the experts on the call and I might be pulling on you. So I'm Dr. Angela Colistra. I'm a Licensed Professional Counselor and Certified Alcohol and Drug Abuse Counselor and clinical supervisor. I'm excited to be presenting this topic today. I don't have anything to disclose.

To get started, the learning objectives. We're gonna review motivational interviewing. I talk a little bit about the stages of change, the work out of Prochaska and DiClemente, and how you begin to implement Motivational Interviewing and kind of overlap it on top of the transtheoretical model or the stages of change. So just a quick little story here. In 2003, I remember working at an inpatient alcohol and drug abuse facility and being handed the Motivational Interviewing book by Miller and Rollnick and kind of eating it up, just feverishly tossing through the pages and thinking about what a great way to work clinically with patients and clients and at the time really struggling with the method that I was being taught and reading chapters and applying, and now fast forward 15 years and still feeling like I have so much to learn about this. So much to learn about Motivational Interviewing and really how it is a way of being with people in an art form. So let's talk a little bit about that. I think when we think about what is Motivational Interviewing, it's important to think about what it's not. And so just to throw that out to everyone, for all of you that use Motivational Interviewing, what is it not? And just go ahead and shout out. Unmute yourself and share what it's not. Anyone. Go ahead.

- [Participant] It's not telling people what to do.

- [Angela] Fantastic. It's not telling patients or clients what to do. What else is it not? One more thing. David.

- [David] It's not... Sometimes I feel this way with patients. It's not being like a clown, throwing all these ideas at them of what they can do to try and change but more so using the motivation to help them figure out what it is that they want to do, not what we want.

- [Angela] Right, it's not, "Have you tried this?" "Have you tried that?" And "Have you done this?" "Have you done that?" Right? Good. So it's an alternative way of being with patients. It's not clinician driven. It's not directive. It's not telling them what to do, all of those things that you said. It's this idea of eliciting and listening for the person's own motivation in their language and pulling on that, and it's also this compassionate and collaborative person-centered approach. It's a way of guiding the conversation, so if we're listening for certain things, those are the things we're reflecting on, we're evoking, we're engaging with, right? And we're just kind of pushing the other stuff to the side or hitting the mute on it.

We're not pulling it forth as much. So to do that, we often pair Motivational Interviewing with Prochaska and DiClemente's Stages of Change. Most of you are probably familiar with this, but these are pre-contemplation, contemplation, preparation, action, maintenance, and most models include a version of relapse. It's a good idea to have a grasp of the Stages of Change because when we recognize where a client is in their stage of change, we're giving recommendations of what to do clinically with a client during that stage of change. And so the goal is to kind of guide and support the patient at where they are and then moving them to the next stage of change if you will.

So if you think about pre-contemplation, the client is thinking, "I don't have the problem. "Rather, you have a problem." Or "The system has the problem, "but I'm not ready to recognize or acknowledge "that I have a problem." Contemplation is this place of... That I'm not ready to recognize that I have a problem. I maybe not verbally stating it, but they're listening. Their ears are perked up. It's as if they're considering some things.

Obviously, preparation is beginning to prepare to do some things differently, to act on some change and action is actually doing, making changes towards their recovery. Maintenance is the stuff we do to maintain the change. And then what do we do if somebody has a relapse or a lapse in the recovery plan? So essentially, MI, it's certainly patient-centered, but the therapist doesn't simply follow the patient. MI provides guidance and directions to the patient. It's consistent with the patient's goals and aspirations, and we help him or her in the direction of harm reduction and treatment. So essentially if we think about the recommendations that with a client that is saying, "I don't have a problem. "I'm just here because I was told "I have to have an assessment," or "I'm just here because they told me I have to be here." "My goal is simply to get the screening done," right? We've all seen patients in that stage. The recommendation in that stage is to listen to the client, build a relationship with them, and education. Simply raising their awareness.

So we think a little bit about the roadmap that's provided to us by Motivational Interviewing. And essentially it's these four underlying processes in Motivational Interviewing, where step one is patient engagement; step two is focusing therapeutic relationship on the patient's goals and aspirations; step three is evoking change, evoking the change talk, and so there, we have to learn to listen to the change talk; and step four is collaborative planning for change behaviors. So let's look at these a little bit closer in this Motivational Interviewing toolbox.

So during a introduction of Motivational Interviewing, clinicians can sometimes get overwhelmed with all the language we use to talk about Motivational Interviewing. You might hear about the spirit of MI

and this idea of being collaborative and evoking change and client autonomy. The core competencies, we often use these terms and they roll off our tongue: learning how to roll with resistance or using the skills to develop discrepancies, expressing empathy, avoiding argumentation, and supporting the client's self efficacy. And then the techniques we use, you might hear the word "OARSE": open ended questions, affirmation, reflective listening, summaries, and then eliciting change talk. This is a nice toolbox to think about this language and the semantics we use around MI.

So the Stages of Treatment versus the Stages of Change. MI is best used in guiding patients along the first three stages of change. That's the best place to use Motivational Interviewing techniques: pre-contemplation, contemplation, and preparation. So we're moving them towards action if you will. And then ideally, once your patient is ready for action, he or she is open to the recommended treatment if you will, which might include medicated assisted treatment and support groups. And then relapse prevention or relapse management are critical during the maintenance and relapse phases. Supporting your patient during these trying times if you will.

So educating patients and their loved ones around these stages and essentially setting realistic expectations is critical in helping your patients, especially through times of failure and self criticism. What's always interesting to me, though, with the patients that I work with, often I see people at multiple stages with multiple substances of use, right? So they might be highly motivated and highly action-oriented to be on a recovery path from opioid use disorder, but they might be at different stages of change with other substances of use, such as marijuana or alcohol or even amphetamine-like substances. Or they're saying, "I don't have a problem. "You're the ones that have a problem." But they have high motivation around their opioid use. Does anybody else see patients at different stages of change with different substances? Just feel free to unmute yourself.

- [Anna] This is Anna. I have.

- [Angela] You have. Great. And so Sandra, do you use Motivational Interviewing, and do you find it easy or difficult to oscillate in between the different stages and the application of the skills, or is that something that you've thought about?

- [Sandra] Actually, I use it a lot. It helps get them to open up and then when you... Making sure that I'm hearing what they're saying. I like to let them know, "This is what I heard. "Is this right?" I've been using it for quite a while, and to me, I find it so so much easier than just asking them a question and, "Tell me about it." But if you would turn around tell 'em, "Would you mind explaining to me a little bit more?" Instead of saying, "Well, tell me about it." If you give them that chance to say, "Oh yeah, yeah," or... I love using it.

- [Angela] Great.

- [Sandra] It's very helpful.

- [Angela] Great. That's fantastic. Thank you for sharing. So it sounds like you stay in this core competency mode with the skills, where you're always expressing empathy, avoiding argumentation, rolling with resistance, regardless of where they are with their Stages of Change, if I'm hearing you right.

- [Sandra] Yes, ma'am.

- [Angela] Okay, let's move on. Thank you. When you think about how do you begin, I think a lot of things you need to ask yourself is are you really ready to meet clients where they're at? I mean, often, I think this is harder than what we really... What it looks, right? It's harder than what meets the eye. Are we really ready to be curious and not judge and assume nothing? When I say those things, I think often, I'm training clinicians to suspend all of that, right? When we're actually into listen and be and what I like to call, I pull up a chair next to the client on their journey, and I think this is really hard to do when patients have use disorders, and there's so much at risk. But you ask yourself, and you check yourself constantly. Am I being humble? Am I being curious? Am I not judging? And essentially, am I allowing the patient to be the expert consultant in the process? The idea here is that the more that we engage with these core competencies, that they also discover their narrative, that they also discover where their motivations lie.

They also discover, "Well, this is what I want, "and this is a discrepancy. "My behaviors are conflicting with this, "and I see that," because we're giving them the space to explore that without judgment, by being curious, by having no expectations. And so through using the Motivational Interviewing toolbox, it kind of allows their... Their story to surface if you will. So although through curiosity and understanding your patient, can you begin to connect patient values and aspirations to possible change behavior? So only through doing that do we begin to connect this idea that "I value being a mother, "and I value wanting my kids back, "but maybe these behaviors are conflicting with that, "and I now see that, and I begin to have motivation "to do one small thing differently "that aligns with that value." But it can't be the provider starting that narrative. It has to come from our patients.

So to get there, we have to be curious. We have to suspend our judgment. Do I have a sense of my patient's values? And you have to ask yourself, do you know what their aspirations are? And I love that on these ECHOs, when somebody presents a case, we always ask, "What do they want?" "What do they want to go to school for?" Or "What do they value?" And then connecting the answers to these questions can essentially help promote their change behaviors. So do I understand my patient? So here are some sample questions to help further your understanding of your patient. Essentially, you wanna make every effort to keep these questions open-ended.

I know we all know what an open-ended question is, but when you sit down and start practicing this and observing your work, you might realize that sometimes you ask more closed-ended questions and have a forced choice answer than we're asking open-ended questions. Sometimes I feel like my training has trained me better to ask closed-ended questions, like assessment or screening questions, or because I'm looking for a certain answer for a certain something. So being real intentional when we're sitting down to pull up a chair next to a client, we're in this open-ended question mode. And these questions really are driven by your genuine curiosity about your patient and a desire to better understand them. You don't have to ask all the questions.

These are just sample open-ended questions that can promote understanding of your patient. They certainly don't have to all be asked in the same session. Gaining an understanding of your patient essentially and while you do that, you're reflecting their responses. So what was your patient's childhood like? We don't just sit there and listen, but we express empathy through reflective listening, reflecting content, feeling meaning in what they're seeing, making eye contact, being nonverbally present. We appreciate what we're hearing from them. We're affirming their values or goals, their aspirations, their culture that they're bringing in the room. And we're essentially engaging with the story. We're actually listening. I love that the words listen, the letters that are in listen, are the exact same letters that are in the word silent. And so we have to quiet ourselves. We have to do what we need to do to be silent and have no expectations and no judgment so we can purely listen to our patients' stories and our patients' responses to these questions. It really is in their narrative that they begin to unlock where their motivation lies. And then they begin to feel like we care and that we really are listening to their story, and it essentially leads to better engagement.

So what motivates my patient? So even the pre-contemplated patient, "I don't have a problem; you have a problem!" "I don't have a problem; the system has a problem!" They are motivated. No one is unmotivated. It can sometimes be a struggle to understand what motivates a patient. We've all been there. We've all worked with that patient that we feel like is going backwards, that is making very little progress towards their recovery goals. But that frustration can throw us off the MI therapeutic stance, so remember that the expert is sitting right in front of you and that he or she is motivated towards something.

Even in my work with patients that were in treatment or care because of the criminal justice system, and they would say to me, "I'm motivated "just to get off of probation and parole," "I'm motivated; I'm just here "because I don't wanna go back to prison." Well that's a great start, and we're gonna start there, and I'll go to pull up a chair next to that. And you're gonna tell me what you need to do to reach those goals. And essentially what we come back to is, "I have to participate in therapy, and you're gonna have to make a report saying that." So it engages us in this idea of what therapy is and at what level do they feel like they can participate? So they're motivated towards something and starting there, pulling up a chair next to them, and saying, "Okay." And then moving as we begin to build that relationship, as we begin to collaborate, express empathy, have unconditional positive regard, over time, the patient begins to tell their story, begins to tell their narrative, and share their goals, values, and beliefs.

And if we can create that safe environment for them to do that, I really believe, and I have been witness of, that they begin to see their own aspirations unfold before them, and I think that really is when the

beauty begins to happen with this skillset. So when we think about other things that a client is motivated towards, we also have Maslow's hierarchy of human needs and that also helps us begin to question what they're working towards: psychological motivation, security motivation, love and belonging motivation, esteem, self-actualization. And it seems if clients have these overarching themes that begin to be present in their narrative, right?

So perhaps you have a client that begins to tell stories about being abandoned, and it's not just in this one relationship that their fear of abandonment exists, but it's an overarching theme in their life: being abandoned by their parents, being abandoned by loved ones, not being lovable, not belonging. When we begin to see that in their narrative, and we begin to see, perhaps, and they begin to see as well a connection with their drug, a connection with what it is that they're... Why they're reacting and responding in the world like they are. And it's not... It's important that we create an environment for them to tell their story and for us to see maybe the themes that help guide them, but it's even more important that they begin to see the picture that they're putting on the canvas, too.

And they begin to see what it is they really want. And maybe they can show their motivation towards how they're going to get there and reach those goals. So another graphic representation of Maslow's hierarchy of needs. If you're thinking about a client and feeling as if you're stuck, what are they motivated towards. This can help you refocus and reengage with the process. So where do I start? By understanding the patient, you've already started MI, this engagement process if you will. As long as you're sitting down, asking questions, being curious, suspending your judgment, expressing empathy, you've already started, but there's four underlying processes in Motivational Interviewing, so beyond engagement, we're gonna look at focusing, evoking, and planning.

And so once you start galloping here, you get more specific and kind of ground more into the skills that you're using and the techniques that you're using with your patient. So the engaging process is critical. None of this can happen without it. It's the foundation of Motivational Interviewing, and it's not... Motivational Interviewing isn't effective if you haven't engaged with your client. So essentially during this stage, the patient is asking him or herself, "Do I feel respected by my provider?" "Does the therapist or medical provider "listen and understand me?" "Do I trust this person?" "Do I have a say in what happens?" "Am I being offered options, "or is it a one-size-fits-all model?"

And as somebody that applies Motivational Interviewing, I realize I ask myself these same questions about my providers, whether I'm getting medical care or dental care, I'm saying, "They're engaging with me. "They're listening to me." And sometimes we might say, "They have great bedside manners," right? All of these things mean that the patient or the client feels that they are being heard, that you care about their story. You've pulled up a chair next to them. So once that has happened, by understanding your patient, you consider focusing the process on MI. This will help you elicit the patient's goals for change, and then you can determine and monitor if you're collaborating and working on a common purpose. So this is where you begin focusing, which is the second stage.

You begin identifying areas or behavior that could be the focus of change. So for example, your patient might indicate that she is unemployed, not accessing medical care, and staying up until 3:00 a.m. everyday. I feel like that's been part of some of the cases recently, and so through focusing, you're going

to work with your patient to identify which of those areas are a priority in hopes of promoting change behaviors, but you're going to focus in on one of them. Your patient may decide that finding a primary care doctor would be the desirable change, right? So you're focusing, but you're deciding that together. I think that's the key here. We're not necessarily being the ones to decide which behavior they're motivated to change. It's through understanding them and pulling from them that they begin to tell us what's going to be the most important thing to focus on.

So during this process, in the next stage, you're going to be evoking and uncovering, if you will, the patient's very own reasons for considering and engaging in change. So during patient interaction, it's critical to listen to what we call change talk. So example, the person arguing or pushing for change cannot be the therapist or medical provider, which we identified earlier. This needs to be led through the patient and through their narrative and through change talk. One important technique that helps elicit change talk is this technique called developing discrepancies. And so once you have a good understanding of your patient, you can guide your patient towards understanding that there is discrepancies between his or her goals, values, or aspirations and then their behaviors.

So, "It is a goal of mine to get my kids back, "but my current behaviors aren't what is necessary "and sufficient enough for me to reach that goal." Now again, we have to ask the right questions for them to say that, and this is where we're guiding them. We're facilitating a guiding process, but it has to come from them, and so once we get that in their narrative, we use that to just develop the discrepancy, where I might say, "On one hand, you're very... "One of your goals that you've outlined "is to get your children back, "but on the other hand, "your current substance use "and not following your medical plan as provided "and not receiving your mental health care "is getting in the way of you meeting that goal. "What do you make of that? "Where do we go from here?"

And then I ask another open-ended question. Essentially, that can help them focus in on or evoke some sort of change talk. And once they say that, once they say, "Yeah, you're right. "I'm never going to get my kids back "if I continue to test positive on my urine drug tests "for marijuana, alcohol, amphetamines, "in addition to this medicine. "Maybe I need to think about doing something about that." And so then at that time, we might look at some other ways to evoke change and how ready are they to do that.

And in Motivational Interviewing, essentially to assess a patient's readiness for change and at the same time deliver affirmations and elicit change talk, we're going to look at their readiness. And they use a lot of scaling questions. So on a scale of zero to 10, how important is it for you to... get your children back? And so whatever they say, maybe they might say, "It's a seven," or "It's an eight," and then I'd say, "Why did you say it's an eight, and it's not a zero?" "So tell me a little bit about that." Or you can say, on a scale of zero to 10, how confident are you that you can get your children back? And let's say that your patient answered a three, I would say, "What would it take "For you to go from a three to a four?"

So again, this uncovers what their needs are, what they need to get there. It gives us more opportunities to pull their narrative and for them to hear for themselves what it is they need to do to get there. So we focused in on what their goal is. We develop the discrepancy, and now we're trying to understand how ready they are and how confident they are that they can get there, all coming from them. So again, this

stage needs to be led by the patient. The plan must be uncovered and elicited from the patient, and it cannot be prescribed. So look for an understanding of what can help this patient move forward. If information is needed, you need to ask yourself, "Did I ask for permission before offering?"

Let's say that you're going to make a recommendation. You are going to suggest something. It's often better received if you ask the patient or the client to do that. And you might say... "I'm wondering if it would be okay "if I can offer you some suggestions on what's worked, "or we could explore a menu of options "on what might help you with your goal "to abstain from marijuana use." And the patient might say, "Yeah, I'm open to that," and you can explore some options. But the idea with Motivational Interviewing is that you don't give unsolicited advice. And so as you build a plan with your patient, you can also consider SMART goals.

All of you are behavioral and medical providers, so specific, measurable, attainable, relevant, meaning that it's meaningful to the patient, and it's time downed. It's a SMART goal. We're gonna be very specific in planning for that goal. So another overview of the Motivational Interviewing toolbox beginning with the treatment plan, the treatment stance, this idea of the spirit of how to be with the patient to specific techniques that can help the clinician patient diad move along the Motivational Interviewing roadmap. The core competencies of the work. When I first started working with individuals that had use disorders, I remember, it was 15 years ago, telling my clinical supervisor, and I often reflect on this with my own supervisees that why does it feel like everyone comes in with their boxing gloves on? And I thought, "I don't wanna put my boxing gloves on "and work with patients."

And I have supervisees say that very same thing to me, and the great thing is I feel like Motivational Interviewing gives us permission and the skills to learn to dance with the client where sometimes you're leading, and sometimes you're following, but you're dancing together. And if it feels like the client has put their boxing gloves on or you feel like you have put your boxing gloves on, then you have stepped out of the Motivational Interviewing stance. And that's always a sign to me that I am not rolling with the resistance. Now if the client is being resistant, they're arguing, they're looking at me sideways, they're feeling very aggressive, right? That tells me that I'm not listening to them, that I haven't heard them, they do not feel heard, and I need to start again. I haven't been effective at pulling up a chair next to them and listening to their narrative. So those are key internal signs for myself when I work with clients where I'm getting it wrong.

And again, I feel like the techniques in Motivational Interviewing are intellectually really easy to get. I think the work is much harder than what meets the eye in my opinion. Okay, so in summary, Motivational Interviewing is designed to activate patients' own motivation for change. So essentially your patient is the expert on him or herself. Of course, right? I think yes! You are the expert on the process. We're gonna rely on the patient's wisdom and uncover their intrinsic motivation for change because we are all motivated toward something. There's power in the therapeutic relationship with the patient. I have built a whole career on this, that the therapeutic relationship is so powerful, and when we pull up a chair next to somebody... I believe when we reach our hand out to somebody and pull up a chair, I really believe that is a sacred place, especially if someone invites you on that journey with them.

We need to be able to do that with compassion and empathy and unconditional positive regard. So essentially we're working with the patient, guiding him or her to generate change talk. Self-generated change talk is more likely to lead to client behavior, so the tools are about pulling certain things, certain change talk, conversations from the client, focusing in on it, engaging with it, planning around it, and the client becoming... Moving towards and through their stages of change. And that's all. Any questions or comments? Feel free to unmute yourself.

- [Participant] That was terrific. Thank you. I've not had the benefit of being formally trained in Motivational Interviewing. I've had a few, a little bit of exposure to it. I'm thinking about the patient that was presented last week, and I think you were there last week. It was somebody who was, if I remember correctly, very seemingly unmotivated, and I questioned their cognitive status and whether they were really capable of being engaged in their own treatment. And my question for you is... Is there anyone who cannot engage in Motivational Interviewing? Are there any patients that would not be appropriate for Motivational Interviewing, or can you do it with anyone as long as you get at their level?

- [Angela] Thanks, Deborah. I think that's a really great question. I've worked in a group home with men and women with cognitive delays, and I have found that it even works towards their motivational straight, especially the core competencies of the work. When I look at the work, it's laid on the foundation of Carl Rogers's person-centered work, which is essentially the core conditions of creating a therapeutic environment, which is bound up in expressing empathy and affirmations. As human beings, I think something really... When I'm in the presence of it myself, something magical happens to me, and I see that same thing happen with patients, whether they're realizing it or not, and even with cognitive impairments, I think these core conditions in a therapeutic environment still help somebody move towards either minor or major change behaviors. Does anybody else have any thoughts on that?

- [Anna] This is Anna. One of the things that I have noticed, when you first start using it, you may catch yourself going the way we used to. The number one thing, it takes time to really put it into practice. One of the things that helped me is... I also have worked with delays, and you kind of have to bring them back to the question at hand or whatever and redirect them. But one of the things I can suggest is get different friends or families to role play, and that will help you get it directed in the right way.

- [Angela] Thank you. Deborah, I'm curious, too, have you had any training on just that question that you asked?

- [Deborah] I'm not sure I understand your question.

- [Angela] Yeah, so... Are you aware of any information of it not being quite appropriate for people with cognitive delays?

- [Deborah] No, I'm not. I'm really curious. I imagine somebody must have looked at that.

- [Angela] Yeah, surely.

- [Deborah] But I would think that... And just thinking about it, I think it's great to have an approach for Motivational Interviewing. I think that it's something that I strive to do anyway is to get where the patient's at and to really understand what motivates them and what's gonna work. That's always been my philosophy is I wanna do what works and get them to do what works or help to motivate them to do what works. And it occurs to me that maybe that patient, I don't know if the person who was actually treating that patient is here today, but I'd be really curious to get an update and to get a sense of where they might approach that patient in this kind of way to really try to get a sense of what does motivate him, what are his goals, even for tomorrow. And I would think that there would be a way to help him to engage if they could really get to that point.

- [Angela] Yeah, it's funny you bring it up. The case came up for me as I was lecturing today. I was exactly thinking of that case last week. So thanks for asking it. Any other questions?

- [Brent] Angie, this is Brent from ECHO. I had a question for you actually. Would you please stop sharing your screen?

- [Angela] Yes.