PREPARATION (PRE-WORK!) FOR THE WORKSHOP

Please write down two statements (one for MI and one for CBT) about changing some aspect of behavior or self that you have heard from your clients (or others), and that you would find it easy to respond to in an:

1. MI-consistent way
2. CBT-consistent way

ABCT 2018 Convention
Washington, DC

INTEGRATING MOTIVATIONAL INTERVIEWING INTO CBT

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- Adjunct Professor – Dalla Lana School of Public Health, University of Toronto
- Licensed Psychologist
- Trained Hundreds of Psychologists, Social Workers, and Community Workers in Motivational Interviewing (MI)
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Licensed Psychologist

"LET'S BEGIN" EXERCISE: SCALING IN MI

- A common way of assessing, as well as cultivating confidence or importance, is scaling by the client. Scales can help clients/patients to verbalize and further process their **ambivalence**.
  - ***"On a scale of 0 to 10, how important do you think it is for you to quit smoking?"*** **(Client says 9 out of 10)**
  - ***"On a scale of 0 to 10, how confident are you that you can quit smoking?"*** **(Client says 4 out of 10)**

READINESS TO CHANGE: IMPORTANCE AND CONFIDENCE

- Scaling and use of rulers

On a scale of 0 to 10, how IMPORTANT is it for you right now to change?

0 1 2 3 4 5 6 7 8 9 10
Not at all Important — Extremely Important

On a scale of 0 to 10, how CONFIDENT are you that you could make this change?

0 1 2 3 4 5 6 7 8 9 10
Not at all Confident — Extremely Confident

READINESS TO LEARN: IMPORTANCE AND CONFIDENCE

Importance

0 — 5 — 10

Not Important To Use MI — Important to Use MI

READINESS TO LEARN: IMPORTANCE AND CONFIDENCE

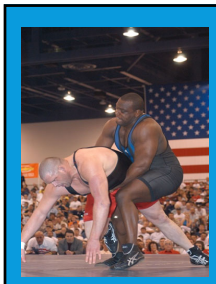
Confidence

0 — 5 — 10

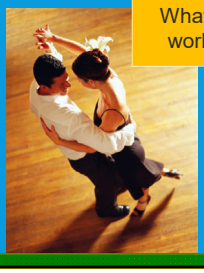
Not Confident in Using MI — Confident in Using MI

LEARNING OBJECTIVES

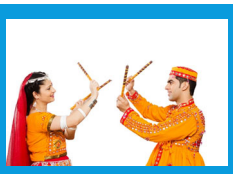
- This workshop is designed to help you:
  - To integrate MI with various CBT approaches
  - To employ methods for eliciting MI change talk in clients in the context of CBT
  - To apply key MI processes to increase client motivation for behavior change within ongoing CBT treatments



MI and CBT –
What are our views of working with clients?



MOTIVATIONAL INTERVIEWING IS MORE LIKE DANCING (THAN WRESTLING)



(R) Roll (Dance?)

with Resistance

And, how can MI and CBT best dance together?

MI DEFINED

- *"A method of communication rather than a set of techniques. It is not a bag of tricks for getting people to do what they don't want to do; rather, it is a fundamental way of being with and for people – a facilitative approach to communication that evokes change.* (Miller & Rollnick, 2002)
- *"Motivational interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change".* (Miller & Rollnick, 2009)
- *"Motivational Interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change."* (Miller & Rollnick, 2013)

MI CAN BE CHALLENGING TO DO IN CBT PRACTICE…

TEN THINGS MI IS **NOT**:

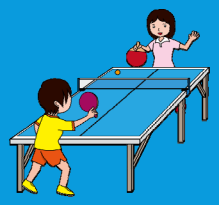
1. Based on the transtheoretical model of change
2. A way of tricking people into doing what you want them to do
3. A specific technique (MI is a counseling method)
4. Decisional balance (just exploring pros and cons)
5. Assessment feedback
6. **A form of cognitive-behavior therapy** (but related?)
7. Just client-centered therapy
8. Easy to learn
9. What you are already doing
10. A panacea for every clinical challenge

(Miller & Rollnick, 2008)

MI AND CBT: SIMILARITIES AND DIFFERENCES

	CBT	MI
Empirically supported	✓	✓
Directs toward behavior change	✓	✓
Action oriented	✓	✓
Teaching about maladaptive thoughts	✓	×
Teaching skills / education	✓	×
Socratic Questions	✓	×
Explicit about client's values	×	✓
Knowledge comes from client	×	✓
Solutions come from client	×	✓
Roll with resistance	×	✓

PING PONG EXERCISE: DEVELOPING AND POLISHING SKILLS



POINT/COUNTERPOINT EXERCISE: MI AND CBT

- I'm feeling so depressed… Can you help me?
- I married and having an affair, but I can't seem to stop it.
- I am such a loser – why can't I quit smoking already?
- I am extremely anxious about public speaking, but I really need to apply for this promotion that includes regular presentations… What can I do?

DECISIONAL BALANCE

	Good Things	Not-so-good-things
Continuing Target Bx (CBT)		
Changing Target Bx (MI)		

WHEN TO INTEGRATE MI WITH CBT

- Beginning
- Middle
  - "Motivational Interactions"
- End

CONCEPTUALIZING MOTIVATIONAL INTERVIEWING

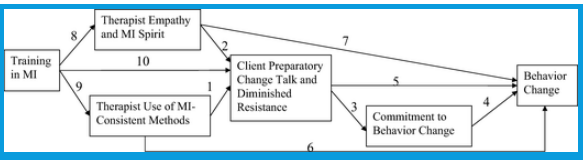
2 Conceptualizations

A treatment intervention based on principles from humanistic psychology that is patient-centered but directive, seeking to increase internal motivation for change.

OR

A style of interacting with patients that is respectful, listening, and which helps to elicit behavior change by helping patients understand their own ambivalence about the "costs" of change and to resolve it.

Hypothesized Relationships Among Process and Outcome Variables



PATHS of Influence on Behavior Change

1 – Technical Factors *(Use of MI-Consistent Methods)*
2 – Relational Factors *(Empathy and Support)*

From Miller & Rose (2009). Toward a theory of Motivational Interviewing. *American Psychologist*, 64, 527-537.

SELECTED SUMMARY OF EMPIRICAL SUPPORT

- Multiple meta-analyses show small to moderate effects for MI, often in areas in which in areas we also see smaller effects for CBT
- Burke, Dunn, & Atkins (2004)
  - 39 studies in the areas of alcohol and drug problems, smoking cessation, HIV risk behaviors, diet/exercise, treatment compliance, eating disorders, asthma management, and injury-risk behaviors
  - Effect sizes ranged from .35 (e.g., smoking cessation) to .56 (e.g., substance abuse)
- Martins & McNeil (2009)
  - 37 studies in the areas of diet and exercise, diabetes, and oral health
  - Good evidence for MI effectiveness in these areas
  - Noted issues of fidelity as paramount for the field
- Randall & McNeil (2016)
  - "Motivational Interviewing as an Adjunct to Cognitive Behavior Therapy for Anxiety Disorders: A Critical Review of the Literature"

SUMMARY OF MI RESEARCH FROM MILLER & ROLLNICK (2013)

- Effectiveness varies greatly across clinicians, studies, and sites within studies
- Therapeutic factors and MI proficiency contribute to MI efficacy.
- Fidelity of service implementation is important when attempting to interpret outcomes of MI.
- Future studies should document (through use of reliable observation codes) the fidelity of MI delivery.

GENERAL CONCLUSIONS FROM RESEARCH

- MI can be useful with a variety of health conditions and behaviors
  - MI works best with clients who are angry, resistant, or less ready to change
  - MI works less well with clients who are already committed to change and ready for action
- MI typically is more effective than no treatment
- Adding MI to other active treatment improves outcomes
- MI may have double the effect size with certain cultural minority populations
- Both RELATIONAL and TECHNICAL factors may be important in outcomes.

SOME SUGGESTED READING

- Arkowitz, H., Miller, W. R., & Rollnick, S. (Eds.). (2015). *Motivational interviewing in the treatment of psychological problems*. Guilford Publications.
- Martins, R. K., & McNeil, D. W. (2009). Review of motivational interviewing in promoting health behaviors. *Clinical Psychology Review, 29*(4), 283-293.
- McNeil, D. W., Addicks, S. H., & Randall, C. L. (2017). *Motivational Interviewing and motivational interactions for health behavior change and maintenance.* Oxford Handbooks Online. New York: Oxford University Press.
- Naar, S., & Safren, S. A. (2017). *Motivational interviewing and CBT: Combining strategies for maximum effectiveness*. Guilford Publications.

Spirit

Processes

Core Skills (Techniques)

MI SPIRIT

Global characteristics of behavior that are associated with positive patient outcome and patient change talk (e.g., Thyrian et al., 2007)

- Partnership
  - Working together
- Acceptance *(Respected, supported by therapist)*
  - Honoring the client's autonomy, resourcefulness, and ability to choose
  - Acceptance that the client may choose not to change
- Compassion
  - Authentic caring
- Evocation
  - Emphasis on drawing out the client's ideas

MI SPIRIT AND THE RIGHTING REFLEX: CBT APPROACH AS A "TRAP?"

Many of us as humans have a built-in desire to set things right.
That focus is what brings many of us into the helping professions.

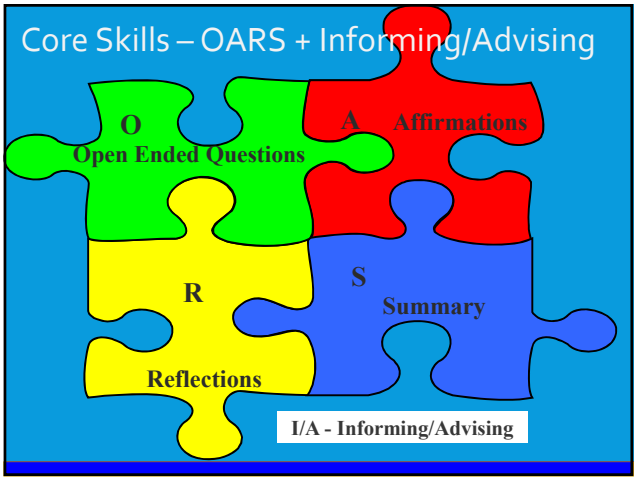
Righting reflex (Miller & Rollnick, 2002) - Practitioner's impulse to use information and persuasion to increase a patient's motivation to change.

4 PROCESSES OF MI

- Engaging – The relational foundation of MI
  - Involves listening with empathy
  - Trying to understand client's point of view
  - Using OARS non-directively
- Focusing – Guiding to a target behavior
  - Helping client to identify a target area of ambivalence or struggle
- Evoking: Drawing out intrinsic motivation
  - Pull out client's own ideas and reasons for change
  - Recognize, reinforce, and summary change talk
- Planning: The Bridge to Change
  - Reinforce commitment language
  - Assisting with change plans

(Miller & Rollnick, 2010)

Core Skills – OARS + Informing/Advising



(O) OPEN-ENDED QUESTIONS

It's not as easy as it sounds!

Avoiding yes/no, short answer, and rhetorical questions

MI -consistent therapist behavior
When a question IS asked, make it an open–ended one 70% of the time

Changes across time as assessment/treatment progresses?

(A) AFFIRMATIONS

"Affirmations are like salt, a little makes things taste good; too much is hard to swallow"

- Emphasize a strength
- Notice and appreciate a positive action
- Needs to be genuine
- Express positive regard and caring
- Strengthen therapeutic relationship (builds rapport)
- Need to use your natural style

(R) REFLECTIONS

- A statement not a question
- Hypothesis about ***meaning***
- Can often turn a question into a reflection (carefully)
- Think of your question
- Cut the question words "Do you mean that…?" and change it to "You mean that…"
- Inflect your voice DOWN at the end

(R) REFLECTIONS

- Reflections
  - Simple
    - Repeating
    - Rephrasing
  - Complex
    - Paraphrasing
    - Feeling Reflection
    - Amplified or Understated
    - Double-Sided

(R) REFLECTIONS (SIMPLE)

- Repeating
  - The simplest reflection simply repeats an element of what the speaker has said.
- Rephrasing
  - Listener stays close to what the speaker said, but substitutes synonyms or slightly rephrases what was offered.

(R) REFLECTIONS (COMPLEX)

- Paraphrasing
  - Listener infers the meaning in what was said in new words.
- Reflection of feeling
  - Paraphrase that emphasizes the emotional dimension through feeling statements, metaphor…

(R) REFLECTIONS (COMPLEX)

- **Amplified or Understated**
  - Client will usually take the opposite stance
- **Double-sided: reflecting ambivalence.**
  - The use of AND rather than BUT can change resistance to ambivalence.
  - "On the one hand……(negative) AND on the other hand…(direction of change)" (Use of a GESTURE)

(S) SUMMARIES

- A summary lets the client know you have heard and understood what they said.
- Can help you to move on
- Can include a check out for accuracy
  - "Is that a fair summary?"
  - "Have I understood you correctly?"

PROVIDING INFORMATION / ADVICE (I/A): RELATION TO CBT

FIRST – Asking for permission (e.g., to give homework)

ELICIT

What would you most like to know about…?

What do you already know about…?

PROVIDE

Information and choice wherever possible

ELICIT

Open-ended questions about the information

EXERCISE: THE DC REEL

- Please stand in 2 circles, one inside of the other
- Client:
  - **"Hi, I've been thinking about changing…"**
  - **"I'm going to change . . ."**
  - **"Maybe I should change . . ."**
- Clinician:
  - Uses OARS

PROCESS 1: ENGAGING

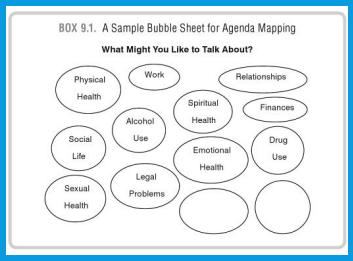
- Definition: "…the process of establishing a mutually trusting and respectful helping relationship." (Miller & Rollnick, 2013)
- Definition: "…the process of establishing a mutually trusting and respectful helping relationship." (Miller & Rollnick, 2013)
- Beginning with too much focus on assessment places patient in passive role
- Avoid expert-driven behaviors
- Premature focus trap = focusing on a goal without sufficient engagement from patient
- "Accurate empathy" and active listening
- First place where the therapist uses core skills (OARS)

PROCESS 2: **FOCUSING**

- In order to be a guide, you need to know your client's destination, one he/she chooses
- Focus can come from client, context, or the clinician
- Directing ← →Guiding ←→ Following
- Identify 1 or more goals or outcomes
- Agenda mapping can assist focus or help redirect
- When goals are unclear, orientation and formulation can yield focus
- Elicit – Provide – Elicit (info exchange honoring autonomy and expertise of client)

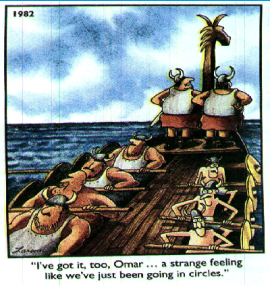
AGENDA MAPPING

(MILLER & ROLLNICK, 2013)



PROCESS 3: EVOKING

- Developing Discrepancy
- Promoting Change Talk
  - Implementing
  - Preparatory
- Rolling with Resistance



CHANGE TALK

Any verbalizations (and nonverbal communication) that favors movement towards change.

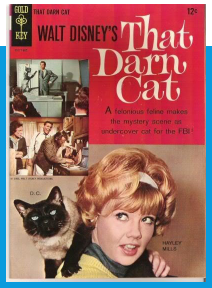
An important part of Motivational Interviewing is learning to recognize change talk when you hear it from your patient, and then reinforce it.

I guess I need to get my "sugar" under control.

CHANGE TALK

Two Types of Change Talk:

- Preparatory Change Talk (DARN)
- Implementing Change Talk (CAT)



PREPARATORY CHANGE TALK (DARN)

- **Desire:** I want/wish/prefer to/like
- **Ability:** I can/could/am able/possible
- **Reason:** if...then..., specific arguments for change
- **Need:** important/have to/must/got to

IMPLEMENTING CHANGE TALK (**CAT**)

- **Commitment** (intention, decision, readiness)

"I will, intend to, am going to…"

- **Activation** (ready, prepared, willing)

"I am ready to, willing to…"

- **Taking steps** (reporting recent specific action toward change)

"I have done…"

ELICITING CHANGE TALK

- Ask evocative questions
- Ask for elaboration
- Ask for examples
- Look back
- Look forward
- Query extremes
- Use change rulers
- Explore goals and values
- Come alongside

FIVE QUESTIONS ABOUT CHANGE

1. *Why would you want to make this change?*
2. *How might you go about it in order to succeed?*
3. *What are the three best reasons for you to do it?*
4. *How important is it for you to make this change, and why?*
5. *So, what do you think you'll do?*

(Miller & Rollnick, 2006)

SOME ADDITIONAL KEY QUESTIONS

- *Key Questions* to get the client talking and thinking about change:
  - What do you think you will do?
  - What does all this mean about your behaviour?
  - What do you think has to change?
  - What could you do, what are your options?
  - It sounds like things really can't stay the same, what can you do?

YET MORE POSSIBLE KEY QUESTIONS

- *More Key Questions . . .*

- how would you like things to turn out now in your life?
- of the things that concern you, what are the most important reasons to change?
- what concerns you most about changing?
- what would be some of the benefits of changing?

EXERCISE: DRUMMING FOR CHANGE TALK

- Drumming for *preparatory change talk*
  - D - Desire
  - A - Ability
  - R - Reason
  - N - Need
- Clapping for *commitment*
  - Commitment, Action, Taking Steps
- Silence for *sustain* talk

STRATEGIES FOR STRENGTHENING COMMITMENT - 1

- *Negotiating a Plan*
  - Setting goals:
    - How would you like things to be different?
    - What is it you would like to see changed?
    - If you were completely successful in accomplishing what you want, what would be different?

STRATEGIES FOR STRENGTHENING COMMITMENT - 2

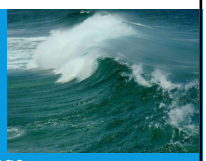
- Considering Change Options
  - presenting a menu
  - patient-treatment matching
- Arriving at a Plan
  - the most important reasons why I want to change
  - my main goals for myself, in making a change are....

STRATEGIES FOR STRENGTHENING COMMITMENT - 3

"Confidence Talk"

- The therapist should refrain from advice-giving, and stick to the OARS, being careful to offer more reflections than questions.
- "Trying to do a bit more" - Ask open questions, the answer to which is confidence talk
- Use the confidence ruler
- Review past successes
- Discuss personal strengths and resources.

AVOID A "LOSING BATTLE:" ROLLING WITH RESISTANCE



- The client is the primary resource for finding answers and solutions
- Resistance is a signal to respond differently – shift to different strategies
  - Avoid trying to persuade or arguing for change
- Use the client's "momentum" to further explore his/her views
  - Resistance tends to be decreased rather than increased, as clients are not reinforced for becoming argumentative and playing "devil's advocate" to suggestions
- New perspectives are invited but not imposed

TYPES OF RESISTANCE

- Argument
  - Challenging
  - Discounting
  - Hostility
- Interruption
  - Talking over
  - Cutting off
- Ignoring
  - Inattention
  - Non-response
  - Non-answer
  - Side-tracking
- Denial
  - Blaming
  - Disagreeing
  - Excusing
  - Reluctance
  - Minimizing
  - Pessimism
  - Unwillingness to change
  - Claiming immunity

Jonathan Fader

SNATCHING CHANGE TALK FROM THE JAWS OF AMBIVALENCE

When ambivalence is present, it is normal for change talk to occur within the context of sustain talk

Bill Miller and Terri Moyers

SNATCHING CHANGE TALK FROM THE JAWS OF AMBIVALENCE - EXAMPLE

- *I really don't want to stop smoking, but I know that I should. I've tried before and it's really hard.*
  - A. You really don't want to quit.
  - B. It's pretty clear to you that you ought to quit.
  - C. You're not sure if you *can* quit.

Certainly a double-sided reflection would be possible here, but which response focuses on change talk?

Bill Miller and Terri Moyers

SNATCHING CHANGE TALK FROM THE JAWS OF AMBIVALENCE - #1

"It's just such a hassle to take all those pills. I'm supposed to remember to take them four times a day, and half the time I don't even have them with me. And I hate how they make me feel. I guess there's a good reason for it, but it's just not possible for me."

Bill Miller and Terri Moyers

SNATCHING CHANGE TALK FROM THE JAWS OF AMBIVALENCE - #2

"I was worried there at first, but I don't think I really have diabetes. The doctor said it was "borderline" or something like that, and I feel fine. Well sure, I'd like to be as healthy as I can, but I'm 68, for heaven's sake. I figure I can get away with some bad habits now. They won't have time to catch up with me."

Bill Miller and Terri Moyers

A NOTE ON ROLE/REAL PLAYS

For some of the practice activities, you can either use a situation that is not personal to you, but one that you know quite a bit about, likely because of your clinical work.

Or, you may wish to talk about something real to you, usually something that you would like to change or about which you feel ambivalent. Please only use situations you feel comfortable sharing and that you think others will feel comfortable hearing.

EXERCISE: "SPEED DATING" (THERAPY)

Instructions (for 3 min encounters)

Therapist – Follow therapeutic role on card

Client – Start off the conversation, speaking about your problem

Possible Client Topics **(all involving ambivalence about changing)**

- Been feeling down and depressed for past year
- Lonely and socially isolated due to anxiety
- Lack of motivation at work; would like to quit, but need the job
- Washes hands and cleans compulsively

BASIC DECISIONAL BALANCE

- Conceptualized by Janis and Mann (1977) as a decisional "balance sheet" of relative potential gains and losses.
- Ambivalence is a normal part of the process of change
- Use "conflict" to promote positive change
- Weighing **pros and cons** of one's behavior
- Increasing discrepancy

Decisional Balance Evolved

- New perspective = Counseling w/ neutrality
- Used when a clinician consciously takes a neutral stance rather than directing change
- Goal: to resolve ambivalence and make a decision
  - ***IS NOT*** to guide a patient in a particular direction
  - ***IS*** to explore both pros and cons of change thoroughly to assist patient in making a difficult decision

DECISIONAL BALANCE WORKSHEET

No Change	*Change*
PROS (Behavior)	PROS (Change)
_____	_____
_____	_____
_____	_____
CONS (Behavior)	CONS (Change)
_____	_____
_____	_____
_____	_____

Decisional Balance:

Advantages of smoking:	Advantages of quitting:
- It's my coping strategy for stress - I get smoking breaks - It's a social outlet - I enjoy smoking (taste, meditation, smell, etc.) - It's easier to keep smoking than quitting	- I'll breathe better - I won't hack and cough - I'll be more athletic and healthy - I'll save money - I won't have to worry about running out of cigs
Disadvantages of smoking:	**Disadvantages of quitting:**
- I get winded and cough while working out - My allergies and health are worse - I spend money on cigarettes - Accommodating my need to smoke is a hassle	- Losing the enjoyment of smoking after being used to it for so many years - Sense of loss and disorganization in routine - Loss of social opportunities

FACILITATING A DECISIONAL BALANCE DISCUSSION

- Accept all answers. (Don't argue with answers given by client.)
- Explore answers.
- Be sure to note both the benefits and costs of current behavior and change.
- Explore costs/benefits with respect to client's goals and values.
- Review the costs and benefits.

PROCESS 4: **PLANNING**

Recognizing Readiness

↑ Importance + ↑ Confidence = READINESS

- Decreased resistance
- Decreased discussion about the problem
- Resolve
- Change talk
- Questions about change
- Envisioning
- Experimenting

Change Plan Worksheet

1. The changes I want to make are:
2. The most important reasons I want to make these changes are:
3. The steps I plan to make in changing are:
4. The ways people can help me are:

Person	Possible ways to help

5. I will know that my plan is working if:
6. The things that could interfere with my plan are:

SO WHAT MAY MOTIVATIONAL INTERVIEWING LOOK LIKE IN CONJUNCTION WITH CBT?

APPLYING MI AT CRITICAL JUNCTURES IN CBT

- Beginning of treatment with ambivalent or resistant clients
- Anticipating (more) exposure
- Chronic or episodic experiential avoidance
- Clients facing difficult life choices (e.g., maintaining or terminating committed relationships)
- Noncompliance with treatment (e.g., response prevention)
- Others?

(SENSITIVE) AGENDA SETTING WITH CBT

- Ask permission to discuss topic

  "I wonder if it would be ok with you if we talked about your strategies to work on the clutter in your home?"

- Explain you will not insist on immediate action

  "I'd like to get a better idea of how you feel about your organizing, donating, and disposing of things. Don't worry, it doesn't have to happen right away."

REAL LIFE CONSIDERATIONS INTEGRATING MI AND CBT

- MI as Preparation
  - MI as a catalyst
- MI as a Method to Work with Ambivalence during Therapy
  - Session attendance
  - Completion of homework
  - Prior to and during exposure treatments
  - Prior to and during behavioral activation therapies
  - Working with sensitive topics (e.g., cultural differences, sexual behavior)
- Synergistic Effects with CBT
  - Building confidence

APPLYING THE 4 MI PROCESSES TO USE IN A CBT SESSION

- Engaging
  - Use core skills (e.g., reflections)
  - Scaling and use of rulers
- Focusing
  - Agenda Mapping
  - Elicit – Provide Information - Elicit
- Evoking
  - Decisional Balance
  - Key Questions
- Planning
  - Reinforcement of Change Talk
  - Envisioning What It Would Look Like to Make Change
  - Open Approach to Experimenting with Change

READINESS TO CHANGE: IMPORTANCE AND CONFIDENCE

- Scaling and use of rulers

On a scale of 0 to 10, how **IMPORTANT** is it for you right now to change?

0 1 2 3 4 5 6 7 8 9 10

Not at all Important — Extremely Important

On a scale of 0 to 10, how **CONFIDENT** are you that you could make this change?

0 1 2 3 4 5 6 7 8 9 10

Not at all Confident — Extremely Confident

EXERCISE: RE-DOING A CBT SESSION

- Choose a partner
  - One is client
  - One is therapist
- Choose a situation in which you were previously feeling stuck
- Therapist uses MI processes and their related core skills
- See what happens!
  - Remember – you are experimenting with change with therapist behaviors that may be new to you
- Switch roles after ~3 minutes

COMPLEX CASE EXAMPLE: *ROLE PLAY IN TEAMS OF 3*

- **Ambivalence about CBT.**
- Samira is a 35 year old Malaysian-American mom of three young children who works part-time as an office clerk.
  - **Please feel free to change the gender of Samira/Samir as you wish.**
- Her husband works full-time and is not engaged in childcare.
- She reports constant worry about:
  - her family's finances
  - the mediocre grades of her eldest son
  - the health of her youngest daughter who has asthma
  - taking care of shopping, cooking, cleaning, and helping the kids with homework
  - maintaining her family's Muslim values in a neighborhood where there are very few Muslims
- You assessed Samira and found out that she has a diagnosis of GAD and MDD, Recurrent, Current Episode Mild.
- When you brought up the possibility of therapy she reported
  - "If I don't worry about my family, everything will fall apart. It is my responsibility to take care of family matters in my culture."

GENERAL APPLICATION OF MI AND SUMMARY

MI IN EVERYDAY PRACTICE

- Integrate in existing service delivery
  - By training a few to all staff
  - Use MI in intake and initial services = retention
  - Diffuse person-centered throughout service
- Workshops are a start
  - Feedback and coaching yield best mastery
- Shifting from directing to guiding style promote the most effectiveness
- Effectiveness is based on fidelity of MI delivery

HOW CAN I EMPLOY MI STYLE IN MY WORK?

- Talk less than your client does (less than 50%)
- On average, reflect twice for each question you ask (2:1)
- When you reflect, use complex reflections more than half the time (about 50%)
- When you do ask questions, ask mostly open questions (about 70%)
- Avoid getting ahead of your client's level of readiness (try to be MI consistent about 90% of the time)

(Moyers, Martin, Manuel, Miller, & Ernst, 2007)

HOW YOU KNOW WHEN YOU HAVE GOT IT RIGHT?

- You are speaking slowly
- The client is doing much more of the talking than you
- The client is actively talking about behavior change
- You are listening carefully, and gently directing the interview at appropriate moments
- The client is actively asking for information and advice

(Rollnick, Mason, & Butler, 2002)

8 TASKS IN LEARNING MI

1. Overall spirit of MI
2. OARS: Patient-centered counseling skills
3. Recognizing change talk and sustain talk
4. Eliciting and strengthening change talk
5. Rolling with sustain talk and resistance
6. Developing a change plan
7. Consolidating commitment
8. Transition and blending

(Miller & Moyers, 2006)

LOOKING TO THE FUTURE

- Full day introductory workshop or advanced one or two day workshop
- Books available
- Practice, practice, practice
- Additional training
- Consultation

WRAPPING UP

- One thing I learned was . . .
- I relearned . . .
- I polished my skills in . . .
- I gained . . .
- I appreciated . . .
- One thing that surprised me was . . .
- I could use MI to . . .
- I am more confident now that I can . . .
- I can't wait to try . . .

For your devotion to your clients and patients, and yourself, in learning about MI, and giving us the opportunity to learn with you!

THANK YOU!

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