

Florida BRITE Project



Motivational Interviewing Advanced Skills

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The Change Process



- What is it?
- Why do we do it?
- Are Substance Abusers Different?
- What are the issues of working with BRITE clients?
- What's our Role?



Why should individuals change?

- There is significant ambivalence
- Hot Stove, or Rolling the Dice?
- The “problems are not that bad”
- Blame & Shame
- Attachment - My Best Friend

Elements of Success

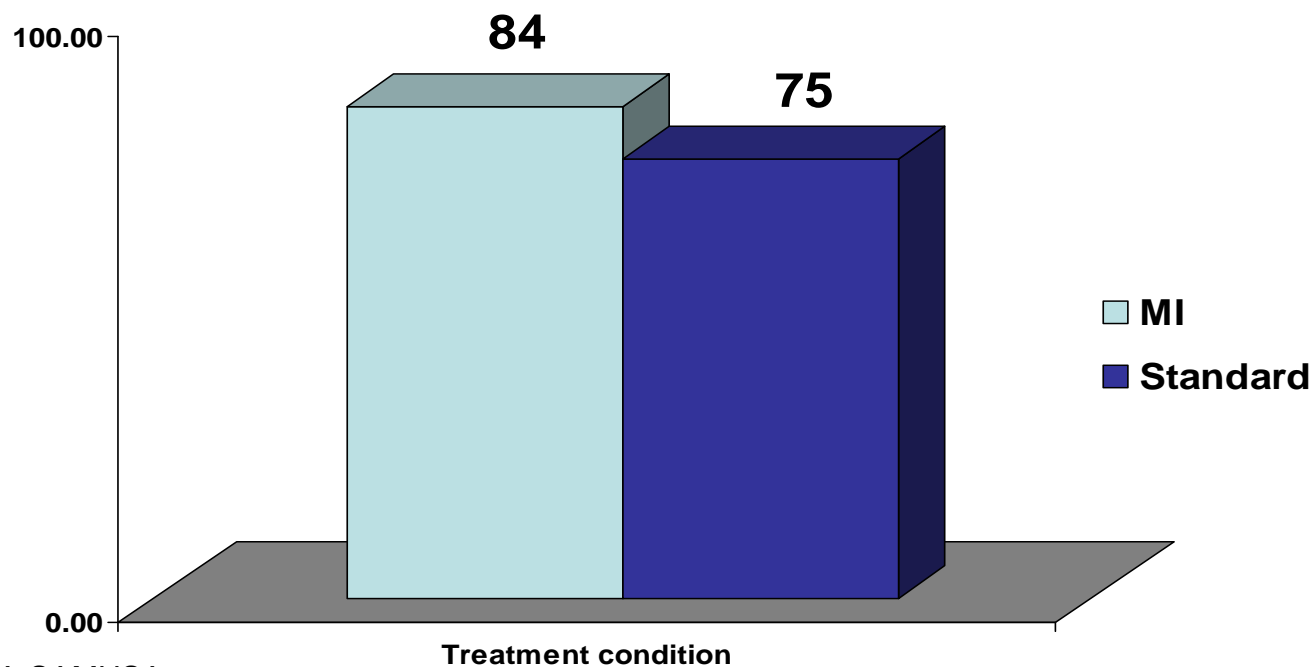


- Engagement
- Engagement
- Engagement



Research findings

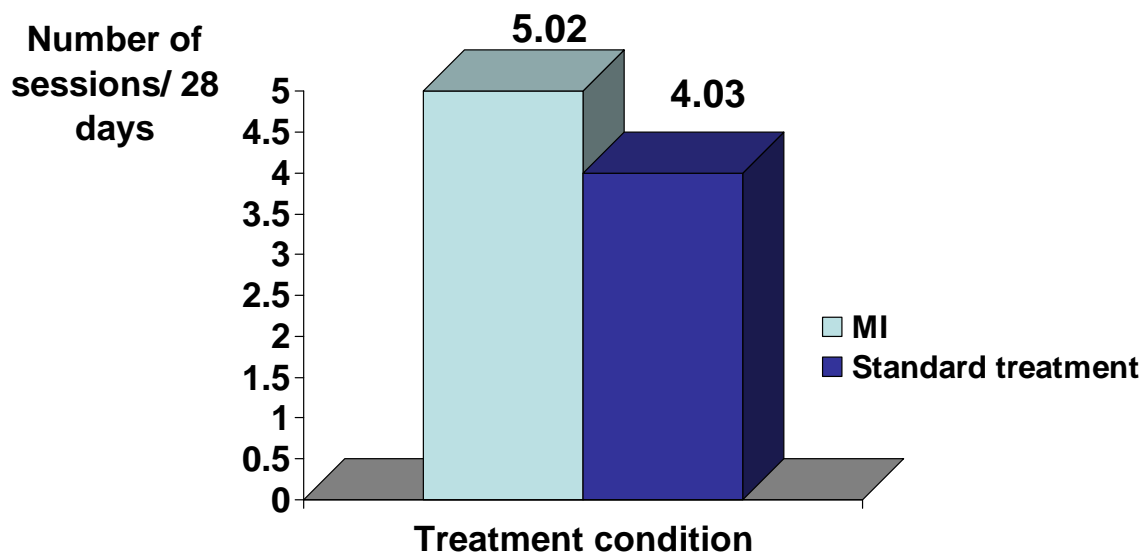
2. MI retained more people in treatment at the 4 week point than standard assessment.





Research findings

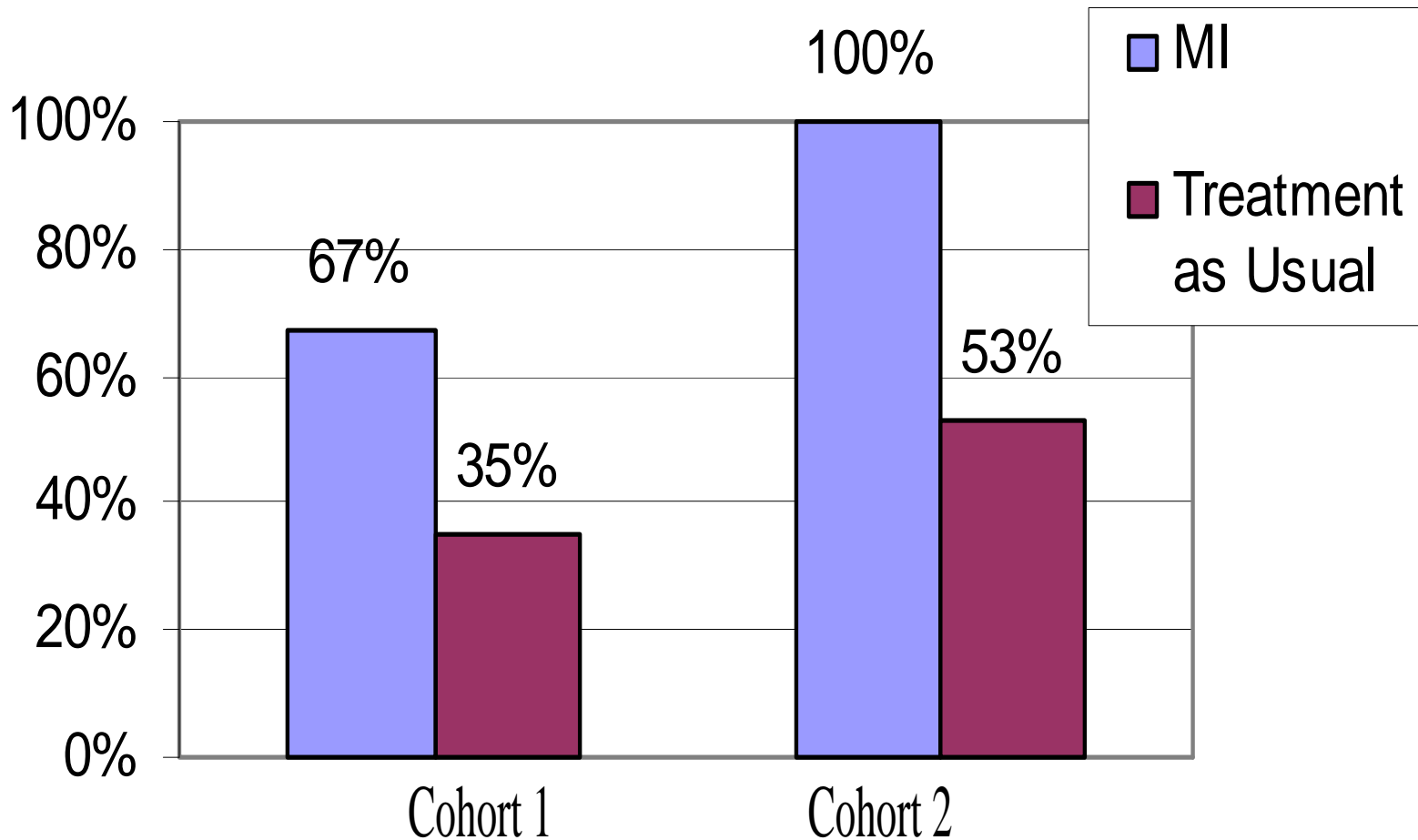
1. People receiving MI assessment completed more sessions in 4 weeks than those receiving standard intake.





Daley & Zuckoff, 1998

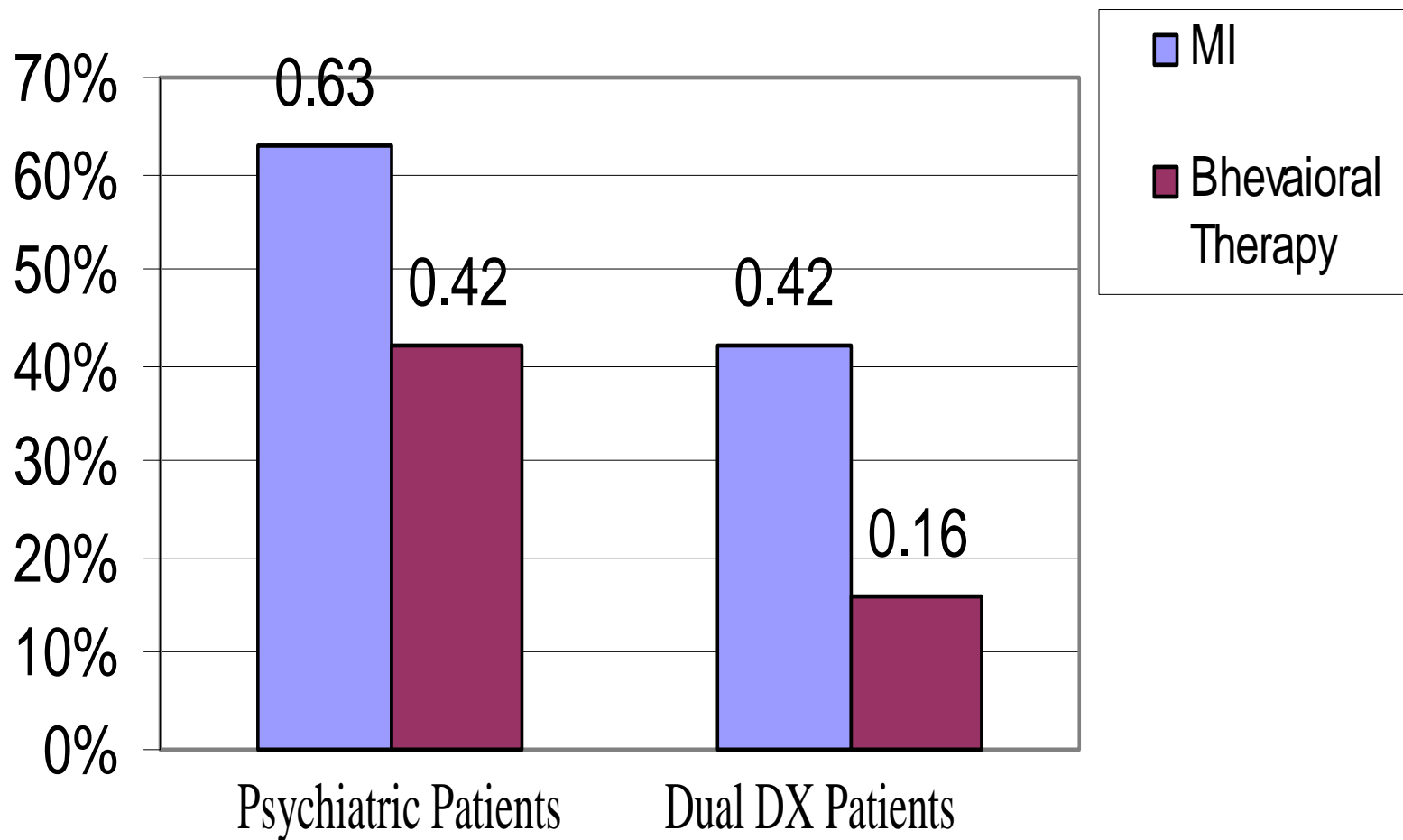
Percent Attending 1st Aftercare Session





Swanson et al., 1999

Percent keeping first Aftercare appointment





What is the **purpose** of EBP?

EBP = Well defined practice and procedures that have proven to help a person achieve a desired goal

When adherence to an identified effective model is achieved, you can attain predictable outcomes

Fidelity



- A lesson in Baking Blueberry muffin
- The degree to which an intervention is implemented in the way it was designed and tested.

What are the Key Change Factors for the Counselor?



Style

–Wrestling?

or

– Dancing?

• Intentional Dancing

–Improvisational

–Counselor “Led”

Express Empathy



- Genuine, Non-Possessive, Warm
- It is not
 - Agreement
 - Sympathy
 - Stating your feelings (a word about self-disclosure)
- What does it do?
 - Communicates Caring
 - Validates the individual and their experiences
 - Builds rapport



Common Mistake

When the client senses the counselor is more invested in change than they are, it destroys a healthy therapeutic relationship

Rolling with Resistance



- Like Verbal Martial Arts
- Resistance is not challenged
- Use the client's energy to take you where you want to go
- Decreases the clients tendency to play devils advocate

MI & Resistance - The 4 R's or Types



Reluctance

- May recognize the need to change
- May see some benefits of change
- May be concerned about the “unknowns” of change
- Need to verbalize their reluctance & be heard

MI & Resistance - The 4 R's or Types



Rebellion

- May have knowledge
- May have highly invested energy in no change
- Need a menu of options
- Need to hear agreement of “of course, no one can make you change, it is up to you”

MI & Resistance - The 4 R's or Types



Resignation

- No energy for change
- May feel overwhelmed & hopeless
- Need to build hope
- Clinicians belief in the clients ability to make change is a strong predictor of positive outcome

MI & Resistance - The 4 R's or Types



Rationalization

- Has all of the answers
- Has assessed the odds and is OK with rolling the dice
- Utilizes “Harm Minimization”
- Arguing or “rationalizing” further intensifies

Stages of Change*



- Pre-contemplation - doesn't see need to change.
- Contemplation- both considers change & rejects it.
- Preparation - Wants to do something about the problem.
- Action - Takes steps to change.
- Maintenance - Maintains goal achievement.

*Prochaska & DeClemente's (1982) Six stages of change.

Motivational Tasks for the Helper*



- **Precontemplation**
 - Raise Doubt
- **Contemplation**
 - Evoke reasons to change
- **Preparation**
 - Help client find best course of action
- **Action**
 - Help client take steps toward change
- **Maintenance**
 - Help client prevent relapse

* Miller & Rollnick (1991), p. 18.

MI Core Competency Consistent Items



Core Items

- MI Style & Spirit
- Open Ended Questions
- Affirmations Of Strengths & Self-Efficacy
- Reflection Statements
- Fostering a Collaborative Relationship/Autonomy

Advanced Items

6. Motivation to Change/Change Talk
7. Developing Discrepancies
8. Pro's, Cons, Ambivalence
9. Change Planning Discussion
10. Client-Centered Discussion & feedback

1. MOTIVATIONAL INTERVIEWING STYLE OR SPIRIT:



- *To what extent did the clinician provide*
 - *low-key feedback*
 - *a supportive, warm, non-judgmental, collaborative approach*
 - *empathic sensitivity through words and tone of voice, demonstrate genuine concern and an awareness of the client's experiences*

6. DISCUSSING MOTIVATION TO CHANGE - CHANGE TALK



- *To what extent did the clinician:*
 - *try to elicit client discussion of change (self-motivational statements)*
 - *Desire for change*
 - *Ability to Change*
 - *Reasons for change*
 - *Need for Change*
 - *Commitment to change*

6. DISCUSSING MOTIVATION TO CHANGE - CHANGE TALK



- *A higher Frequency/Extensiveness rating* would be achieved if the clinician attempts to elicit remarks from the client indicating either recognition of a problem, statements of concern, intention to change or optimism about change. The clinician will often use techniques that are meant to encourage “change talk” on the part of the client. The clinician may also explicitly assess the client’s current motivation to become abstinent or decrease their substance use, especially if the client continues to use.

6. DISCUSSING MOTIVATION TO CHANGE - CHANGE TALK



Examples:

- *Clinician:* “What concerns you about your current use of substances?”
- “What are some reasons you might see for making a change?”
- “What do you think would work for you if you decide to change?”
- *Client:* “My wife really believes it is a problem, so she’s always on my back about it.”
- *Clinician:* “How do you feel about your drug use? What are your concerns and what do you think might need to happen?”

7. EXPLORING PROS, CONS, AND AMBIVALENCE:



- *To what extent did the clinician:*
 - *address or explore the positive and negative effects or results of the client's substance use*
 - *use decisional balancing, complete a cost-benefits analysis, or develop a list of pros and cons of substance use*
 - *express appreciation for ambivalence as a normal part of the change process*

7. EXPLORING PROS, CONS, AND AMBIVALENCE:



This item focuses on the extent to which the clinician facilitated the discussion of specific consequences of the client's substance use. This may include the positive and/or negative results of the client's past, present, or future behaviors as related to active substance use. Specific techniques used include decisional balancing, a cost-benefits analysis, or listing and discussing the pros and cons of substance use. An important stylistic component accompanying these techniques should be the clinician's verbalizing an appreciation for ambivalence as a normal part of the change process?

7. EXPLORING PROS, CONS, AND AMBIVALENCE:



Examples:

- *Clinician:* "What do you see as the positive and negative consequences of your drinking?"
- "You have had a lot of chest pain after using cocaine and seem very concerned about your health, your family, and where your life is going. And you have identified many possible benefits of stopping use, such as...."
- "So by getting high, you feel good and can avoid painful feelings. What are some of the downsides to using."
- "What are the Good things about_____. Are there any not so good things about _____"

8. DEVELOPING DISCREPANCIES



- *To what extent did the clinician:*
 - ***create or heighten the internal conflicts** of the client relative to his/her substance use*
 - *increase the client's **awareness of a discrepancy** between where his or her life is currently versus where he or she wants it to be in the future*

8. DEVELOPING DISCREPANCIES



This item involves efforts by the clinician to prompt the client's increased awareness of a discrepancy between where they are and where they want to be relative to their substance use. The clinician may do this by highlighting contradictions and inconsistencies in the client's behavior or stated goals, values, and self-perceptions. The clinician may attempt to raise the client's awareness of the personal consequences of substance use, and how these consequences seem contrary to other aims stated by the client. The clinician may engage the client in a frank discussion of perceived discrepancies and help the client consider options to regain equilibrium.

8. DEVELOPING DISCREPANCIES



Other common techniques used to create or develop discrepancies include 1) asking the client to look into the future and imagine a changed life under certain conditions (e.g., absence of drug abuse, if married with children), 2) asking the client to look back and recall periods of better functioning in contrast to the present circumstances, and 3) asking the client to consider the worst possible scenario resulting from their use or the best possible consequences resulting from trying to change. Sometime double-sided reflections that bring together previously unrecognized discrepant client statements are examples of a clinician's attempt to heighten discrepancies.

8. DEVELOPING DISCREPANCIES



Examples:

- *Clinician:* "You say you want to save your marriage, and I also hear you say you want to keep using drugs."
- "On the one hand, you want to go out to the bar every night. On the other hand, you have told me how going out to the bar every night gets in the way of spending time with your son."
- "You're concerned about your health, and being in the hospital is clearly not fun, but you are not sure if you need to make any changes in your lifestyle..."

9. CHANGE PLANNING DISCUSSION



- *To what extent did the clinician:*
 - *discuss with the client his or her readiness to prepare a change plan with the client in a **collaborative and timely** fashion*
 - *cover critical aspects of change planning*
 - *identify obstacles to the change plan that might exist*

9. CHANGE PLANNING DISCUSSION



This item measures the extent to which the clinician helps the client develop a change plan. This process may include an initial discussion of the client's readiness to prepare a change plan. It may include a more formal process of completing a Change Planning Worksheet or a less formal clinician-facilitated discussion of a plan without completing a worksheet. worked.

A higher Frequency/Extensiveness rating would be achieved if the clinician guides the client through a thorough discussion of change planning.

9. CHANGE PLANNING DISCUSSION



In either case, the intervention typically involves a discussion that includes many of the following areas: (1) the desired changes, (2) reasons for wanting to make these changes, (3) steps to make the changes, (4) people available to support the change plan, (5) impediments or obstacles to change and how to address them, and (6) methods of determining whether the plan has worked

9. CHANGE PLANNING DISCUSSION



Example:

- *Clinician:* “So, it sounds like you have made a decision to stop using drugs and reduce your drinking. Let’s spend some time figuring out a plan that will help you get started working toward that goal. What is the first thing that comes to mind?”
- “What do you think might get in the way of this plan or make it hard for you to continue to make these changes?”

10. CLIENT-CENTERED PROBLEM DISCUSSION AND FEEDBACK



- *To what extent did the clinician:*
 - *facilitate a discussion of the problems for which the client entered treatment*
 - *review or provide personalized, solicited feedback and the evidence or indications of problems in other life areas*

10. CLIENT-CENTERED PROBLEM DISCUSSION AND FEEDBACK



This item involves explicit attempts by the clinician to inquire or guide a discussion about the problems for which the client entered treatment. This discussion can include both the substance use as well as the many related problems in living that are associated with substance use. The clinician facilitates the development of a full understanding of the nature of the client's difficulties.

10. CLIENT-CENTERED PROBLEM DISCUSSION AND FEEDBACK



This process may involve the review of assessment results obtained during prior clinical assessments, worksheets completed by the client, or more formally through use of specific feedback forms. The method is less important than is the task of learning about the client's problems and providing feedback to the client about his/her problems in an objective, client-centered manner. The clinician guides this discussion and provides feedback using a non-judgmental, curious, collaborative client-centered style. If the clinician provides formal feedback, the clinician implements this strategy only when solicited by the client or when seeking the client's permission first.

10. CLIENT-CENTERED PROBLEM DISCUSSION AND FEEDBACK



- **Examples:**
- *Clinician:* “I wonder if we might start by your sharing with me some of the concerns that brought you into treatment. What brought you into treatment?”
-
- “You have given me an excellent description of some of your concerns. I would like to put this information together with some of the other information you provided when you began this study so we will both have a complete view of what might be helpful for you. Would that be alright with you?”

MI **In**-consistent Items



11. Giving Unsolicited Advice, Directions or Feedback
12. Emphasis on Abstinence (SA Only)
13. Direct Confrontation & Creating Resistance
14. Powerlessness, Loss of Control (SA Only)
15. Asserting Authority, Arguing
16. Use of Closed-Ended Questions



Questions?

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