UFL
Motivation Interviewing Webinar

Good afternoon. Welcome to today's webinar, "Motivational Interview, Guiding Positive Change in Patient Behavior," sponsored by the Southeastern National Tuberculosis Center. My name is Meghan Nodurft-Froman. I'm a training coordinator for the SNTC.

Before we begin, I'd like to do a few housekeeping items, go over them, so that we're clear on any questions that might be out there. Today's event is scheduled for 1.5 hours, including the question-and-answer period at the end of the presentation. To verify your participation in this event, please provide your e-mail on the bottom of the pod that's in the left bottom corner of your screen. If you provide us with your e-mail address we will send you an e-mail with the link to the online evaluation following today's presentation. Please be aware that you must complete the online evaluation by 5:00 p.m. Eastern time on Friday, November 22, if you want to receive nursing or physician credit.

You may submit questions for the speaker at any time during the presentation by typing your question in the Q&A pod. Questions will be addressed after the presentation. Thank you so much for joining the Southeastern National Tuberculosis Webinar's today. Now I'm going to turn this over to Tennessee's TB Controller and immediate past president of the National TB Controller's Association, Dr. Jon Warkinten. Dr. Jon?

Hello everyone. It is truly an honor for me to serve as the moderator for this webinar and one in a series, a very notable project of the Southeastern National TB Center. I was going to begin by saying good afternoon, which is what it is here in Nashville, Tennessee, but I see that we have participants as far east as Ukraine, as well as the West Coast of the United States, and from north and south across the U.S. So wherever you are, good morning, good afternoon, good evening, good night, and welcome to the webinar today.

Our topic today is "Motivational Interviewing, Guiding Positive Change in Patient Behaviors." The instigation, if you will, behind this webinar was our issue here in Tennessee, and I suspect many of you share it, in dealing with individuals in our practice of TB control and prevention who have issues which we might think distract them from our goal of them completing their therapy, being treated, and cured, as well as protecting the public. And for this reason, we've asked Dr. Ann Landes to join us today as our resource person, and it's with pleasure that I share with you some details about Ann's background.

Dr. Ann Landes is currently a primary care psychologist at the Malcom Randall VA Medical Center in Gainesville, Florida, where she is an active member of the Interdisciplinary Primary Care Psychology Team. After earning her doctoral degree in counseling psychology at Georgia State University, she went on to receive her internship and postdoctoral training doctoral at the Audie L. Murphy VA in San Antonio, Texas. It was during these training years that she specialized in behavioral health psychology.

Currently, Dr. Landes remains focused on program develop and the provision of individual, couples, and group interventions for veterans and their spouses, for issues such as behavior health promotion, post-deployment, reintegration, and posttraumatic stress. Her clinical research and training interests includes primary care behavioral health, positive psychology, couples and family resilience, and posttraumatic stress disorder. So it's my pleasure to welcome Dr. Ann Landes.

Hello everybody. Thank you so much for joining us today. I feel very honored to be able to come here today and speak to you about a topic that's very dear to my heart, which is motivating change and motivating collaboration between us and our patients. So I'm so excited and I thank you for welcoming me into your group.

The picture on the first slide, actually, the title slide, is actually a picture that represents the interaction between TB and drug interactions. And to me it was such a beautiful picture to be begin with, but what it shows, in my mind, is a symbol of what we have to deal with when we actually engage any kind of professional relationship or personal relationship with our patients. There's so many factors that go into their decision making, the way that we interact with them. And so as we go through slides, I want you to consider all these factors that we have to consider as we make these decisions as we help to move them towards positive change.

The heart of motivational interviewing is what I'd like to start with. It's really about allowing the patient, or the client, or however you'd like to refer to them, to guide us as we guide them, to remain engaged in what I call a "dance," because it is a collaborative effort. And I hope that you can appreciate the joy on the faces of these Peanut's characters, on how happy they are in collaborating.

Another aspect that I've done many hours, hundreds of hours of training in Motivational Interviewing on various topics, and one of the basic questions that I have from medical providers and staff is, "Why? What's the benefit to me?" And one, I thought, first, it help us to establish a firmer foundation for later work and collaboration. It really is the foundation. Many of the providers who have taken my course have come back later and said, "You are so right." What has happened is, if I lay down the foundation at the beginning, my work is done up front. And as I do follow-up visits there really aren't as many questions and complexities as there would be if I hadn't addressed them to begin with.

Two, it strengthens the provider/patient interaction. It says we're all on the same page. We're looking in same direction. We're looking at the same thing and making sure that we all agree. It's a map of where we want to go. It clarifies our roles and responsibilities. And three, it provides good outcomes and it's actually evidence based, and I'll talk little about that later.

So what are learning goals? Today we're going to start by talking about what is motivational interviewing, the basic, basic definition. And I hope by the end of this session you will state at least one to two applications to the health-care management of TB. Number, two, to identify the spirit of MI in your interactions and, hopefully, some of the tools that you'll use that you'll learn through this seminar, and it's four primary processes. And three, identify at least one MI skill that can be employed to guide and address patient ambivalence towards change, and we'll talk about what ambivalence is.

So, essentially, what I want you to think about is, pick a tool, any tool and just wear it out like an old pair of blue jeans. And I hope that you can see that. This is where I want you to tailor these tools to who you are. My goal today is not that everyone walks away from this seminar being all little Ann Landes', because everyone's different, and that's the beauty of who we are as we bring ourselves into this field, it's how can we uniquely provide care and suffering and guide people about better lives.

So we are now going to poll the audience, yay. So I'd like for you to actually look at this. Please now mark the statement that describes you; A, I have attended at least one other training in Motivational Interviewing; B, This is my first training in MI (and I am ambivalent); or, C, This is my first training (and I'm very excited). So hopefully you all can see that. Yay. So it looks like the majority of people actually say that this is their first training, and they are very excited. All right, thank you. Wonderful.

So I want to start with a disclaimer, because I know that -- again, I've taught hundreds of hours of this, and we have a lot of questions about well how about this situation, how about this situation, very different vignettes. As we all know, remember all the little dots that I showed at the very beginning of the slide, there are a lot of different dots out there, and the dots represent a whole bunch of multifactorial combinations. So the disclaimer for this presentation is, one, when using any tool or intervention, please exercise clinical judgment. What that means is know your patient, know the environment, know yourself, and make sure that whether or not this is the right tool for that exact situation. Okay? Such is the case with MI, for example.

Some circumstances may present a lot of challenges and may actually be a major barrier to employing motivational interviewing. Here are some cases. I put dire cases that request immediate decision making or actions, okay. These might be imminent life and death issues. I'm a psychologist. If someone walks in my office and says, "I really want to kill myself," I'm not going to use MI at that moment. I might use it later on when he or she comes back to my office to talk about how we can reduce the likelihood of self-harm.

Catastrophic consequences, emergencies, what I call outliers, and what I like to refer here is massive hierarchy of needs. The bottom layer is the basic what we need. We need food to survive, and water. The

next one is protection and safety. So if the person that is sitting across from you, they don't have that, more than likely MI is probably not going to work in that moment. So just keep that in mind.

All right, getting personal. I want you to sit of breathe wherever you are, on your couch, on your floor, or in your office, relax and breathe, and I want you to think about the type of patient or patient issues that get you stumped, okay. This is where I kind of picture the symbolic shot to the stomach, this punch to the stomach where your air is sucking out of you and you kind of sit there with your mouth gaping open. Okay, as we go through these slides in this class, try to picture this individual or the situation, and try to apply at least one MI tool to this issue.

All right, so right now, depending on what timeframe you're in, right now at this moment in time, I want you to think about this question, on a scale of zero to ten -- all right, zero being not at all, ten being absolutely -- how important it is to you to learn skills in motivational interviewing to assist you in your practice? Zero being, "none at all," ten being, "absolutely." So you might have to scroll down to get to number ten. The screen, I think, is a little bit. I'm a little small. So this is the importance to you, no right or wrong answers. All right, so it looks like number ten, we have about 50% of people say number ten. Wonderful. Wonderful, thank you.

All right, so the next question will be right, now in this moment in time, on a scale of zero to ten again, how confident do you feel -- now this is very moment in time -- in your ability to use MI with your practice of care? Remember, there are no right or wrong answers. All right, so it looks like we're falling around the five mark, about 22% of the people, yes. So we're looking, that's a very nice number. All right, thank you. All right, this is fun. I like doing these pollings. Thank you for engaging.

All right, so we're going to go on and we're going to look at the first concept of what is motivational interviewing, and I have a picture of this person standing at the crossroads scratching his head, because we are all at crossroads. We all have decisions to make every day. And it's so salient, too, when we have a major medical condition like TB.

So MI is an evidence-based clinical method found to be effective at promoting positive behavioral lifestyle changes while addressing what we call "patient ambivalence." Patient ambivalence is feeling more than one way about a situation. For example, you might be ambivalent that you're sitting inside on a beautiful day, and, yet, you want to be here. You might be actually wanting to watch some kind of "Lost" series on TV, and, yet, you're here also wanting to learn. So ambivalence is feeling more than one way about something. Everyone has ambivalence, especially when it comes to change.

MI is about collaborating, about having a person-centered practice approach and is guiding our patients to an intrinsic motivation. When I say "guiding," I mean picture someone helping someone across the road who might be elderly or blind. You take them behind the elbow and you guide them along. You don't pull them, you don't push them, you don't lead them, you guide them. It's collaborative and it's person-centered, meaning that you're engaged with the person and what their values are.

So right here is the next slide about TB motivation and change, and I chose the picture here about a waterwheel because sometimes, just like that picture on the very first slide of all those dots, when we work with patients with chronic or severe illnesses, we may feel as if we're all grasping for a waterwheel. It may seem impossible, and, yet, it looks as if people are actually doing it here in this picture. Great things can happen when you work together.

All right, so the research shows that TB is a disease that impacts the individual and the system. So we're talking about the sort of the Ross and Bruner's micro/macro systems, method systems. All the systems that they are embedded in are impacted, so it has a medical and social issue to it. Research shows that the patient's first reaction to the diagnosis according to Eram in 2006, is one, 30%, tension and anxiety; 26%, loss of interest; 6%, denial; 20%, I just can't, I don't know what I'm feeling; and 18% quite hopeful, and, also, I want to add, do you watch suicidality and hopelessness.

So why am I asking about this? The reason I'm presenting this about the reactions is when we work with veterans -- or I'm sorry -- with patients in general, their reaction to the diagnosis is very important to gauge, to see where they are in the process for you to be able to guide them and be where they are, because it's very important to engage with the patient. If the patient is at one stage and you're at another stage, you're not going to match, and it actually may be really hard to actually move forward.

So here are some factors that impact motivation for change related to TB. It's very important to realize, again, because when we're working with a patient, when we're trying to engage them in the process of maintaining engagement with us, we have to realize that there are a lot of dots out there, a lot of dots. The first dot might be physical. They might be struggling with fatigue; lower strength; having to do with healthy choices, I never had to eat healthy by and now I have to; sleep issues; comorbid medical issues and pain. The other areas, psychological, emotional, cognitive. There might be the fear of stigma or discrimination. Oh, I can't speak about this because no one will understand, and that might be coming from a cultural sense as well, as far as from a social stance.

Motivation or lack of motivation can lead to long-term adherence barriers, lowered self-efficacy and sense of powerlessness or helplessness, and that might come from, "Well I can no longer work because I'm so tired," and so there's lowered self-efficacy. They can't identify who they are without them working, and paranoia. And, again, that might be something that comes from a political background. Maybe they come from a country where having TB was highly frowned upon and you weren't going to be treated, and being found out by the government could have been very dangerous. So think about all those issues.

Further psychological, emotional, and cognitive issues include dependence on abusive substances. Are they misusing substances to self-medicate? Are they depending on it to deal with the depression? Their perception is going to be very important. As we all know, how we see our reality is our reality. However, as providers, it's very important for us to ask questions. Motivational interviewing Invites their story. What's your perception of the disease? That perception right there will guide you into the next step of treatment and change.

Depression, anxiety, anger, change in identity is another area that we have to be aware of. Reduced concentration, problem solving, decision-making ability, they're just tired. The treatments are very hard. As you all know, the treatments have very bad side effects and can leave a person feeling very, very paralyzed in their ability to functions; and reduce quality of life.

So what are the social, cultural, and occupational, financial issues? Isolation, lack of social support. There's that stigma. Is it contagious? What happened? It could be a religious or spiritual type of thing. Well they must have done something wrong. Ask the questions. Ask the questions. Decreased ability or inability to work, family and emotional strain because of the finances or not just understand thing disease, and the financial stressors.

So when we look at motivation interviewing and we look for areas to consider for change, some areas to focus on might be healthy choices like diet, exercise, stress management, coping and management of depression and stress, and adherence to physical, mental, and emotional treatment, and social connectedness. So those are just some made areas. I'm sure you'll have more as we go along, but these are the four that I thought would be nice to start with for your thinking.

All right, as we go along, things to remember, things to remember, there's a big scary picture here of a monster, well several monsters. I want you to remember that ambivalence accompanies change. Change happens to everybody on a large and small scale every day, so change can be scary. Change can be seen as a monster. And what I want you to be aware of is, as we work with our patients, don't become the monster. And the way that we do that is to continually be aware of where you are in the process, where you want to be, and making sure you don't put anything on the patient that they don't want. Okay?

And also very helpful to remember, we as providers are not responsible the change. I'm going to say that again. We as the providers are not responsible for the change. We are there to help them to collaborate,

to guide them, but, essentially, they will be responsible for that. And I'll take to you later about why that's so important.

All right, yes, yes, yes, yes, one major point is quality of communications. Research shows -- I have the link at the bottom -- a positive relationship between patient and provider greatly impacts patient adherence, very important. This is why Motivational Interviewing is so important for us. Some keys to success, focus on the spirit of MI, okay, the stance towards your patient. Be aware of where the patient is. Are they in a place where they want to go where you want to go? Okay. And where are you? Are you pulling them, pushing them, or are you guiding them? Be aware of where the patient wants to go and where you want them to go. Remember, don't be the monster. Don't be the monster.

So the spirit of MI, autonomy,focusing on patient choice. Are you allowing them to make decisions, even if those decisions and those choices don't resonate with who you are as the provider? And I know this is very hard for the area of TB, but remember, MI is not about those dire situations. MI is about times where you can help them grow and make the right decisions. And even when it seems dire, make sure you respond in a way that keeps the window open. Asking permission to provide assistance, and this is going to come in the way of, "I know that you just got a diagnosis of TB, and I'm wondering if you would mind me sharing with you some information about that." Again, you're inviting them to be a collaborative partner with you.

Collaboration, coming alongside in a non-judgmental, non-confrontational manner. You've viewing who as an expert? You're viewing the patient as the expert, because they are the expert in your lives. You're the expert on TB, but they're the expert in their lives. Evocation is exploring what motivates the patient, making no assumptions at all about what their world view is, and appreciating their ambivalence. All right. Ambivalence means they're rocking back and forth. They're saying on the one hand and on the other hand.

So the other main point I want to make is carry your own ball. Everyone has a beach ball, and this means you want to be responsible for your ball. Patients will come in and say, "You're the expert, show me what to do." Make sure that you hand them back their ball at the end of the session, or as soon as they say, "You're the expert," hand them back the ball, and we'll show you how to do that. This helps you to decrease burnout. This helps you to increase collaboration empowerment of the patient.

All right, so now that we've talked about the four MI spirits, we're going to take another poll of the audience. Of the four MI spirits that we just spoke about, nurturing the patient, nurturing patient autonomy, collaborating with the patient, practicing evocation, or appreciating the patient and your own ambivalence, which one do you think is the most important? Oh, I love this. So we are seeing a resounding, yes, for collaborating with the patient. Wow, about 75% right now. This is exciting. This is like election night. So very nice, thank you. Excellent.

So as you think about your important piece, focus on how you can do that. All right, so the four processes of MI, we're going to move on. What are the processes of MI? Engaging, focusing, evoking, and planning, and we'll talk more about those in a few minutes. All right, so engaging, what is engaging? It is about listening to understand, listening for what the patient has to say, and there is an acronym called "ROAS." It's R-O-A-S, and I'll talk more about that in a few minutes.

The second part is focusing. This is where we have, both of us looking in the same direction, okay? You're looking not at each other but you're looking in the same direction, goal setting. DARN-C, that be another tool that we talk about. Evoking; selective eliciting, responding, summaries toward what we call "change talk," again, DARN-C. This is kind of where you pull from the patient their desired change and for planning. So realize that processes one through three are necessary to be considered MI. However, four, to me, is just very important as well, because you're moving them forward. All right.

So process one, engagement and collaboration, okay. This is where you're building the foundation, and you're saying, "Please tell me your story." And this is where you practice mindfulness. Set aside your biases. Be open. At this stage you're saying, "I am going to listen, and I'm going to understand." I know

you have a lot of mandates. I know that you have a lot of legal issues that you have to deal with; however, as the provider, at this point, invite their story. Suspend judgment. Two, encourage dialogue, make it safe. Ask, open-ended questions, questions that can't be answered with a yes or no. Use empathic listening and responding. Nothing judgmental, you, you, you, or you should, you should, you should, those are not very good.

Connect to genuine affirmations, and we'll talk more about that later. And then check that you're on the same page; all right? Once in a while, check in, making sure that you hear what they hear and that they hear what you're saying; okay? Summaries and highlight themes of change is very important. Again, the most basic part is letting them know that they are understood and they are being heard, engagement.

ROAS: R, the first R, listen and reflect back what you hear. When a patient yells, for example, "I hate these drugs," you might respond in two ways. Two levels of reflection, simple, "You don't like taking the medication," simple reflection. It's almost a parroting. You're just saying, "I hear you." The complex reflection really has an emotion added. This is where you have to sort of guess, and it's okay to be wrong, just guess. Again, this is getting them engaged. "You feel very angry about having to taking these medications." Okay, so those are two levels, and we'll talk more about that later, but the two levels of reflection.

So when you engage, reflections do this. They invite them to tell their story to participate, to generate more change talk, to focus on collaboration instead of you taking charge. Remember, you have your own beach ball. You want them to have their own beach ball. It's great for addressing ambivalence. On the one hand I feel, and on the other hand I feel. Research has shown that when we do Motivational Interviewing, the best ratio is two reflections to one question. So they say something, you reflect. They say something, you reflect. They say something, again, you ask an open-ended question. That's what they show. I know the tendency is to ask questions, questions, questions, and, yet, what they show is the best practice is two reflections to one question.

All right, O&A, pose open-ended questions; for example, "How do you feel about receiving diagnosis of TB? What difficulties do you face in adhering to the treatment?" Open-ended questions, you're asking them to tell you more. Three, provide affirmations. These affirmations are not confirmations of what they say. People get really confused during training because they think I'm saying give a confirmatory statement. I'm saying affirmations. You might say something like, "You've done so well attending your appointments. You look more at peace since deciding to tell your family about your medical condition." This is where you're really helping to build them up, building up their confidence.

Confidence building is very important in MI, because you're building a relationship. So in affirmations you're building them, their confidence up in themselves, and through confirming them, you're building their confidence in you. It's a two-way street. Many times, as you probably realize, is I know, for me as a psychologist at the VA, I find that the veterans who come see me, they often live alone, they have a lot of different issues, and I may be the only one that gives them positive affirmation. I might be the only one that's seen them in the entire month that gives them positive affirmations, because they just suck it up like dry land. So, remember, you have a great impact there.

Summarize; for example, if a patient says "My life has changed too much already, now you're telling me I have to quit smoking and drinking." No, what you do is you take everything you hear and you summarize it. You want them to hear that you understand and you hear them. You might say something like "You're upset because so much has changed in your life since your TB diagnosis, and you don't want to give up yet another thing, especially something you enjoy." Again, you're captioning the feeling, you're captioning what they're saying. When you do that, you pause and you ask them, "Am I hearing you clearly." And then that's the engagement. All right.

So going on to open-ended questions to promote change. As I go through these, I want you to mark one or two that you find that you could use in your toolbox. Remember, wear it off, an old pair of blue jeans. If this is one thing you use the entire time you do MI, use it. So the first one is disadvantages of status quo. This is an open-ended question that says, "How do you feel about your current situation?" How do you

feel about" -- you're asking about how does it feel to stay the same. Number two, advantages of change. "What would you think the benefits would be for you if you were to start or if you were to stop." Okay? So you're asking them to think about, just sort of role play with you, "What if you did," you're inviting them to think outside the box. "Or how might things be different for you if you did make the change?" Okay?

So you 'asking them the look at change. And you might -- you probably will receive some resistance, because people don't want to go there. And, yet, what you're doing is you're planting a seed, because the next time they go to Publix or Wal-Mart and they reach for that thing that they know they're not supposed to go for, or they decide they're going to skip their TB appointment, their treatment, they're going to hear you ask that question. So you're planting seeds.

Optimism for change. As you can see, I've highlighted the word "now," because what you're planting the seed is, is what makes you feel like now is a good time to try something different. Now this question may not always be applicable at the time, because they may come back at you and go, "I never said now is the time." However, if you use this, remember, the important word is "now," because you're planting the seed, because you want to say, from this day forward, where will you go and how will you do it.

And then the other very powerful question that I've used in my sessions is, "Okay, so how would you know if now is the time to change?" So they're saying, "I don't want to change." You could say, "Tell me when the time is to change." Again, you're planting a seed.

Intention to change, what would you like to see happen? Again, all these four questions really focus on the you or the patient. You're asking them. You're giving them back the beach ball. What would you like to see happen, and how would you know when the time is right to change?

So now let's check. Okay, in MI, here's a question. When we engage the client, we -- okay -- ask a lot of closed-ended questions to give out our best advice; make sure to be judgmental and critical of the patient's experience; reflect what the patient says, ask open-ended questions, provide affirmations, and summarize what the client has shared; summarize and highlight themesof change; or E, both C and D. So let's see what the answers are. Ah, we're seeing a trend. Very good. Very good. The answer is C and D. Very nice.

Remember, open-ended questions, withholding judgment. Don't criticize. Remember, we don't want to be the monster. And reflection and summarize it. So the big thing is looking at highlight themes of change, highlighting themes of change.

All right, process two, focusing. So we just got through engaging and collaborating. Let's focus. Let's focus. This is where we spend an agenda. We're not going to spend a lot of time on this section, because I want to spend more time on engagement and evoking. But focusing is really looking at strategic goals. This is about not directing but guiding. This is about having a direction. So instead of coming and saying, you know, a very random off-handed question, you would ask an open-ended question like, "The last time you were here and you expressed ambivalence about starting treatment, what are your thoughts right now about it?" You're focusing the agenda; okay?

So open-ended questions for agenda setting might be the person comes and sits down and they have this laundry list of questions, or they look concerned. "Well what would you like to make sure we take care of today? What are your primary concerns? What's most important to you for us to work on? What would you like to change, or where would you like to start?" So you're handing them back what? You're handing them the beach ball.

So here, I love DARN-C. DARN-C is a tool for listening for and evoking change talk. Change talk, here we go, is D, desire. I want to learn or manage whatever, fill in that blank, better. A, ability. It will take a lot, but I can do it. R, reason. I just can't go on upsetting my family. I know it's important that I complete the round of treatment. N, need. I'm always in pain. I don't like the way the medication makes me feel. Something needs to happen. And C, commitment. I'll look into childcare options so I can attend my medical sessions. Okay?

Now the next slide, where I is my -- all right. So DARN-C is listening for patient motivation or energy. Energy is very important, because wherever someone puts their energy is where they're willing to go. Gather information about what's important to the client. Listen to them. Identify what barriers may exist, both internal and external, and ask questions in order to move the patient towards what's acceptable to them. Remember their beach ball, what's acceptable to them may be not acceptable to you at this point, and, yet, remains hopeful to move in the right direction. So a question you might ask is "What have you done to help to this point" -- wait -- "What have you done to this point that helps? What can be done to move you forward?" That might be a nice DARN-C question.

Okay, so here is a knowledge check, the little guy with his book over his head. So this patient comes in and says, "I do want to feel better so I can spend more time with my children. I just have to find the time again to attend my appointments." Tell me if you hear DARN-C.

Just one second, it's taking me a little bit of time to get this one up. Give me just a second.

Oh, that's fine. Thank you. Very good. Now this was a little tricky one, because I know a many people say there is a desire. The answer is, actually, it's more desire, you're right. You could also make an argument for DARN and C. The desire is she wants to feel better. The ability is that she, in the past, has attended her medical appointments. Okay? The reason is for her children, and the need is that she wants to spend time with her children. That's the need. And she needs to attend appointments so she can feel better. And there is a commitment. So this is a little tricky one. But you're right, there's a big desire component. In this one there's actually all five components. Very nice.

All right, so let's do a practice scenario; okay? A patient comes in and says "I've been consistently taking my medications and coming to appointments during the last six months, and I feel great. I feel great. I feel cured. It's a relief, really, and I've decided to stop taking the medication. They make me sick anyway." Okay? So go ahead and tell me what you feel there. Is it D, A, R, N, C, or no change? Yes, very good. The majority said R, reason. Yes, R is the right answer. You could also make an argument for all of them. D is the desire, consistently taking medications and attending appointments. They're saying they do that. A, that have done it for the last six months. R, big one, I want to feel better. I want to be cured. N, the need, I want to be cured. And C, I'm doing what I can. Have done it, and I know I can do it again, but they make me sick. So there is a C there too as well, but very good. You are all doing very well.

Okay, so here, a reflection, what might be a reflection? So the patient comes in and says, "I've been consistently coming in and taking my medications and coming to appointments, during the past six months, and I feel great. I feel cured." So how would you respond? Give me the best response in MI. Is it A, what I hear you say is that you feel better after six months and now you want to quit the medication; B, you're feeling hopeful about your improved physical health, and, because of that, you think it's time to stop taking the meds; or, C, you think you're cured.

All right, so it looks like the majority of people so far have chosen A. Both A and B are very good reflections. B, however, it shows it would probably work more because it's more affirming. It adds more depth to it. In A it doesn't actually bring in the emotions or actually feeling at the time. So B says you're feeling hopeful. So both A and B are excellent choices. C is just a little of an assumption. It's kind of very simple. You're cured. Very good.

All right, so let's practice some open-ended question. So she says, "I've been consistently taking my medications. I'm coming to the appointments." Okay, how would you respond with an open-ended question here? A, what might be some possible benefits to completing your treatment? B, how do you know what's best for you at this time? C, how would you feel if quitting your medication could lead to a quick death? Very good. Everyone chose -- very good, A; correct. Very nice.

All right, A is the best because it shows advantages of change. Okay? B would work as well, but A is probably best. C is a little scary. It's a very different stance than what we want to take in MI, because right

here you're actually bringing in almost a veiled threat to their well-being. Very nice, you all are doing great.

All right, let's look at an affirmation. The same patient comes in, "I've been actually taking my medications and coming to appointments." Would you choose A, you really don't see a need to finish treatment; B, you want someone to applaud you; or, C, I can' tell you've worked hard to attend your own health and it's paying off. Yay, ding, ding, ding, very nice, 100%, ding, ding, ding.

All right, let's do one more. Summary: Okay, the same patient comes in and they say -- they say this to you, okay, "I've been take my medications." What would you say as a summary? A, is it showing up?

Donna, can you pull up that.

A, you're excited about being cured; B, you have been committed to your health and are seeing definite benefits in the medications and the medical appointments. You actually feel so good you believe it would be okay not to complete your treatment. There is a sense of self-relief, or relief because you feel that now is the time to stop taking the medications that are causing side effects; or, C, I can see how hopeful you are, and now I understand why you're trying so hard to convince me about your reasons for wanting to stop treatment.

Yes, so it's B. A, it's a good one. It would be a nice complex reflection, a nice simple complex reflection. You're excited about being cured. B really pulls together everything. B pulls together all the thoughts, it adds feeling, and C is another one; however, it is a little shorter, and it doesn't really capture all the main points. And in a way, you could come across a little bit misunderstood by the patient as far as you're trying to convince me about your reasons for wanting to stop treatment. So B really is more of the MI spirit, very nice.

All right, process three, evoking. So we've gone through collaboration. We've gone through focusing. Three is going to be evoking. This is where we have these little cute little guys that hold up these questions marks. This is where you're listening or asking in order to encourage change talk. This is where you maintain, what we call an "open stance," evoking.

So, again, here is that DARN-C. DARN-C, evoking with open-ended questions. As we go through this, put a star by one or two item that is you might -- questions that you might use in your process; okay? Desire, what are some reasons you might want to work on clearing up your infection, you know, for example? Ability, how about you go about increasing your physical activity. Reason, what do you see as benefits to being honest with your medical team? Need, how important is it for you to adhere to your treatment plan . And C, what might you do to help remember to take your medication. So desire, ability, reasons, and need, these are DARN-C open-ended questions that help evoke or pull change talk.

All right, evoking change talk, here is another tool. Exploring where the main emphasis should be. This is -- remember that earlier I asked you on a scale of zero to ten, how important, on a scale of zero to ten, how confident? The reason I hoped the session up with that is because this is a very, very basic tool. It's called the "ruler exercise." And most of you, I'm going to say the majority of you, probably know the national pain scale, so this is a very common comfortable tool for patients to use. So what you might ask, for example, when you talk to a patient is, "On a scale of zero to ten, how important do you feel it is to," for example, follow the treatment protocol. "And on a scale of zero to ten, how confident do you feel in your ability to follow through with the treatment and the plan for action?"

When that happens, for example, let's say you see a patient and you say "On a scale of zero to ten," and they say, "Oh, I'm a five as far as importance in completing my treatment." Okay. This is what you want to do, you want to follow up with some questions with the patient and you want to say, "All right, I hear that you said a five. What's the reason you said five and not maybe a four? Okay?

So what you're wanting to do is you're wanting them to sell to you their reasoning for why they chose that; okay? And the reason why you choose a lower number is you're saying to them, "You said five, so there

must be a reason you said five, and not something lower." So you're having them talk to you. When they say that, we listen, reflect, and ask. So it says that you chose five instead of four because you have seen some change in your family members since you're taken the treatment. And then reflect, and you would like to actually maybe consider going through the treatment like your family did, and then ask them a question. What kind of question? You ask them an open-ended question. "So what could you do that could be done to increase this number to" -- so they said, "I'm at a five, or a confidence of five." "What made you say a five instead of four?" And then you listen, and you say, "Now what can we do to increase you to, like, a seven?" So whatever the number is, add plus two. If it's lower than eight, if the number is lower than eight, ask them what's the reason for they said that number instead of a lower number. Okay?

Evoking change talk, highlighting ambivalence, here are some tools. Again, here is a cute little toolbox. I don't know if you can see it, but it's some tools that are crocheted. Someone knitted it, I think. So, as I said, we're highlighting ambivalence, so as we go through this, star the tool that you think you could use. Double-sided reflection, I have to admit, this is one of my favorites, because when I do it -- I can't see anybody, I use a lot of hand gestures, so I use a scale. It highlights how we could have competing feelings and thoughts.

For example, on the one hand you realize that TB could really wreak havoc on your health and it would be dangerous if you do not seek treatment. And on the other hand, you're wondering how you're going to be able to take time off from work. Where does that leave you? So what you're saying here is the important word "and."

Everyone that I've ever gone through class with says, "I don't understand that." And they'll do it and they'll go, "On the one hand you believe, but on the hand," watch the "but" word because but negates. Everything before the butt gets negated. Okay? So the important word is "and." Highlight the ambivalence; okay? On the one hand, you understand the need to be tested, and on the other hand, you're scared. Where does that leave you? Okay.

The second type is querying the extremes. This is when they say their motivation is low. I know it's important, Doc, to do this. I know it's important. I just don't think it's important right now. So you might say, "What are worst things that could happen if you don't" -- fill in the blank -- "and what's the best thing that could happen if you make this change?" Okay, so that's querying the extremes. A very nice way of, again, just proposing the two areas; okay?

When the importance is low, when the person says, "I'm motivated. I am so motivated. It's just no very important right now, it really isn't." I hear that sometimes from patients about quitting smoking. They'll say, "I know it's important for me to quit smoking, because; one, I can't afford it; and, two, it's really affecting my health. You know, I'm sorry, I'm motivated but the importance right now is not very high because I have other things that are more important. So they might say they're motivated to quit smoking, but right now, meeting the mortgage is much more important to them.

So you might ask hypothetical questions like, "So let's just pretend -- let's just pretend, okay, that you're going to make some changes, remembering that only you can decide when or where you're going to do it. So what would you do? Where would you begin?" At this point, if they don't engage with you, you might want to just help them. "So I'm thinking that some of the changes that occur could be" -- so you could help them along.

Looking forward is another way. When a person is caught in making a decision, yes, but; yes, but; yes but, okay. If you look ahead several months, for example, how will things be for you if you don't make these changes, and how will it be for you if you do make the changes, okay, looking forward.

The second one, that next one, is looking at their values, looking at what they find important. "So let's take for a moment, let's focus on the things that are important to you, like your family, your religion, your parents. Tell me the most important area for you." Listen to them and say, "So it's important that you be a good parent, a good child, a good whatever. How does that value align with the way that you're managing your pain or the way that you're managing your health at this moment?" So you're actually bringing up

stark comparisons sometimes to what they're saying versus what they're doing. Again, remember your stance. Don't be the monster. Do it in a way that helps them collaborate.

All right, so we have gotten to the practice skills section here. We have a series of statements, of scenarios. Please choose which tools would be best to use. Scenario number two, okay, a 20-year-old woman, in her first trimester of pregnancy, presents to clinical for care. After counseling, she agrees to or volunteers for HIV testing and is found to be HIV positive. She is now enrolled in the pregnancy HIV clinic for antenatal care specific to her medical needs. On history -- this is the patient's first pregnancy -- it is unplanned and occurred due to unprotected sexual intercourse. She denied the use of oral contraceptives and safe sex practices. She complains of unexplainable weight loss and a persistent cough. Upon examination, she is found to be underweight. She has no disease of the lymph nodes. There are crackles in her upper lobe or left lung, and there is a positive smear test for TB. So that's the background; all right?

Now if you'd rather picture someone else in your mind, like the patient that comes in and knocks the breath out of you, that's fine, too. So here we go, based on the MI, how might you start? A, you're going to start planning, you're going to start problem solving, you're going to give a lot of information; B, focus on engagement and collaboration, listen and understand; or, C provide affirmation? So what would you do, A, B, or C? Oh, my goodness, very nice. Very nice. Very good.

All right, so the majority of you have chosen B, focus on engagement and collaboration. Now some of us like -- so why did we not choose A? A is sort of making the assumptions. We're starting the planning. Oh, my gosh, we're getting into the crisis mode. And there is a time and place for that, sure. However, in this situation she's already going to a program, she's motivated it seems like, so A might be a little premature. And C, you know, an affirmation at this point might be good as well; however, if you just met her, it might come across as disingenuous, so be careful about how you use affirmations. All right.

So, here, the clinician comes in and says, "How do you feel about being diagnosed with HIV and TB? Okay, so engagement with open-ended questions. It's an open-ended question. If the patient says tearfully, "I don't think it's all that serious really. I'm just pregnant really. It isn't possible that I have HIV and/or TB. I'm just too young." Okay?

So here's the patient. Using MI, how would you respond; A, provide a simple reflection, so you don't believe that you have HIV and TB; B, set agenda by saying "what's your primary concern"; C, start planning, problem solving, giving more, let me tell you, let's start planning your next visit here, what can we do; or, D, provide a complex reflex, it sounds like you're really concerned and you're confused about how this could have happened to you.

Very good. So I see the majority of people saying provide a complex reflection, and we have a third saying a simple reflection. I think you are both right, you can do A and D. Again, what I try to encourage when I train an MI, if you hear at any hint of emotion, try to go there. I was in grad school and my professor said to me, "You know you're going into a field where you're manipulating people." And I was appalled, because I don't do it to manipulate. However, what motivation interviewing does, it takes every opportunity to bring someone deeper into thoughts and feelings, and what you do here is, when you see any hit of emotion, try to do a complex reflection, because, inevitably, if there is an emotion there, and you reflect it, it will just go deeper.

All right, let's provide a complex reflection. Choose the best MI complex reflection. A, you are in denial and you need to listen and to me and read these brochures; B, you think that you are too young to be ill; C, you're upset and scared over the news of your condition. A, B, or C? Very nice. So the answer is C. A is a simple reflection, but it's definitely not an MI spirit, because it says you're taking control. "You need to listen to me and read these brochures." B is a simple reflection. There's no emotion there. People confuse this. Any time you have the word "that," you feel that, that is not an emotion, that's a thought. So C is you are upset and scared over the news of your condition. Very nicely done. All right.

Let's do a complex response. So the clinician says you are upset and scared over the news of your condition. The patient responds with more crying, "Yeah, I don't even know what TB is. Will my baby die

from AIDS? Is there anything I can do for the baby?" So here is her response again. Tell me if you hear DARN-C, D-A-R-N-C, or no change talk. D is desire, A is ability, R is reason, N is need, C is commitment or no change talk. Very nice.

Yes, this is a complex one. Very nice. This is another one. You could have D, R, N, and C. So very nice. I see that people split that in that area as well. But D is very high on the listing, desire. And the desire is I don't even know -- is there anything I can do, the very last question. Very nice.

All right, so some additional steps that we can take in this is summarize the main points of her concern. Okay, at this point, when you're talking to the patient, summarize, "I hear that you're concerned, you're confused about what TB is, and how you contracted both TB and HIV and you're concerned about your baby," and summarize, making sure that you highlight her -- making sure that you're highlighting so she knows that she is heard; okay? Provide simple and complex reflections. Use open-ended questions to invoke change talk. Again, using the ruler or competence exercise is very good; okay? All right.

So what is the take-home message? What is the take-home message? MI is about engaging and collaborating. How do we engage the patient? How do we keep them in the room with you? And oftentimes what you might see is the patient -- I have this sometimes, the patient may be the in the room with you, but they're not engaged. The patient may be in the room with you, but they're not collaborating. I hear patients say to me, they'll come in and they'll have the stance of, "I'm here because my wife asked me to come here," or, "I'm here," like they don't want to be here, and I'll say, "Sir," or, "ma'am, what's the reason you came today?" And they might respond, "Because I got an appointment letter." So engage, engage. Do it in a way that you help not be the monster. Do it in a way that you help to keep the window open. Okay?

Another way is honoring patient autonomy. And how do we do that? We honor patient autonomy by asking them permission to see what they know. I had a veteran one time who came in to see me for some weight management issues, and I made assumptions that this person didn't know a thing about weight management. As we went through the session, what I realized is that this veteran had actually gone through several programs in weight management, and he could actually, because of his intelligence and he was diligent, could actually have taught me more about it than I could have taught him.

So I had to sort of step backwards in my role with him and apologize that I made such assumptions. And I, again, worked towards engaging and collaborating and helping to have him honor his autonomy. So I asked things like, "So what do you know about weight management? What are some things that you still would like to learn? What have has not worked for you?" Again, asking open-ended questions so that you can get engaged, so that you can help collaborate. Honor patient autonomy.

Appreciate ambivalence to change. Now we didn't talk a lot about ambivalence. Well we did. We talked about feeling more than one way. So the one hand you feel scared and on the other hand you feel bothered. And so we have to realize that our patients come to see us will be that way, and the more that we can appreciate that, the more that they're going to feel safe and open to collaborating with you.

The thing that we did not talk about a lot of is what we call "resistance," rolling with resistance. Rolling with resistance is going to knock on your door. That's when someone might appear as if they don't want to be there, and they might be there because their court mandated or because their wife made them or their husband made them, or just because you sent them an appointment letter, and realizing that ambivalence can show up as resistance.

So I didn't go over that, but what we do is we deal with open-ended questions, we provide a forum that they can feel safe, and, again, it's like a circular process. There might be times you have to go back through and reengage. I know that sounds painful, because, you know, you're engaged with this person. Sometimes, depending on where the patient is, go back and re-engage. And what do you do, you invite them, you talk with them; okay? And you express thoughts. "I appreciate your ambivalence, I appreciate you telling me that you don't want to be here," and helping them to express that; okay?

All right, so some of the tools, we talked about ROAS, ROAS, okay, reflections, reflections. There are two levels, simple and complex. Simple is just parroting back. All right? Complex is saying, “I’m hearing that you’re feeling very angry right now over the news.” Okay? So you’re asking them to be participatory, to collaborate. Oh, open-ended questions. Okay, that cannot be answered by yes or no, and they can’t be answered with one word. For example, if I were to say to you, how many drinks have you had a day,” and you say, “One,” that’s a closed ended questions, so open-ended questions.

Provide affirmations, this is for what? For building confidence in themselves. All right, you’re empowering them, and you’re helping them build confidence in you. Summaries, I didn’t show it but a summary is like a bouquet. Remember, what you’re doing is you’re highlighting their path of change, their themes of change. So what I hear is -- let’s take the woman we just talked about in this scenario -- So what I hear is that you’re really frightened and you’re confused about your diagnoses, and you don’t know where to go with this. You’re concerned about your children, and, yet, you want to do something about it. What can we do about that today?” And so that’s a very powerful way. Remember, two reflections to one-open-ended question, that’s what they say to use.

All right, then we have DARN-C. DARN-C is a tool for evoking and listening for change talk through open-ended questions. Desire is D, A is ability, R is reason, N is need, and C is commitment. So what happens if you can’t hear any of that? My back pocket pull out is I just reflect. If for someone reason some says no DARN-C, you can’t force it, I just reflect. So that right there is your magic card. “So what would you like to change?” “Nothing.” “So you feel as if there’s nothing in your life that you can change right now.” “No there’s nothing at all.” There’s absolutely nothing at all that you feel would help you feel better?” “Well, I guess if I could take this pain away.” So just reflect, reflect. Eventually you’ll get to something; okay? And if nothing else, you’ll plant a seed of reflections and questions that they will carry with them outside of session.

All right, now at the end of the webinar, yay, on a scale of zero to ten, all right, how important is it for you to learn skills in MI that will assist you in your practice of care? Very nice. I’m going to follow it with this. I know that there are some sixes; right. There are no right or wrong answers. So a six and a seven is below an eight. So, here, I’m going to say this, “For those who said a six or a seven, I hear that you said that you said on a scale of zero to ten you would raise the importance of learning at a six. I’m wondering why you said a six and not, like, a four?” And I would listen and I would reflect. And I would say, “Well, so what can we do to move from a six to, let’s say, an eight?” So they’re going to say, “Well maybe I would have more skills -- I would have need more evidence that it worked.” All right. So then you would go from there and work with them and say, “So how can we get that evidence for you? What can we do next?” Very nice.

All right, so here it is the last question. On a scale of zero to ten, not at all, and ten being, undoubtedly, a lot, how confident, at this point in time, do you feel in your ability to use motivational interviewing with your practice of care? And I realize this is very brief. When I teach this, I usually do it for six to eight hours, so this is a very brief session. Very nice. So we have the majority around an eight. An eight is the number of the cutoff. Remember, you know, below an eight you don’t ask. But what I might say here is, “If someone said eight,” I might follow it with, “That’s a really high number. Tell me the reason you said an eight and not a six?” Again, you could follow it up with the same kind of question. What you’re doing is you’re having that person tell you their reasoning for choosing that number. You’re going to get a lot of data from that. Or I might say something like, “Well what’s the reason? You know how can we move from eight to a nine?” Again, the same kind of questioning, having them show you and tell you their line of reasoning, so very nice. All right.

Thank you for your time. I know this a very quick run through on motivational interviewing. I hope you gained a lot from this. The tools that we went over are the most fundamental and foundational of motivational interviewing, so I do encourage you to look back through your slides, to look at the tools I asked you to star and choose one. I encourage you to choose one tool and start using that tomorrow, or if you’re off the rest of the week -- and you could also use in on your family members or call a friend. Call your mother or your father or, you know, the president of your grocery store, and just use motivational interviewing on them. So thank you for your time, and so I do think we have some questions.

Dr. Jon?

Yes I'm back on. And, first of all, I'd like to thank you, Dr. Landes, for an excellent presentation. I have to admit that it was very challenging for me. I was trained as a physician, and I think there's a different paradigm in the way we have been trained, and it's very useful. I was disappointed, though, that not once did you suggest we use the phrase "Trust me, I'm a doctor," which actually never works anyway.

We encourage those of you who are on the line at this point to submit questions, and we will call on you. As we wait to hear from some of you through the chat process, let me just raise a couple of issues, if I may, and we in public health and particularly in TB control and prevention programs have -- many of us wear multiple hats and we don't simply have a disinterested third party relationship with the patients who may be infected with tuberculosis germs or who have confirmed or suspected TB. In fact, we are charged, some of us are legally charged with protecting the public health at the same time. So the use of Motivational Interviewing has some caveats to it in our business in order to protect the public health. Could you elaborate a little bit on what you see as some of those differences from what you've learned from earlier conversations?

So let me make sure I have the question right. And I realize that there are a lot of mandates, and so you're saying as far as the caveats to using MI within those confines; is that the correct question?

Yes.

Okay. And as I said, that is such a good question, MI is really about establishing long-term relationships, and it is difficult. However, the spirit of MI, engaging with the patient in those situations, is probably the most important. You may not be able to use the tools because you're having to get them to do something; however you can ask open-ended questions. For example, I heard a clinical case where there was a patient who got really paranoid about getting treatment, and, essentially, ended up trying to leave town, and then came back.

And so my thought about that is this person was scared. And at that point, maybe taking some time and reflecting and saying, "I hear that you disagree with being tested and getting your family tested, and I hear that you're scared. Am I hearing you correctly? And could you help me understand." Those words right there, I got that actually from a physician in an outpatient clinic in a VA. He said the most powerful words he learned to ever use was "I know I don't understand what it's like to have terminal cancer, could you please help me understand. Help me know what I can do to help you." And he said those words right there have turned people around in seconds, from fighting him to actually aligning with him.

So what I'm trying to say is I appreciate and I respect the fact that you all work in such a hard field, and it's difficult. I just encourage you to look at ways that is you can bring in the MI spirit and to continue to engage the patient in the process. And there are going to be some times, like you said, that collaboration is going to be difficult; however it isn't impossible. And I'm wondering if there is anyone out there who has ever had a time where you thought collaboration was impossible, and yet you tried it and it actually was possible.

Well, those of you who are listening, if you'd like to type a response, we will be able to see that here. Please go ahead and do so.

And also, Dr. Jon, we can open, you can unmute by doing "*7." If someone would like to actually talk on the phone, we can accept those questions, so if you'd like to type or if you'd like to unmute by doing "*7." And then to get back on mute, you can do "*6." So if there are any questions for participants, you may open up by pressing "*7."

Well I'd like to give an example of I know that -- just real quickly -- years ago, I had a person come in who disclosed behavior that he had had during New Year's driving intoxicating with his grandchildren. He said he was buzzed. I had to report that, and this person I had, you know, been seeing for three months for

therapy. I had a really hard time because I was a mandated reporter. You know, what I did to the MI spirit was I said, “I don’t know how much you know about having to report this, but I want to talk to you about this.” MI spirit, I had him engage with me. I had him tell me what he knew about that. And I want to tell you -- this is me -- “I want to tell you my concerns about you driving intoxicated with your grandchildren the backseat of your car.” Engaging, helping him hear my side of the story and why I had to do it. “And this is what I have to do. I’m not sure if you realize that when you told me the story that this applies to this.”

You know, I thought my goodness, he is not going to come back. I had to report him. I had to write up a note. They had to go visit him. You know what, three weeks later, he came back to session with me and he thanked me for doing that, because that changed his life. He realized that at that point, if no one had actually aligned with him to talk to him to ask him the hard questions, he never would have stopped drinking. So he went into treatment, and he was able to, you know, become clean and sober. So we may never see the fruits of our labor, and yet, if we keep the door open and not become the monster, there is hope.

You know, Ann this is Jon. And it seems to me that much of what we’re talking about here has centered on the concept of ambivalence, and if there is one thing I remember from my first year of medical school -- actually there may be two or three, but the one that always comes to my mind is a definition for ambivalence as equal and opposite subconscious feelings towards the same person or object at the same time. And it seems to me that, as we consider finding -- as you said, moving toward acceptable solutions, part of that is a process of helping the patient put their finger on these equal and opposite subconscious feelings, and to verbalize that, and to name them themselves, and then moving from that precarious balance to positive change. Would you agree with that?

Yes, very much so. Yes, it really is about -- when I sit across from a patient, what I try to do is be a mirror for what they’re feeling, and sometimes I call it the “jingle jangle.” Everyone has jingle jangle in their head. So when they come to see you, either at the office formally or informally, they have a lot of jingle jangle, and I call it “fears.” I call it “worries.” The jingle jangle prevents them from actually hearing what’s going on in their own heads.

Our job, and if we’re good at it, we can help them hear, help you slow down, help them to hear the jingle jangle, and help them to actually come in touch with the feelings, because change is hard. People don’t like change. And you’re right, ambivalence often is just saying, I feel scared and yet, I feel motivated, and helping them see that. And you’re right, and you bring up a good point, also, Dr. Jon, is we come in session as human beings as well too.

When we are working with a patient, we have our own ambivalence. When we hear a scenario about someone who doesn’t want to take responsibility or someone who is scared to get treatment and could affect their entire family, we are going to have what we call in psychology, “counter-transference issues.” We’re going to have our emotions. So it’s important, when you’re sitting in the room with a patient, to help them be aware of where they are and you become aware of where you are. So that’s an excellent question about ambivalence. And, again, you’re going to have ambivalence as well.

Okay, again, we’d like to encourage those of our audience to submit questions, and you can unmute your phone and voice those if you wish.

And if there aren’t questions, I’d love to hear how you plan to apply that, apply MI.

All right, so I have a question from Janie. It says “How do you gain the trust of immigrants who you are scared you are going to get them deported and do not want to cooperate due to fear?”

Oh, that’s such a very good question. Again, we are all dealing with culture. We’re dealing with politics. We’re dealing with a lot. We’re dealing with very serious things like people’s lives, and thank you for such a great question. The way that you do that is to make sure that you listen to their fears. And just like the gentleman who was driving drunk with his grandchildren, you know, don’t make assumptions that they

already know what might happen in your interaction with them. Align with them and help them to feel safe in knowing that you are more worried about their health and making sure they get better.

And also, going with the fact that, you know, you're right there might be a situation where authorities are going to come in. I think the best thing for that is, and this is what I feel is important in our interactions with anybody-- is how do I say this -- we may never know the fruits of what we do, and it's important that we act with integrity and we act in a way that's going to help them, in the future, possibly seek help. So if they see you as a face of a medical provider who is caring, who is concerned about their health and their well-being, and their family's health and well-being, let's take the dire consequence, they get deported. Hopefully when they go back to where they are, if they're deported, they'll remember the kindness that you expressed you them and the concern; that you expressed to them, that you didn't want them deported, and, yet, the focus is getting them healthy.

And, Ann, we have another question coming from Randy. It says, "How does MI apply in situations where certain laws apply to active TB patients that the patient does not have choice or control over; example, isolation of contagious active TB patients."

Excellent, another dire situation. A very dire situation, how can we bring in the MI spirit? How can we engage the patient, that, yes, you're mandated. You're mandated to go and get things done. You're mandated to be in isolation. During that time, how can you help the patient to feel autonomy? How can you help the patient feel that you're collaborating with them in some way? How can you help them to feel that there can be some kind of positive change in their lives, or some kind of control. And helping them, like Dr. Jon said earlier, to identify the ambivalence that they feel. You know, they hate you at this point, and yet, hopefully, through your work, you help them to realize that you're here. I know I hate you at this point. I don't trust you, but in the back of their mind, I realize that you're here to help me.

Sometimes we really can't do anything in that situation because of where they are, and, again, try not to be the monster. Try not to personalize it. Bring in the MI spirit. What can I do? When I became a psychologist, my thing is I want to change the world. I want to make sure that everyone's quote, unquote, healed and that they can go and do great things in their lives. And what I realized is, in life, have rarely do we have big changes. It's the small little daily things that we do for people that make a big impact.

And so in that person, if you, for some reason were the one who had to be involved to get them isolated or hospitalized or, you know, before the authorities, is there a way that you could continue to showing passion and caring so that you don't become the face of the monster so the next time they go see somebody.

We actually have a really good question here that's aligned with some other people who had some questions. And it says, "As I start employing MI into my practice, I am thinking or taking baby steps to change, which, as this week, starting each appointment by using open-ended questions, agenda setting, et cetera, then adding the simple reflection. Does that sound like a successful way to change my practice and start employing it?" But that was the main question, the themes are how do we start with not all this information but piecing it together?

Yeah. So I love that. So MI is about looking -- and I'm going to -- really it's about starting with yourself. As soon as we get off this program, I would love for everyone to sit for a few minutes and think about the situations that really take your breath away, a situation that, really, you go home with at night, where you carry five, ten beach balls and think about that. And then I want you to think about what is my real role? Where I am in the situation? So the important thing is knowing who you are and what you expect of yourself.

I was in a conference a few year ago, in Orlando, and did this presentation, and somebody in the audience raised their hand and just blurted out all this stuff, because she expressed she was totally burnout because her patient population was totally resistant. To me, what that says is she had way too many beach balls. And if she had been willing to listen or talk with me, I would have said, "Let's talk about where you are in session. Where are you? Are you holding the beach ball? Are you balancing your role,

your responsibility, are you taking all the responsibility?" So, one, the most important part know what you believe your role is in your interaction. Two, pick one tool, I would say one tool. If it's open-ended questions, use open-ended questions.

If you want -- for example, I think engagement is probably the most important factor that I found in MI. Engagement is getting them engaged in trusting you, in letting them know that you hear them. So open-ended questions are perfect. I always start with one tool, and if I could I would say open-ended questions.

Now I know in primary care, oftentimes the docs that I work with maybe have 20 minutes, maybe 15 sometimes, tops. If you're pushed for time, use the ruler. Use the ruler tool. "So how important is it for you today to actually, you know, proceed with learning more about TB?" So summarize, know where you are, know who you are, know what's important to you in your work, and see if that really balances out with MI and choosing one tool.

Great. Thank you so much, Ann. We have another question. "It says the client often refuses to name any contacts. I live alone, no church, never go to wherever. You know, how do I open up this line of thought as to their contacts."

Right. So the question, so you say, "Who can we put down as a contact?" "I don't have anybody. I live alone." "So there's no one in your life at all right now whom you feel you could actually put down as a contact?" "No,nobody." "Well if I may, you know, tell you my concern about that and then maybe we can talk about way we can address that. Would you mind if I talk to you about my concern." "Well sure." "Well my concern is that you're going to go through a series of treatments that are going to have really bad side effects, and we know that, historically, our patients are going to need somebody. We care about you, and we want to make sure that you're successful and get well, and that's why. We're not trying to be nosy. We're not trying to get in your business. We're just really trying to make sure that we help take care of you, so that's the reason. What do you think about that?"

So what you're saying is, I think, instead of assuming they're being resistant or assuming they're being paranoid or assuming that they're just withholding information, reflect back to them. "So what I hear you saying there is nobody in your life." "No, there's nobody." Okay, so at that point, just reflect. Remember, reflect, reflect, open-ended question. Give them autonomy. Make no assumptions that they're withholding information from you.

At that point, you know, you could also say, "So where do you think that leaves you? On the one hand you want to start treatment, and on the other hand you won't have anybody there to support you." Listen to their response and see where you can go from there.

Ann, this is Jon. Before sharing the next question, I wanted to tell you that in our work, we frequently use things called "incentives" or "enablers." Enablers are things which are used to remove barriers to care, for example maybe bus passes or assistance with rent and so on and so forth. Sometimes we use incentives after identifying something that a patient would enjoy or would like to have, for example, and that we provide that as a link to the process of completing therapy. But what would you advise doing when there's an uncooperative patient, even after using MI tools? If incentives and enablers, as we understand them, are not effective, and we have tried MI tools, what would you suggest as next steps?

Well what I can understand from what you're, Dr. Jon, I mean there is going to be a point, depending on level of the clinicity or the seriousness of their TB, there are going to be some steps that we really just have to take anyway, which might be hospitalization or some other factors of treatment. So if that's a step down, let's say that they haven't gotten to that point where they're having to be mandated, then I would -- we didn't talk about rolling with resistance. That's a totally different -- I mean I could spend a whole day on rolling with resistance. That might be a really good topic right there, is, one, watch where you are, practice not labeling the patient as resistant for one. And a lot of what you're saying is maybe, you know, thinking in your head what could it be.

Again, open-ended questions, “So help me understand, you realize that you have TB and you realize that it’s a serious disease, help me understand what some of your hesitancies are.” And, you know, see what their responses are. Even if they don’t want incentives, that’s fine. There is something that is of value to them, and, say, you know, “We’ve talked about incentives, we’ve talked about ways that we can help you, but there doesn’t seem to be any way that you find is going to work for you. What would work for you?” What do you think they might say, Dr. Jon?

You know, it’s highly dependent from one individual patient to another, depending on what their -- if there are substance involved and so on, it can be quite all over the map as far as that goes. I apologize that I’m going to have to remind us that we’re very close to the end of the webinar though. I would like to share one more question with you, Ann, though.

Yes.

It is the following: what is the example of provider ambivalence? We’ve been talking about our patients’ ambivalence. Is there provider ambivalence, and what can we do about that?

Yes, that’s such a very good question. Thank you for asking that. Provider ambivalence often comes in the term of what we call “counter-transference,” And that’s when you feel something about the situation or the patient that might actually be impeding or hinder progress. Provider ambivalence might be this in TB: On the one hand I understand they’re being fearful about being deported, and, you know, I need to not be -- you know, I don’t want to deport them, and, on the other hand, it’s really important that we take care of this. So that’s one big ambivalence, is on the one hand I’m mandated to do this, and on the other hand, I really feel for this person. That’s provider ambivalence.

Another one is on the one hand this person’s really hard to deal with. They are being obstinate. They are making it very difficult to help them, and on the other hand, I really feel for his children, because I want to be there. So it’s pulling -- you know, I think in this position especially, it’s the roles that you’re in and what you’re mandated to do versus what you feel your heart would want to do. And those are times that I want you to really stop and think about where you are and make sure that you’re not acting out of your own fear, your own desire to fix things, your own desire to make it all right, to make it go away. So there is a lot of ambivalence, especially in the field that you’re working in. Great question.

Okay, very good. One last question, if I may, from Pinellas County. “What suggestions do you have to develop our MI skills?” That will be our last question.

Oh, I love it. I would get together with groups. If you’re a professional, get a professional group together. There are wonderful workbooks. I know I’ve got some resources in the back page, some wonderful workbooks that actually walk you through scenarios, so it’s practice, practice, practice. Another thing is there’s some YouTube videos called “The Effective Physician and the Ineffective Physician” from the U.S. School of Psychiatry, where you can look at examples of responses. And there are a lot of things on YouTube for free about Motivational Interviewing from Milner and Rollnick, and there are CDs. So you know, practice, practice, practice, again, know who you are as the person in the room, and pick one tool. And then get some workbooks and books. So that’s a wonderful question.

Very good. Well as moderator today, Ann, I’d like to thank you for a wonderful presentation, and for your responses to questions. Also, to every one of the participants on the webinar from across the country and, actually, across the ocean, we thank you for your interest, for your support of the Southeast National TB Center, and for your commitment of our shared enterprise of curing and preventing the transmission of TB to others.

Our host from SNTC, do you have any last comments before we wrap up today’s presentation?

Yes. And we’d like to thank you, Dr. Jon, for moderating this. You’ve done at excellent job in bringing up wonderful points and get our questions asked. We really appreciate you being here and supporting this.

And we just would like to remind everyone that you will receive a link that will send you the evaluation. If you complete that evaluation, you will receive 1.5 CE credits, and although -- I wanted to remind you that for handouts we had a lot of comments of people who would like to actually review this information, as we've been discussing. The handout is -- below the chat pod is the handout pod. There actually is the handouts there. You can take those and then print them or save them to your computer. The presentation is there.

Also, if you go to our website, our homepage, you'll see a title that says "What's happening." Right below that actually shows you where you can grab the handouts and print them from here. Also, this webinar will be archived and it will be posted approximately two weeks from today, is when you will see that posted on our website, if you go to the "Training and Education" tab, and then "Archived Webinars." And also, please take a look at all our archived webinars that are there for you to have at any point. At this point, we do not provide continuing education credits for archived webinars, but you are welcome to peruse and find any information that you need there.

We thank you all for attending very much, as Dr. Warkinten said, and we look forward to having you on the next webinar. Thank you again, Ann.

Thank you everybody. Bye.

Thank you all. Goodbye.