Motivational Interviewing

Strategies to Decrease Resistance

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2 CEs

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Learning Objectives & Outcomes

- Describe the Motivational Interviewing framework -- Transtheoretical Model
- Describe the key components of Motivational Interviewing (MI) and the context in which MI strategies can be used to remove barriers to effective communication.
- List situations in which MI strategies can be used to resolve conflict and increase buy-in.
- Describe 5 strategies to resolve communication breakdowns using MI strategies.
- Effectively describe the difference between “change talk” and “counter change talk.”
- Describe how MI strategies can be used in real situations and the resulting benefits.

Subject Matter Expert

Dr. Gilbert has been working with children, adolescents and adults for almost ten years and has worked with infants and toddlers as an Infant Toddler Developmental Specialist (ITDS). She graduated from Florida International University with a Bachelor degree in Psychology and a minor in Behavior Analysis and Masters of Science degree from FIU in Education with Mental Health Counseling minor. Dr. Gilbert obtained a second Masters of Science in Psychology from CAU. Dr. Gilbert obtained her Doctorate in clinical Psychology (PSY.D). She is fluent in English and Spanish and understands French.

Dr. Gilbert is deeply passionate about what she does as a professional and looks forward to using her expertise as well as gaining further experience in this field. She has extensive experience conducting behavior assessments and supervising clinicians as well as training parents, teachers and staff. Dr. Gilbert has presented on behavior analysis techniques at workshops, Parent-to-Parent trainings, internationally, UMCARD, various autism awareness events, private/public schools, charity events, and foster homes and shelters in both Spanish and English. Dr. Gilbert has co-authored articles in Parent with Special Needs magazine and has conducted RBT (Registered Behavior Technician) trainings as well as the 40-hour required Behavior Assistant training.

Additionally, Dr. Gilbert is an adjunct professor and teaches Applied Behavior Analysis courses at CAU and is an active member of the southern region Agency for Persons with Disabilities, Local Review Committee where along with the other members provides ongoing technical assistance and consultation as well as approvals for behavior plans presented by other analysts in her region.

Panelist

Jennifer Rumfola, MA, CCC/SLP, BCBA/LBA is a dually credentialed professional, licensed and certified as a Speech Language Pathologist and Behavior Analyst (BCBA). She possesses expertise and advanced skills in teaching language to children on the autism spectrum. She has helped clients across the life span from Early Intervention, Preschool through School in both home, center-based, and public-school settings. Over the past 10 years, she has successfully integrated strategies and techniques from both disciplines to help individuals with autism and their educational teams generate better student outcomes.

Jennifer conducts training for a variety of audiences including educators, related service providers, administrators, parents, para-professionals and undergraduate/ graduate students across disciplines. She serves as an adjunct faculty member in the Master's ABA program at Daemen College in Buffalo, NY, and was formerly a part time graduate clinical supervisor and adjunct faculty at the University of New York at Buffalo in the Communication Disorders and Sciences Department.

“People don’t resist CHANGE; They resist being CHANGED” –Peter Senge

Motivational Interviewing

Developed and first described by Miller (1983) and elaborated by Miller and Rollnick (1991)

- Client- centered and directive approach
  - 'Directive' refers to therapists evoking and differentially reinforcing change talk

- A collaborative, goal- oriented style of communication that pays attention to the "language of change" (AKA change talk)

- Method that works on facilitating and evoking motivation within the client

- Recognizes the fact that clients who need to make changes in their lives approach therapy at different levels of readiness to change their behavior

- Operates under the current presumption that people are much more likely to do things that **they say** they will do versus things that **they are told to do**

Aim: To elicit and evoke change talk in relation to a specific goal

What have studies shown?

- Patterson and Forgatch (1985) monitored the interactions between consultants and families in a meeting and found that teaching/ giving instructions/suggestions, providing rationale and confrontation tactics led to increase in family **resistant** comments.

- Similarly Miller, Benefield and Tonigan (1993) directly manipulated similar constructs and found that therapists responded to client- resistant statement with direct confrontation and persuasion which further raised client resistance and even generalized and maintained with other professionals after a year.

Patterson, G.R., & Forgatch, M.S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. Journal of Consulting and Clinical Psychology, 53(6), 846-851.

Miller, W.R., Benefiled, R., & Tonigan, J.S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. Journal of Consulting and Clinical Psychology, 61(3), 455-461.

Goal is to Evoke Change Talk and Decrease Counter Change Talk

- Public self-mand to either change or not change the target behavior.
- **Change talk (CT)**
  - Vocalizations towards change
  - Weakens rule governed verbal behaviors
  - Predicts commitment which in turn predicts engagement of behavior towards change.
    - These statements are linked to a specific behavior or set of behaviors
- **Counter change talk (CCT)**
  - speaking against change

“DARN CAT” intro/ explanation

- **D**esire: Wishing, wanting and hoping
- **A**bility: I can, I am able to, I will
- **R**eason (why): I will have more energy if I can get these behavior under control
- **N**eed to (urgency): I need to, I've got to, I have to learn
- **C**ommitment (most indicative of change talk): I am willing to..
- **A**ctivation: I am going to…
- **T**aking steps: I already started…

Motivational Interviewing: Change talk

Counter Change talk	Change talk
Desire: If I ignore him for kicking others it seems like I am allowing him to do this	I wish we didn't have to put up with his kicks anymore
Ability: I have tried this before and I just can't do it	With the right amount of help I think I will be able to ignore him when he kicks me
Reason: He is not really kicking me that much at home. I don't think this will interfere with his life	If we intervene in his behavior now we will be able to go out more often
Need to: His physical aggression is really not that bad, he will grow out of it	If I do not start intervening in his physical aggression they will increase and become a bigger problem
Commitment: I just can't intervene right now I have too much to do	From now on I will not provide him with attention when he kicks me

Let's Practice: Change Talk Example

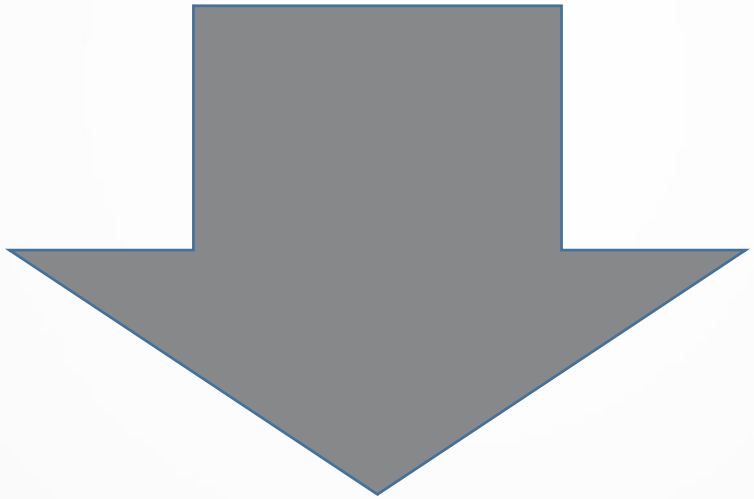
- Instead of hitting tommy with my belt I began to breathe in and out and thought about what I wanted to do. But it was too much and I let him have it.
  - Question A
- I don’t get what I am supposed to do here? You are the therapist and should be working directly with my child.
  - Question A
- Here we go again. I have already heard this before and nothing seems to change.
  - Question A

Motivational Interviewing is:

non- judgmental
non- confrontational
& non- adversarial

Objective of Motivational Interviewing

MI may be seen as a strategy in which the clinician acts to reduce client counterpliance to evoke and reinforce tacting the full range of consequences (change talk and sustain talk) for the occurrence and nonoccurrence of the target behavior.



Leads to elaborated selfmands, which are correlated with subsequent changes in the target behavior.

Example: Clinician to Educator Interaction

Miss Joanna is a math teacher at perfect elementary school. Jade is a BCBA that is currently seeing one of her students.

Miss Johanna and Jade's communications have resulted in conflict to the point where the administrative team has had to get involved.

Miss Johanna is a great teacher but she does not believe in token systems. She believes that token systems ruin intrinsic motivation.

Jade however has research on the effectiveness of using token systems in school settings.

Jade has become so frustrated that she is ready to "throw in the towel".

Example: Clinician to Educator Interaction Role Play

Miss Joanna: “As I previously mentioned I don’t believe in token systems.”

Jade: “I understand but this is what will be effective for the student.”

Miss Joanna: “But you aren’t in my classroom 24/7 like I am. You don’t see how having a token system can be disruptive to the other students and sometimes even impossible.”

Jade: “I hear you, but for Tommy to behave he must be motivated, and this is what research has shown would work best.”

Miss Joanna: Research? “Well, we aren’t statistics, and this is the real life so I don’t know how applicable that research is.”

Jade: “Research is based on data collected from “real world” participants.”

What do barriers in treatment acceptance or adherence evoke in us?

Our job is to avoid the righting reflex…

Righting Reflex

A clinicians natural instinctual response to “fix the problem” with the knowledge they have acquired

Begins with our desire to help others

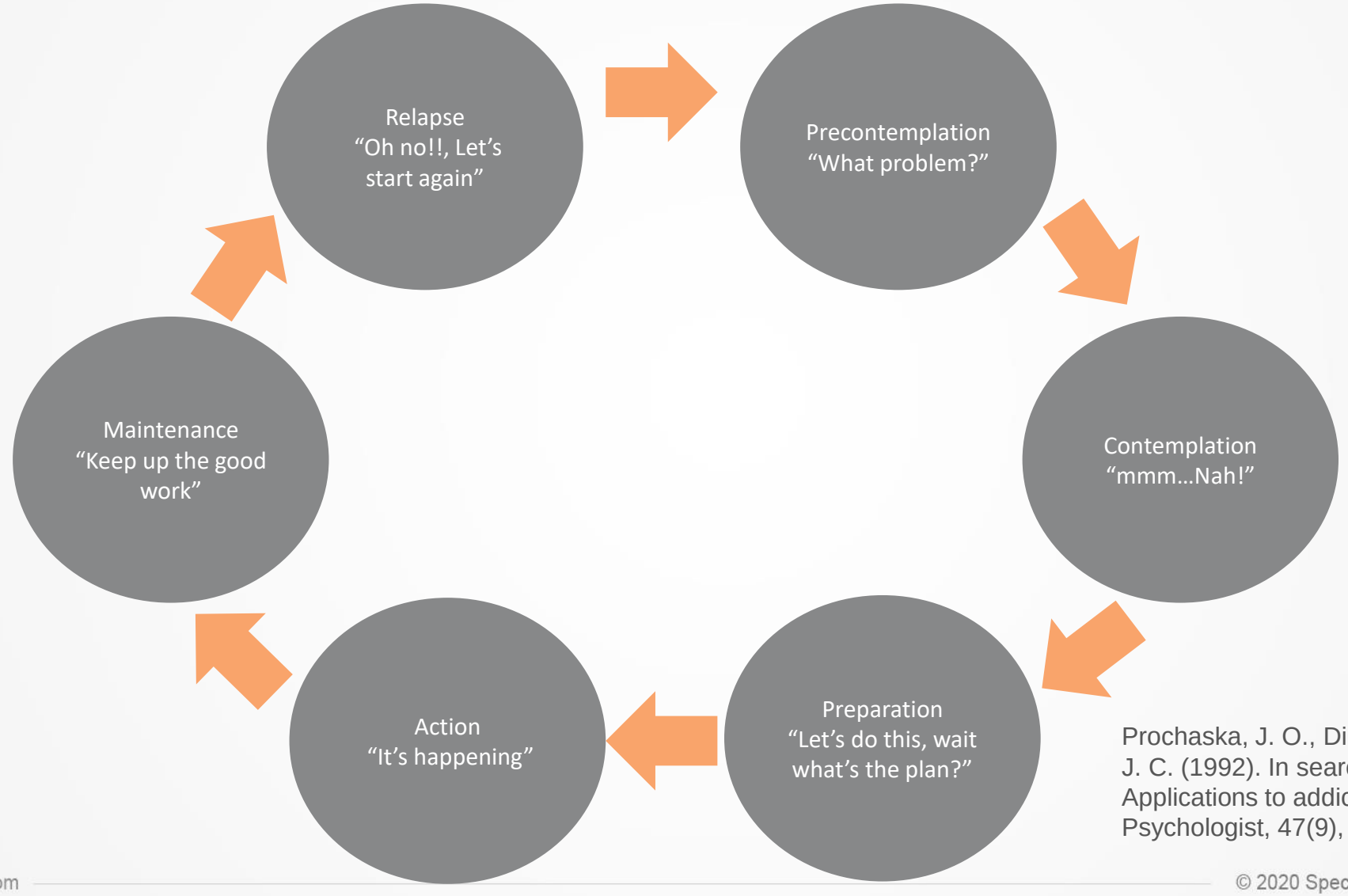
Urge to use “what we know” to “help the world”

BUT

Righting Reflex fails to acknowledge ambivalence

Arguing for change increases resistance

Prochaska and DiClemente's Transtheoretical Model



Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. American Psychologist, 47(9), 1102-1114.

Scenario

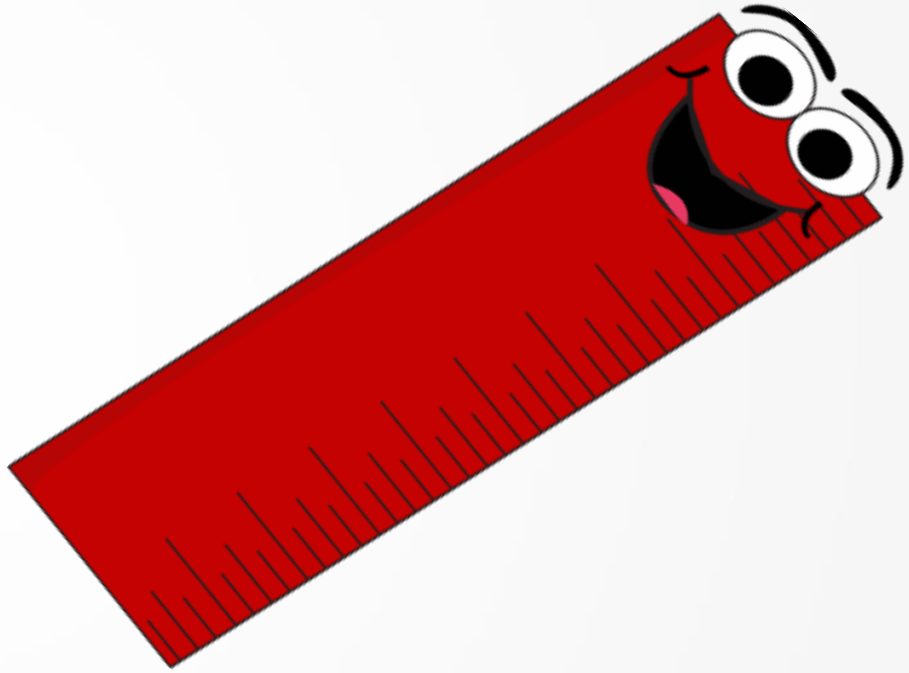
Please share about the time when you identified a problem to fix, but others involved didn't see the problem the same. How did you route around it? What did you learn from the experience?

OT Perspective:

I met with the SLP and BCBA working with a client, after the team noticed a regression in behavior. I mentioned an overloaded schedule, not enough rest, and overwhelmed sensory systems probably contributed. When the team showed signs of disbelief, I provided examples (in an affirmative way) of ways we experience the same thing (after a long day of work, we wouldn’t enjoy music blaring, bright lights, people coming up asking a million questions), and then left it there, rather than trying to gain agreement. They were able to process it, and began asking my opinion on how to provide support. I learned that pressuring someone to see your way often causes resistance, but relating a situation in a way someone can understand, then backing off, makes it more likely they will hear what you are suggesting. *-Karen Thompson, MOT, OTR/L, RBT*

Assessing Stages of Readiness

Rollinick, Mason and Butler (1999) proposed the “assessment ruler” in order to assess the importance, readiness and confidence of participants involved in the MI process



Rollnick S, Mason P, Butler C. Health behavior change – A guide for practitioners. New York: The Churchill Livingston, 1999.

Readiness Ruler Role Play

Importance (1: lowest importance; *10: highest importance)*

How important is this for you right now?_____

Why did you pick _4_ and not_2_? *(Use a **lower** number of comparison to emphasize **importance**)*

What would it take for you to reach an 8_____?

Confidence/ability (1: not confident at all; *10: highest very confident)*

How confident are you in your ability to intervene in your child's behavior? _____

Why did you pick _4_ and not_2___? *(Use a lower number of comparison to emphasize confidence)*

What would it take for you to reach ___9_____?

Ready (1: not ready at all; *10: very ready)*

How ready do you feel about intervening on this behavior ?_____

Why did you pick _6_and not_2__?*(Use a lower number of comparison to emphasize readiness)*

What would it take for you to reach _____9_____?

Principles of Motivational Interviewing

Follow your “RULE”s

Resist the righting reflex

Understand your client’s motivation

Listen to your client

Empower your client

Collaboration

Evocation

Autonomy

Note: Client can refer to caregiver as well

Skills Used in the Interview Process: OARS+I

OARS

Open-ended questions (i.e. “what are some of your concerns”)

Affirmation (“I can really see how hard you are working on this”)

Reflective listening (“That really makes you angry when others say that about you”)

Summarization (Collect, link, transition)

+Information Exchange (ask if you can share information using the EPE approach)

Persuading with permission - Using the EPE approach

1) You really should stop attending to his screaming if you want it to decrease.
2) I know that extinction is uncomfortable, but you can't just continue to reinforce Amy's behaviors like that.
3) We have made so much progress. It is probably a bad idea for you to stop sessions now.
4) Here's my dilemma. If we don't see progress soon, we will have to stop sessions.
5) If we don't get these behaviors under control now, when he turns 18 he will probably end up in jail.

E= Elicit
P = Provide (permission)
E = Elicit (check-in)

Exercise: Practice converting these questions from closed- ended to open- ended questions

- Did the intervention I recommended last session work with Jimmy?
- Did Mary stop hitting others in class after I shared the intervention with the teacher?
- Are you blocking Tommy from escaping when you provide him with his homework?
- Are you applying the intervention the way I showed you?

5-Minute Break

Scenarios and Live questions/ responses

- *Parents*: Being involved in parent training, adherence to recommended hours, maintain consistent therapy schedule, parents interrupting sessions to reinforce child at the wrong moments causing more behavior problems, not following BIP. - *Brenda Boehm, BCBA*

- Navigating the translation of ABA to *educators*. Teachers often have a biased view of unsuccessful ABA applications in the classroom and/or a very constructivist view of education which limits the language pathways for success. Practicing ABA providers have to know how to speak the 'school language' and understand the prioritization process that has to happen in classrooms to get to successful implementation of plans. Without a willingness and patience to learn each other's language quality supports can be lost. *–Jenna Sage, BCBA, PhD*

Reflective Listening

Goal:

- Seek to understand speaker's idea
- Highlights key words towards change
- Helps speaker feel heard, supported and understood
- Allows clinician to check their own accuracy of what they are hearing
- It gives speaker feedback of how they are coming across

3 Levels of Reflective Listening

- **Repeating** : Clinician repeats exactly what the client says or substitutes it with a synonym.
  - Use statements such as “It sounds like you…” “As you see it...”

- **Paraphrasing using inference**: Clinician restates what the client says but the speaker’s meaning or content is inferred.
  - Use statements such as “Let me make sure I understood correctly you are saying that…” “It appears that…”

- **Reflection of emotion**: Clinician emphasizes emotional aspects such as nonverbals that are observed, or the tone of the communication.
  - Use Statements such as “I can see that…” “What I am sensing is that…”

- **Double Sided Reflection:** Clinician identifies two opposite statements using any of the techniques above. Highlight resistant comment and then make a comment towards change
  - Use ”AND” to separate both statements. “You mentioned that.. And …”

Picking the Flowers

- Walk with parent through the garden, listening to their description of flowers and picking only those that have greatest salience.
- Practice identifying and reinforcing the areas that might have change talk inherent in the statements.
- Make a reflection

Listen and Identify the Strengths

- Miss Annie: teacher who was let go:
  - Strengths?
    - Think outside the box, does research, is skeptical, does not follow the crowd
  - Affirmation?
- Mary: Mother who's a workaholic
  - Strengths?
    - Willing to work hard for her family, Commit and stay on task, delays her needs for her kids
  - Affirmation?
- Amon: A man’s man
  - Strengths?
    - Loves his kids and expresses it his own way, want to be a positive example for this kids
  - Affirmation?

Summary (Collect, Link, Transition)

- Make a statement indicating you are going to summarize
  - “Here is what I have heard so far” or “To summarize”
- Identify all major concerns
  - Problem behaviors
  - Failed attempts to improve them
  - Barriers
- Emphasize change statements
  - Use DARNCAT
- Check Yourself
  - Is there anything I missed? Anything you want to add?
- End with an invitation
  - What do you think we should go over next session?

Motivational Interviewing Strategies: (Precontemplation)

Amplified Reflection: Highlight the extreme position implied by the parent's statements. (No sarcasm)

Parent: "Those studies about behavior modifications really don't prove anything."

Consultant:" You really don't believe research findings can be helpful to you at all. "

Examining discrepancies-

Consultant: "you mentioned that his tantrums as you call them don't bother you, and you also mentioned that you have not been to your favorite restaurant for over a year because of his tantrums."

Rolling with Resistance: (siding with the negative) Avoids arguing towards change.

Parent: "I don't think these strategies will work"

Consultant: "It seems pretty hopeless, like why even try if there's a possibility it's not going to work"

Querying extremes:

Consultants: "If things keep going the way they are now, what is the best outcome you can imagine for your child, How about on the flipside what's the worst you can imagine?"

Scenarios and Live questions/ responses

- Currently we have a student who will engage in maladaptive behavior to get parents attention and to get something he wants. Parents consistently reward this and also interrupt ABA sessions to reward the behavior. They are now coming to parent training and it's improving. But Overall this issue caused many more behavior problems and slowed his rate of learning. –*Brenda Boehm, BCBA*

- What is the best way to help a parent see that although changes require effort on the front end, they reduce work in the long end? And how to get a parent onboard with behavioral interventions that causes increases in anger/distress initially, but then quickly dissipate? Parents are often very averse to doing anything that creates more tension with their child, and don't believe us when we explain it will be temporary. –*Karen Thompson, MOT, OTR/L, RBT*

Motivational Interviewing Strategies: (Contemplation)

Normalizing: Having difficulties while changing is common

Consultant: "Its normal for you to feel as though using planned ignoring may be difficult since as a parent it is obvious you do not want to see your child in distress".

Double-sided reflection: Highlight resistant comment and then comment towards change

"I can see your predicament; On one hand you aren't sure that the intervention we spoke about will decrease his aggression and on the other hand everything you have tried so far has not worked."

Reframing: Turning punitive talk into positive talk.

Parent: "I've tried so many strategies, but none of them seem to help."

Consultant: "You are very persistent in trying new things that can help even when you are not seeing a lot of progress."

Agreeing with a twist: Acknowledge parents' position with a slightly different spin.

Parent: "I know how to discipline my kids. NO one can tell me what to do with them."

Consultant: "You know a lot about what works in your house and it really is completely up to you what happens in here. If our sessions are going to work; you need to be the key player in this process."

Scenarios and Live questions/ responses

- When parents are saying that they want to help/support their child and agreed to a program to implement, but they don't implement as we discussed. How can I approach the parents?

- More elaboration on when to throw in the towel after multiple efforts to use these techniques. (Ex: the parents agree to the plan but don't follow through over and over again.) When other techniques are indicated based on the situation.

Motivational Interviewing Strategies: (Relapse)

Emphasizing personal choice:

Parent: "My mother in law forced me to attend to Danny when he began to scream. She really didn't give me a choice since we live in her house and she says the behaviors are out of control."

Consultant: It seems like you have no choice here and its frustrating. When it gets down to it though what you do with your child and how you do it is really up to you. I can't force you to listen to me. It's your decision on how you use our services.

Exceptions Questions: Seek examples of what is happening when the problem is not happening

Consultant: "Tell me an instance where he is being compliant with your demands"

Looking forward/backward:

Consultant: "look into the future and tell me what you want your child to look like in 5 years? What are something's you want him to start doing or stop doing?"

Shifting focus: Acknowledge resistance and then shift attention to a new direction.

Parent: You are probably going to be upset at me since I reinforced his crying by giving him the toy, but is it so overwhelming, I just can't do it he cries and cries, and its so hard for me.

Consultant: That's really not why I'm here. What do you think would be helpful for us to discuss this week? Can we discuss what has worked?

Scenarios and Live questions/ responses-parent training

- I made recommendations to use prompt fading (reducing verbal prompts, ignoring attention seeking, using gestural prompts, picture schedule) during bathing routine. When I zoomed into the routine, the *parent* was able to follow my directions, but when asked how they have been doing outside of sessions, they didn't do it, and complained that the child made it too difficult. – *Karen Thompson MOT, OTR/L, RBT*

- Potty training a child, achieving success, and the parents deciding it was too much work to continue taking their child to the bathroom. This led to a lack of my ability to provide treatment. – *Shelly Henry, BCBA*

Clinical Role Play in a Parent Training Session

Ending Thoughts

- Ask open-ended questions to facilitate clients' story
- Meet the client where they are
- Look for opportunities to develop discrepancy between client’s goals and current behavior
- Use a columbo approach: Become curious about discrepant behaviors without being judgmental or confrontation
- It is the client's responsibility to change not yours!

References

Bearss, K., Johnson, C., Handen, B., Smith, T., & Scahill, L. (2013). A Pilot Study of Parent Training in Young Children with Autism Spectrum Disorders and Disruptive Behavior. *Journal Of Autism & Developmental Disorders*, *43*(4), 829-840 12p. doi:10.1007/s10803-012-1624-7.

Center For Disease Control (2014). Autism Spectrum Disorder. Retrieved from http://www.cdc.gov/ncbddd/autism/research.html.

Crone, R. M., & Mehta, S. S. (2016). Parent Training on Generalized Use of Behavior Analytic Strategies for Decreasing the Problem Behavior of Children with Autism Spectrum Disorder: A Data-Based Case Study. *Education & Treatment Of Children*, *39*(1), 64-94.

Dawson, A. M., Brown, D. A., Cox, A., Williams, S. M., Treacy, L., Haszard, J., & Taylor, R. W. (2014). Using motivational interviewing for weight feedback to parents of young children. *Journal Of Paediatrics & Child Health*, *50*(6), 461-470. doi:10.1111/jpc.12518.

Freudenthal, J., & Bowen, D. (2010). Motivational interviewing to decrease parental risk-related behaviors for early childhood caries. *Journal Of Dental Hygiene*, *84*(1), 29-34 6p.

References

Frielink, N., & Embregts, P. (2013). Modification of motivational interviewing for use with people with mild intellectual disability and challenging behaviour. *Journal Of Intellectual & Developmental Disability*, *38*(4), 279-291 13p. doi:10.3109/13668250.2013.809707.

Gance-Cleveland, B. (2005). Family-centered care. Motivational interviewing as a strategy to increase families' adherence to treatment regimens. *Journal For Specialists In Pediatric Nursing*, *10*(3), 151-155 5p.

Griffin, C., Guerin, S., Sharry, J., & Drumm, M. (2010). A multicentre controlled study of an early intervention parenting programme for young children with behavioural and developmental difficulties. *International Journal Of Clinical And Health Psychology*, *10*(2), 279-294.

Herman, K.C., Reinke, W.M., Frey, A.J., & Shepard, S.A.(2013). Motivational interviewing in schools: Strategies for engaging parents, teachers, and students. New York: Springer. ISBN 978-0826130723

Johnson, C. T. (2007). Development of a parent training program for children with pervasive developmental disorders. *Behavioral Interventions*, *22*(3), 201-221.

References

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. American Psychologist, 47(9), 1102-1114.

Reinke, W. M., Herman, K. C., & Sprick, R. (2011). Motivational interviewing for classroom management: The Classroom Check-Up. New York: Guilford Press. ISBN 978-1609182588.

Rollnick S, Mason P, Butler C. Health behavior change – A guide for practitioners. New York: The Churchill Livingston, 1999.

Williams GC. Motivational predictors of weight loss and weight-loss maintenance. *J. Pers. Soc. Psychol.* 1996; **70**: 115–26.

Williams SK, Scahill L, Vitiellio B, et al. Risperidone and adaptive behavior in children with autism. J Am Acad Child Adolesc Psychiatry. 2006;45:431-439.

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