Special Learning, Inc.
A Global Leader in Digital Autism Solutions

# HOW TO STOP TALKING AND START COMMUNICATING WITH MOTIVATIONAL INTERVIEWING

## A Behavior Therapists Guide on How to Effectively Collaborate with Caregivers

*Dr. Monica Gilbert, Psy.D., BCBA-D, LMHC*

*3pm-5pm CDT • September 30, 2020*

*2 BACB CEs • 2 APA CEs •2 QABA CEs*

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# 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

Dr. Ronald T. Brown, Ph.D., is a nationally renowned expert in ADHD. As Professor and Dean in School of Allied Health Sciences at University of Nevada, Las Vegas, Dr. Brown oversees leading three departments that educate nearly to 4,000 students annually through 10 degree-leading programs and 16 research and training labs. He served as the Associate Vice-Chancellor for Academic (Health Affairs) at the University of North Texas System. Dr. Brown completed his Ph.D. from Georgia State University and has been the past President of the Society of Pediatric Psychology and the Association of Psychologists of Academic Health Centers. He is a board- certified clinical health psychologist and has been an active clinician, teacher, advocate and investigator.

He served as a member of the Behavioral Medicine study section of the NIH and chaired several special panels at NIH. Dr. Ronald Brown's area of specialization includes behavioral sciences, pediatric psychology, attention deficit disorders, neuropsychology, psychopharmacology, learning disabilities and psychosocial oncology. He currently serves as the Editor of Professional Psychology: Research and Practice.

Dr. Brown's research and publications spans several decades with an emphasis on clinical and pediatric psychology. A noted expert in ADD/ADHD, he has published nine books and more than 300 articles, served on the editorial boards of more than 15 journals in the field of health care and child psychology, and has received more than $20 million dollars in federal grants from the National Institutes of Health, the Centers for Disease Control and Prevention, and the United States Office of Education.

# 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.

# Learning Objectives & Outcomes (TOC 1)

- Rationale for Parent Training (PT)
- Parental barriers for treatment adherence
- Resistance and Ambivalence
  - Righting Reflex
- What is Motivation?
  - ABA description of motivation

# Learning Objectives & Outcomes (TOC 2)

- Motivational Interviewing
  - Clinical uses
  - Principles
  - Spirit
  - Foundational Skills
  - Goal (Change talk)
  - Clinicians goals
- Transtheoretical Model
- Strategies in responding to resistance and ambivalence
- Measuring resistance and ambivalence
- Video of MI in Action
- Most asked questions
- Ending thought

# Time ordered agenda

- 5 min Introduction of presenter and topic
- 10 min Introduce motivational interviewing & use of behavioral principles (private events)
- 10 min Rationale for and barriers in parent training
- 10 min Righting reflex, unsolicited advice
- 10 min introduce stages of MI
- 5 min Break
- 10 min Continue stages of MI
- 20 min Strategies for interviewing
- 15 min Troubleshooting-strategies for resistance
- 20 min Case scenarios-practice
- 5 min Ending thoughts

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

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# 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

**Motivational Interviewing is non- judgmental, non- confrontational, and non- adversarial.**

# MI + ABA (Christopher and Dougher)

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.

# Research Behind MI

- Currently more than 1200 publications
  - 700 of which are random control trials
- Primary focus has been on addictive behaviors
- However, research is broadening into;
  - medication adherence
  - Healthcare consultation
  - Corrections
  - eating disorders
  - teacher training
  - children and adolescents with and without disabilities

# Make Sense of Motivation Using an ABA Perspective


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# Quick Review

- SD:
  - Alters the probability of a certain response by" signaling" that reinforcement is available
- MO:
  - (condition) describe environmental variables that have a "value –altering effect" and a "behavior-altering effect" (Cooper et al., 2007).

Private Events?

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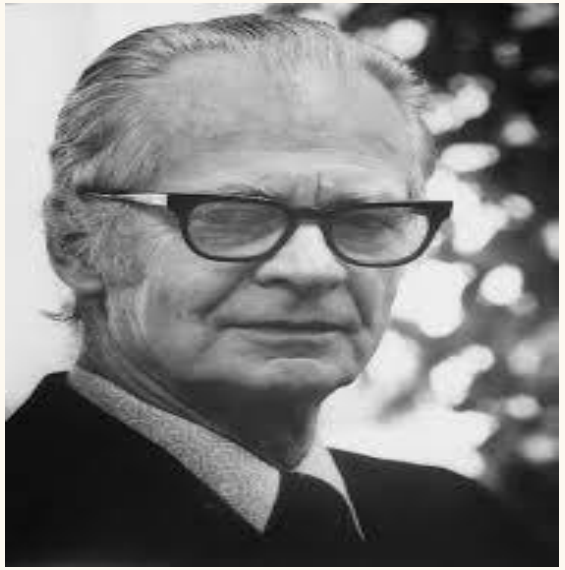
- Private events
  - “some parts of the environment that are within the organism” (p.229).
  - “a purely private event would have no place in a study of behavior, or perhaps in any science; but events which are, for the moment at least, accessible only to the individual himself …must then be considered” (Skinner, p.229).



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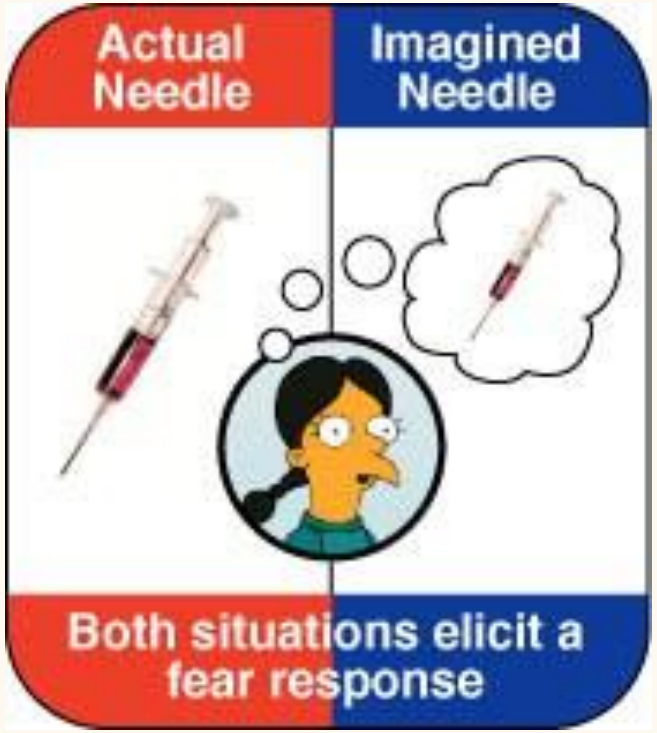
- Private events(thoughts) exist(but difficult to measure)
- Private events (thoughts) can change
- Private events (thoughts) can impact behaviors
- Behaviors can impact private events (thoughts)





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# Can language change our private events?

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# Pavlovian Example

Ex: Dog Becomes “excited” when he hears “cookie”
(attach food to neutral events “cookie”)

What would happen if you feed a dog a biscuit and then say “cookie” when he finishes
Will the dog become “excited” if you say “cookie’ without showing him a biscuit?
NO

# Verbally Able Humans

- Give a child a cookie and say “cookie” after the child finishes eating
- What happens if we said Cookie when the child is a nearby room
- Child will come running to us expecting a cookie
- The sound of the words would make the child think of cookies even though the words had never predicted the delivery of cookie
- The word cookie and the actual cookie enter into a bi-directional stimulus relation

# Using the Contingency to Explain Parental Responses

| Antecedent | Behavior | Consequence |
| --- | --- | --- |
| Analyst gives parent a directive to follow | Refuses to implement interventions | Parent "escapes" interventions |
| Private event (MO): I am not confident or ready to change my behavior | Parents verbalizing or resisting against clinicians' "requests" | |

MO makes "escaping" the demand more valuable and increases all behaviors that have helped parent escape in the past.

SD: Sight of the clinician

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# Motivation


You don’t need a shark, but you do need something….

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# Principles of MI

Follow your “RULE”

**R**esist the righting reflex

**U**nderstand your client’s motivation

**L**isten to your client

**E**mpower your client

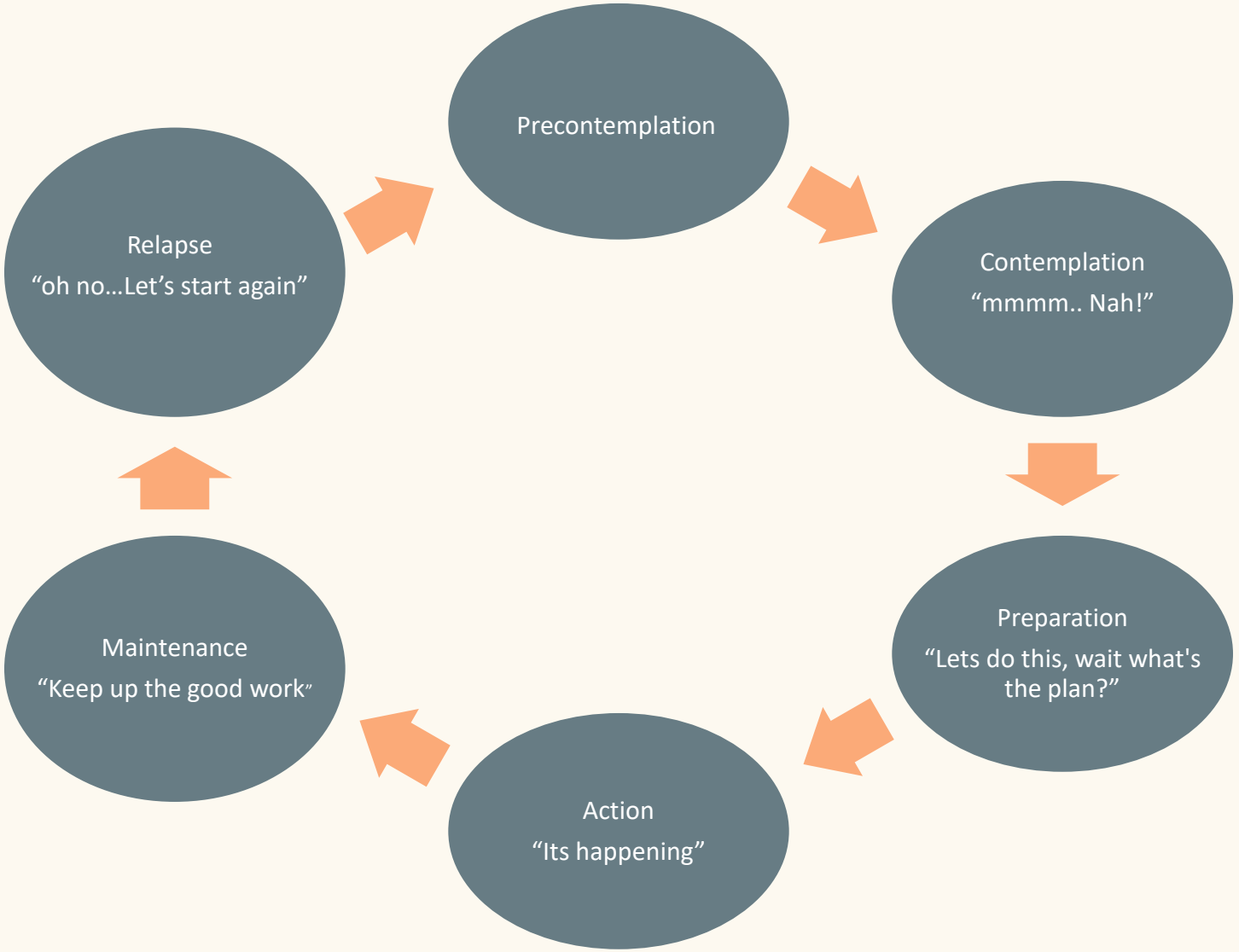
# Spirit of MI

1) **Collaboration**-developing a partnership with parents

2) E**vocation**-Drawing out ideas and solutions from clients (don't choose a destination offer info about a path)

3) **Autonomy**- Decision making is left to client ( they are responsible for choosing their destination)

# Prochaska and DiClemente's Transtheoretical Model



# Most Asked Questions

1. How do I learn about MI?
2. Who can provide MI?
3. Who do I use MI with?
4. How do I know that MI is working?
    - Increase in goal attainment
    - Ruler method
    - Increase in DLS in Vineland
    - Parents attendance to parent training sessions

4. What do I do if it feels “fake”?
    - Don’t do it

# Rationale for Parent Training

- Faster decrease in maladaptive Behavior
- Easier to fade out services
- Lead to generalization and maintenance of behavior change
- Meet “medical necessity” for ongoing therapy
- It’s ethical!
  - 2.15 Interrupting or Discontinuing Services (insurances).
    - (a) Behavior analysts act in the best interests of the client and supervisee to **avoid interruption** or disruption of service.
  - 6.02 Disseminating Behavior Analysis. RBT
    - Behavior analysts **promote behavior analysis** by making information about it available to the public through presentations, discussions, and other media.
  - 2.09 Treatment/Intervention Efficacy
    - (a) Clients have a right to **effective treatment.**
    - (c) In those instances where more than one scientifically supported treatment has been established,
      - **efficiency and cost-effectiveness**
      - **risks and side-effects of the interventions**
      - **client preference**
      - **practitioner experience and training**

# Barriers of Treatment Adherence

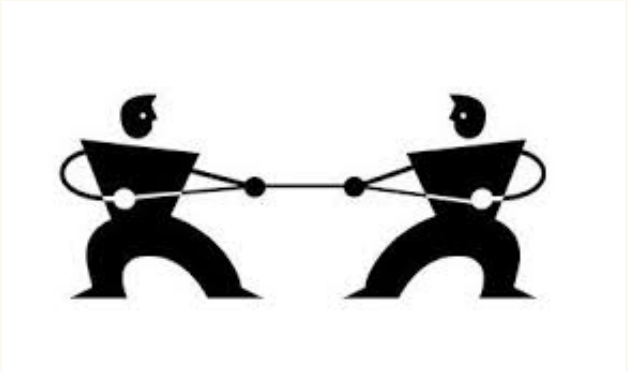
- Gance-Cleveland (2005) found that some reasons why families may have a difficult time adhering to treatment may be due to

  - Difficulty with practicality of treatment
  - Unrealistic expectations
  - Lack of knowledge or education on treatment
  - Little hope that things will “get better”
  - Negative Reinforcement
  - Demands of treatment on family members
  - Lack of resources and support from other family members
  - Cultural  beliefs
  - Clinician-Parent communication style

# What happens when there is a breakdown in communication?

- Results→ Resistance (sustain talk) defined as the refusal to accept, comply with a demand; the attempt to prevent something by action or argument.

- Maintain →Ambivalence is defined as state of having simultaneous conflicting reactions, beliefs, or feelings towards an idea



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# Observe the Following Pictures

What do each of these individuals elicit?


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# What do these pictures elicit?

# Clinician to the rescue!

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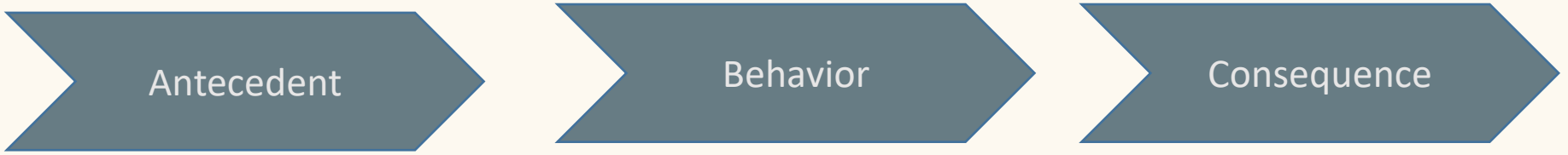
# Righting Reflex

- A clinician's 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

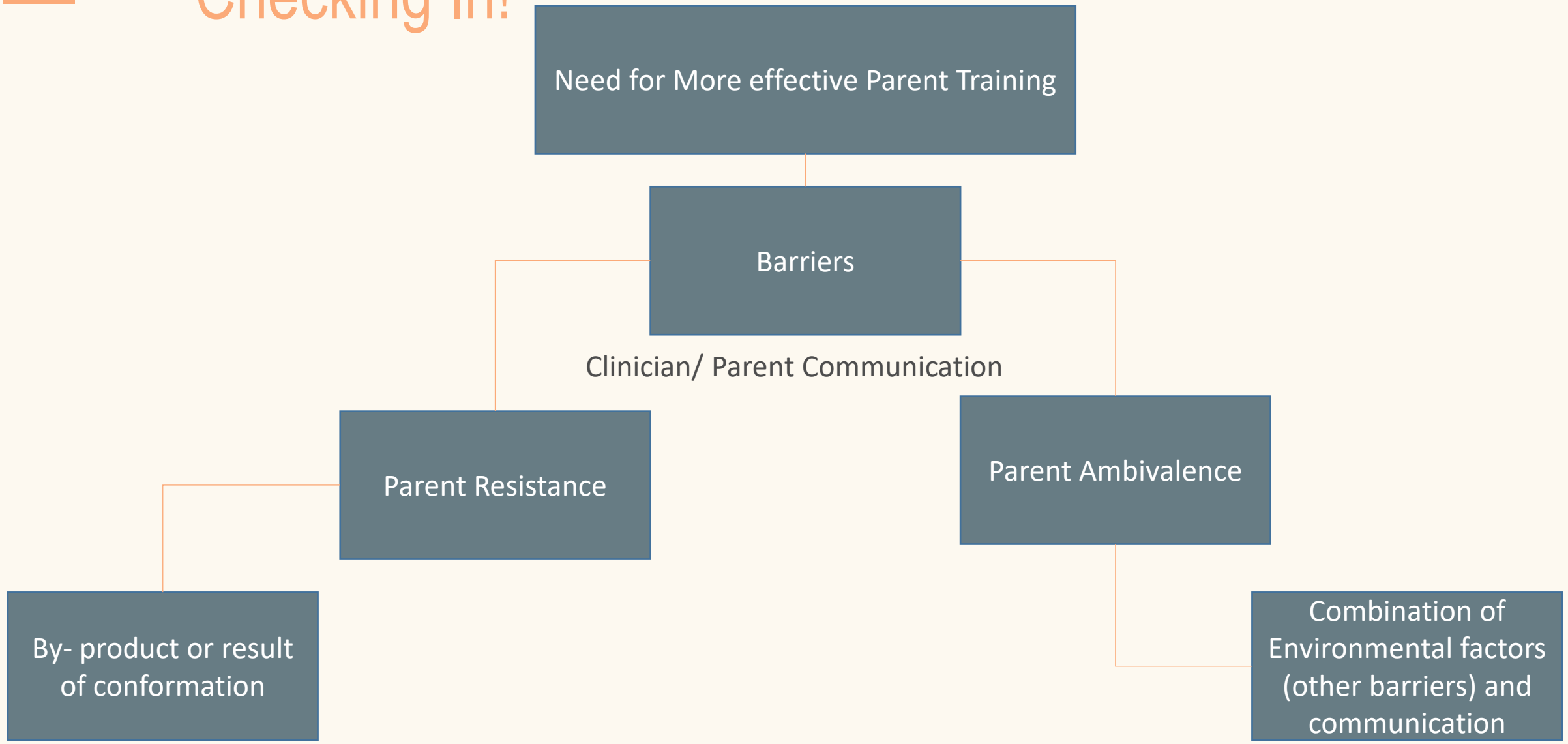
# Parental Responses Using the ABC's After MI




| | | |
|---|---|---|
| Private event of "I am able and confident that I can do this intervention" | Parents adhere to interventions and use CT (Change talk) | Will lead to feelings of accomplishment in the form of sensory, tangible or/and attention |

When these private events come into verbal behavior (parents speak about their thoughts) it may have a function altering effect, specifically the function of escaping may change to a different function after the MI intervention (instead of behaving to escape now the parents behaves to obtain praise as a form of attention or automatic reinforcement "feels good") changing this from a negative reinforcement process to a positive reinforcement one.

# Checking In!



# How do we manipulate private events and evoke change talk?

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# A Proposed Solution…

# MOTIVATIONAL INTERVIEWING- Skills & Strategies

# How to know when parents are ready for change?


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# Precontemplation

- Client profile
    - Client is not considering change
    - Is unlikely to take action
    - Client is likely to say, “I was recommended this therapy, but I don’t know why, everything is really not that bad”.
- Treatment Needs
    - Client needs information linking current problems to future potential maladaptive problems (child slaps you gently when he wants something and he is three what will happen when he is 15)
    - General education on how behaviors are maintained and reinforced. (Teach functions, ABC, + and – R and P)
- Motivational Strategies for Clinicians
    - Establish Rapport: Using RULE and OARS, ask permission and build trust.
    - Raise Doubts or concern in client
        - Exploring “why now”-reasons that brought client to seek treatment
        - Examining discrepancies- “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.”
        - Express concern and leave the door open!
        - Consider the “miracle question”- How will you life be different if your child did not engage in this behavior?
        - USE EPE

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# EPE: Elicit- Provide- Elicit

- E-Elicit: Ask client what they know already and then (elicit) their area of interest
- P-Provide: Provide them with the information
- E-Elicit: checking in with client

- This method
  - Avoids telling clients what they already know
  - Respects their skills and knowledge
  - Allow practitioner to provide only the info that clients need

# Contemplation

- Client profile
  - Client has considered change but has not yet decided to commit to change
  - Is aware of some pros and cons of child' behavior
  - Client is likely to say, "I know we are reinforcing this behavior inadvertently but its just so hard to tackle"
- Treatment Needs
  - Increase client's awareness of consequences
- Motivational Strategies for Clinicians
  - Normalize ambivalence: "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".
  - Help tilt the "balance" the decisional change
    - Using Double sided reflection: "I can see your predicament, On one hand you aren't sure that this intervention will decrease Tommy's behaviors and on the other hand you you feel as though his behaviors will get worse if you don't intervene at all (always finish it with the reflection for change)"

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# Preparation

- Client profile
  - Client decides they want to change and begins to plan steps toward change
- Treatment Needs
  - Client is ready and needs specific interventions that will help them deal with problematic behavior and intervene on their child's behavior.
- Motivational Strategies for Clinicians
  - Clarify parents' goals for being able to implement intervention/treatment effectively
  - Offer a "menu" of options for treatment
  - Explore treatment expectations
  - Help client Incorporate treatment goals for client/ and self into every day life

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# Action

- Client profile
  - Parent engages in behavior, but these behaviors are not yet stable or generalized.
  - “first active step toward change”
- Treatment Needs
  - Parent may need reinforcement and encouragement and more so if experiencing extinction burst of child's  behaviors.
- Motivational Strategies for Clinicians
  - Reinforce parents intervening effectively
  - Encourage consistency
  - Support realistic view of change through small steps.
  - Crisis intervention: Help parents identify “high risk” situations and develop management strategies for this situation.


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# Maintenance

- Client profile
  - Parent establishes new behaviors on a long term basis.
- Treatment Needs
  - *Develop a “fire escape”/Relapse prevention: anticipate difficulties
- Motivational Strategies for Clinicians
  - Help parent see progress
    - Introduce graphs
    - Mastered goals and objectives
    - Possibly decrease intervention hours to assure independence of implementation of tasks
- Review long term goals

# Relapse


- Parent engages in “bootleg reinforcement”
  - Reasons:
    - Breakdown of plan
    - New family members in home or interact with client
    - New Behaviors arise
    - Parent’s current stressors increase…
- Motivational Strategies for Clinicians
  - Help parent reenter the change cycle
  - Explore what can be learned from “relapse”
  - “Road block” does not mean “end of the road”- UTURN!
  - Assist parents in developing new replacement strategies
  - Maintain support

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# Foundational Skills

OARS

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

**A**ffirmation (“I can really see how hard you are working on this”)

**R**eflective listening (“That really makes you angry when others say that about you”)

**S**ummarization (Collect, link, Transition)

# Practice converting a closed ended question to an open- ended question

- How are you?
- How is Sammy behaving?
- Are you providing him with breaks when he says “break”?
- Are you ignoring his attention seeking behaviors?

# 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

# Examples of phrases that can be used

- “From your point of view…”
- “As you see it…”
- “Seems like…”
- “What you are saying…”
- “You mentioned…”
- “It appears that you…”
- “You believe…”
- “You figure…”

# Case of Rob

Listen to the following case illustration and then recording to hear examples of reflective listening.

# Practice Reflective Listening

For the following statements generate at least 2 alternative hypothesis for each statement below.  (hint: answer with “you mean, It sounds like”)

1) “ I don’t like conflict”
2) “I let things bother me more than I should”
3) “ I am loyal”

# Goal of MI

# “Change Talk”

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# Change Talk and 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

# Lets Practice

- Think about a behavior you want to change
- Now rate how ready and confident you are to change the behavior from 1-10(totally ready and confident)
- Make a List

| Why not higher?<br>(Sustained talk against change “counter change talk”) | Why not lower?<br>(Change talk) |
|---|---|
| | |
| | |

# Let's Practice

- ID which phase is demonstrated by the following quotes
  - P1: "I have thought about the intervention you proposed the other day but I just can't see how I can do that"
  - P2: "I just don't think anything is going to help right now"
  - P3: "I feel like now I am able to intervene by applying extinction"
  - P4: "I am going to ignore him when he cries and when he says "mommy look at me" then I will give him attention
  - P5: "oh no! I did it again, I told him to stop when I should have ignored it.


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- Hunter, Button and Westra (2014) compared clients amount of change talk (CT) verses client counter change talk (CCT)
- Similarly, Glynn and Moyers (2009) developed a manual for motivational interviewing that coded CT and CCT and labeled the different change domains as
    - “reason for change,”
    - “desire for change, ”
    - “need for change,”
    - “ability to change,”
    - “commitment to change,”
    - “taking steps toward change” and “other.”
    - They then coded using tally marks how many times participants engaged in a CT or CCT in each domain

# DARN CAT

- Desire
  - Wishing, wanting and hoping
- Ability
  - I can, I am able to, I will
- Reason (why)
  - I will have more energy if I can get these behavior under control
- Need to (urgency)
  - I need to, I've got to, I have to learn
- Commitment (most indicative of change talk)
  - I am willing to..
- Activation
  - I am going to…
- Taking steps
  - I already started…

# Examples

| 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 |

# CT vs. CCT with Examples

**Target Behavior:** Inability to Ignore tantrums by withholding attention

* **Change Talk**: Any verbal utterance that indicates movement towards change the target behavior.

* **Counter-change talk**. Any verbal utterance that indicates movement away from "change" or indicates sustainment of target behavior.

**Change Talk (CT) +**

| Categories | Examples |
|---|---|
| • **Reason to change** *(statement indicating a rationale for changing the target behavior)* | "If Sam did not have tantrums we would be able to go out more" |
| • **Ability to change** *(statement indicating that the client is able to change)* | "If I put my mind to it I know I can ignore his tantrums" |
| • **Need to change** *(special type of reason stating the client's need to change)* | " I have to do this now because I know it will get harder later" |
| • **Commitment to change** *(statement that the client will change, or an idea for how the client could change"* | " I can start my going to another room when he starts to tantrum" |
| • **Taking steps toward change** *(statement that the client has already begun to change; this represents steps taken in the recent past (within approximately the past week).* | " I tried ignoring the tantrum by focusing on something else last night and he stopped right away" |
| • **Other** *(Any other statement about changing the target behavior. Includes hypothetical. Situations or circumstances that would convince the client to change, and problem recognition* | "If I could get some help, or maybe a distraction I could be able to ignore his tantrums"<br><br>" I know that providing him with attention is only going to make it worse" |

**Counter Change Talk (CTT) -**

| Categories | Examples |
|---|---|
| • **Reason to change** *(statement indicating a rationale for not changing the target behavior)* | "If I ignore his tantrum I will be neglecting his needs" |
| • **Ability to change** *(statement that client is unable or unconfident about change)* | " It is just too hard for me right now to ignore his screams" |
| • **Need to change** *(special type of reason stating the client's need to stay the same)* | " I don't necessarily think that his tantrums are a big deal right now" |
| • **Commitment to change** *(statement that the client will not change, or an idea for how not to change/to stay the same)* | " As soon as he cries I will ask him what he wants since he is indicating that he needs my attention" |
| • **Taking steps toward change** *(A statement that the client is already resisting change; this represents steps taken in the recent past (within approximately the past week).* | "It was just too much today, after he began to scream for about 10 seconds I just gave in and gave him what he wanted" |
| • **Other** *(A statement that is clearly CCT but does not fit reasonably into the other categories. This includes minimization of problems and hypothetical statements about non-change)* | " I have tried this before and it hasn't worked" |

# Tools for Your “Tool Box”

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# Strategies in Responding to Resistance

1) Reflective Listening: Responding with non-resistance to acknowledge parents' perspective.

"It sounds like you have tried many interventions that have not been effective, and this makes you frustrated"

2)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."

3) 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. "

4) 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"

5) 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."

# Strategies Continued…

6) 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.”

7)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?

8) 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.

# Strategies Continued…

9) Normalizing: Having difficulties while changing is common

Consultant: "I know it is probably difficult to hear your little one crying even though you know this is what has to be done"

10)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"

11) 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?"

12) 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?"

# Let's Practice Some More

Take some time and respond to each question with an MI consistent response.

- 1) You can’t help me you don’t know what it is like
  - Amplified:
    - It seems like there is no chance at all that I can help you
  - Simple Reflection:
    - You are concerned that I won’t be able to help you
  - Double sided:
    - On one hand you feel that I may not be able to provide you with the help you are looking for and on the other hand you are eager to find help
  - Agreement with a twist:
    - I may not know what it is like which makes helping you difficult, tell me what would you want me to know so that I can try to understand the situation a little more.

- 2) “I don’t have the time to fit this into my schedule with everything else I have going on right now”
  - Shifting focus:
    - “I can tell that time is very valuable to you, If its ok with you we can get to the point and I can share some strategies that you can use that can be the most effective for you and your family.”
  - Emphasizing personal choice:
    - “It is up to you on how you will use our time together. Please let me know what you would like to focus on.”
  - Agreeing with a twist:
    - “You have a very busy schedule and being consistent with these interventions does take time. What would happen if using these interventions actually decreases the amount of time that you are dealing with the maladaptive behaviors?”
  - Querying extremes:
    - “What is the worst thing that can happen if you invest time in these interventions and they don’t work? What is the best that can happen if they do?

# Measuring Ambivalence/ Resistance

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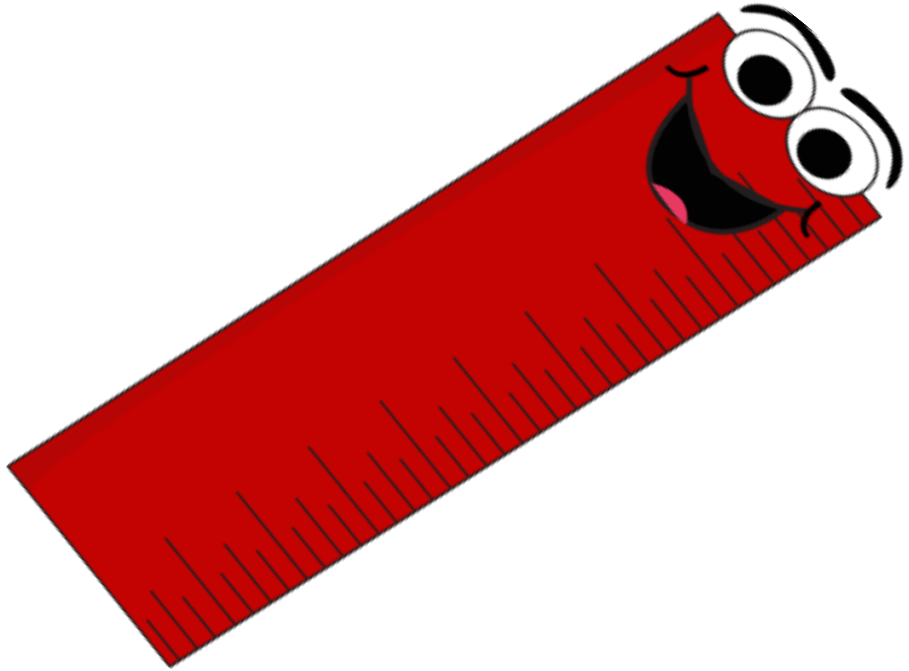
# Readiness Ruler

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



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# Readiness Ruler


**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**

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**

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_____?

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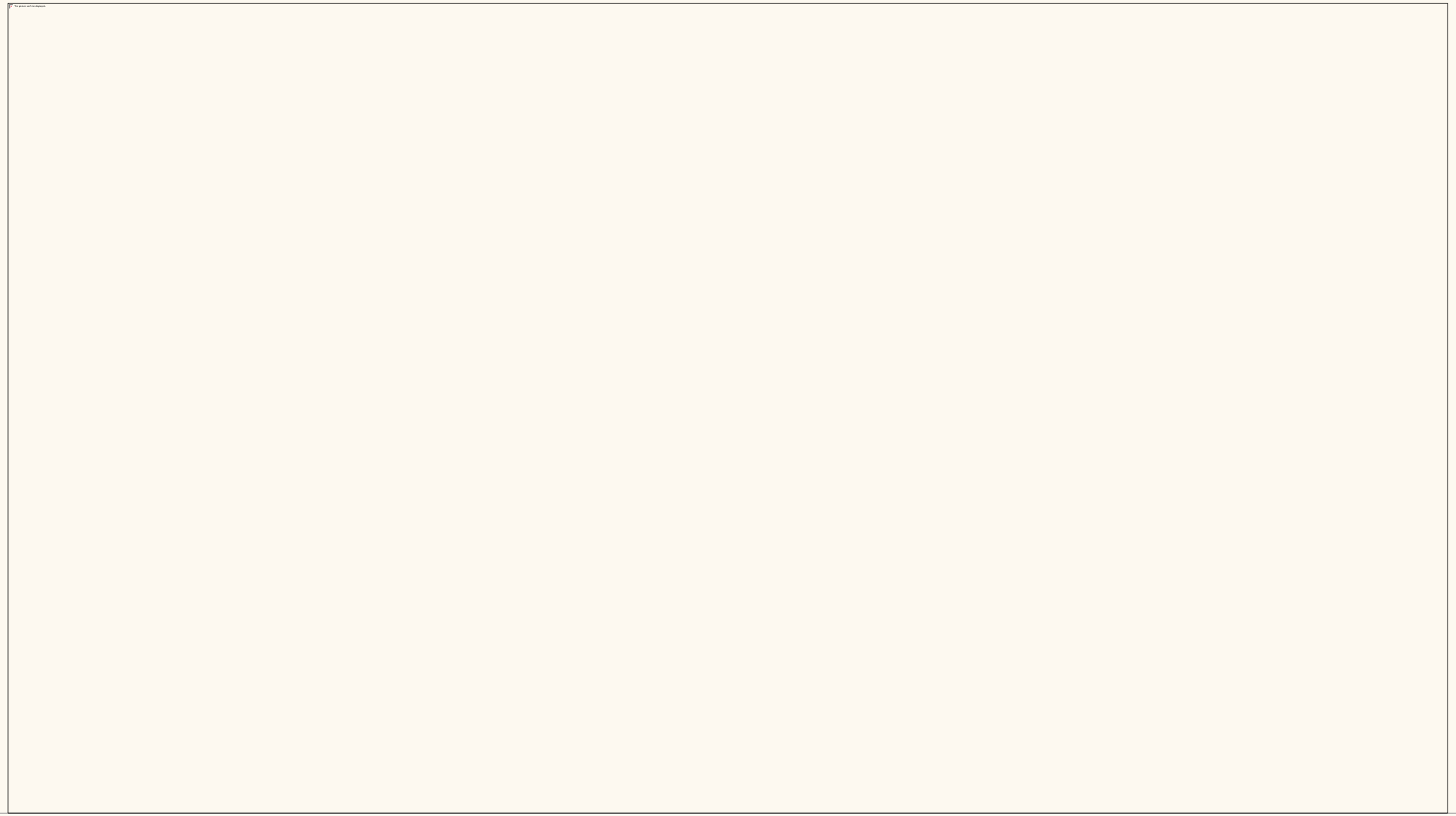
# What does MI look like in a PT Session



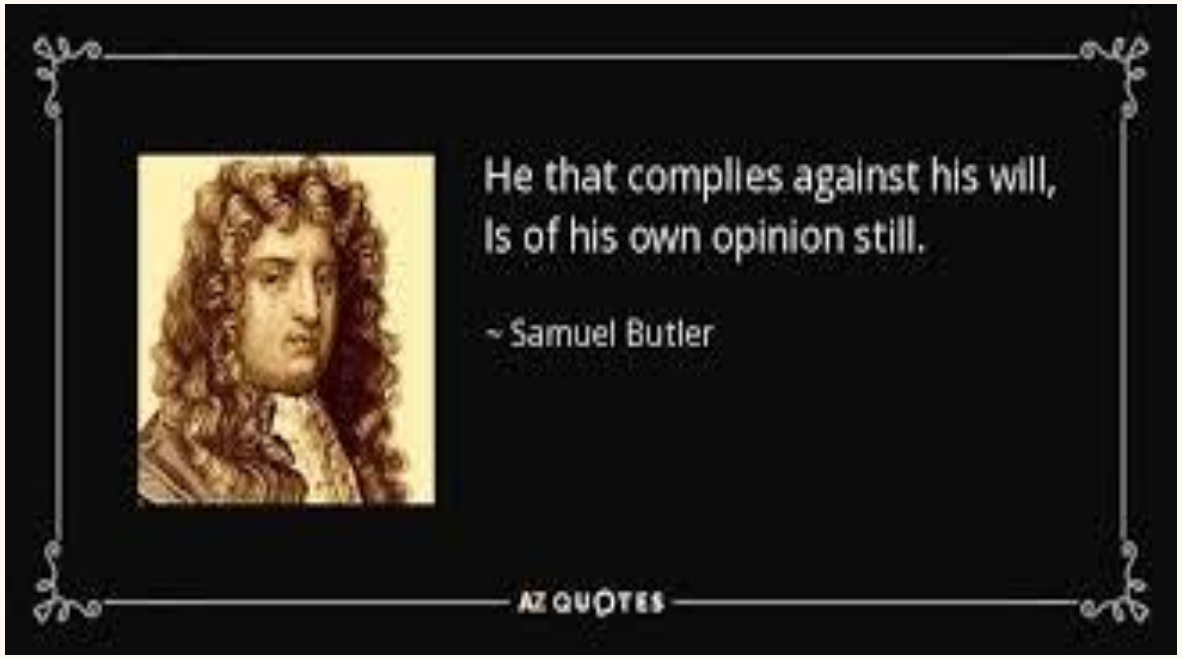
# Ending Thoughts

- “If you don’t use sit you loose it”
- MI is an approach that increases motivation by using a style of communication that elicits change talk
- MI is not psychotherapy
- Once parent has moved passed the precontemplation stage, clinicians can build on engaging, focusing, evoking and planning
- Remember to: Focus and reinforce “change talk” (the DARNCAT)

# 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 curios about discrepant behaviors without being judgmental or confrontation
- It is the client's responsibility to change not yours!

# Questions?

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