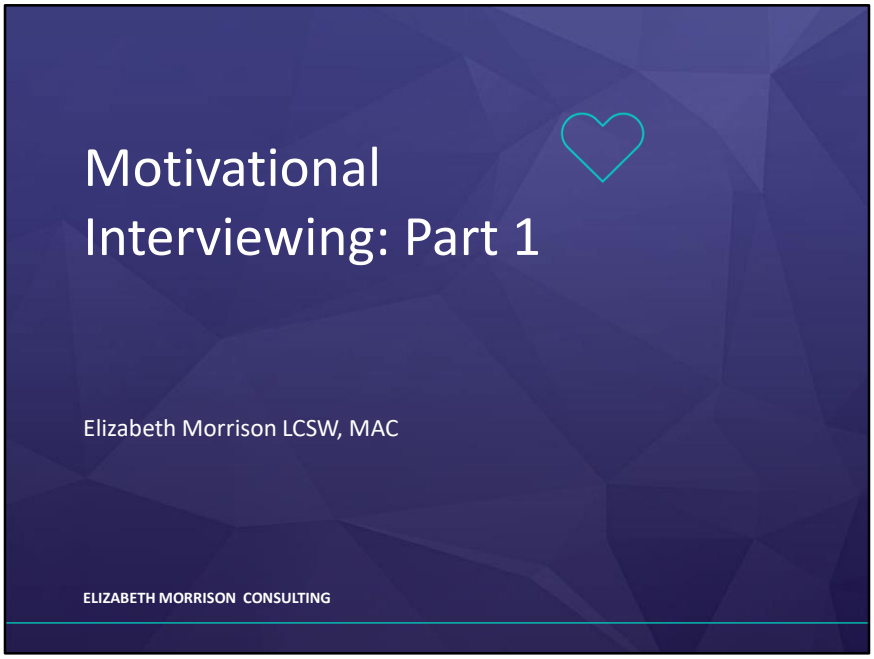


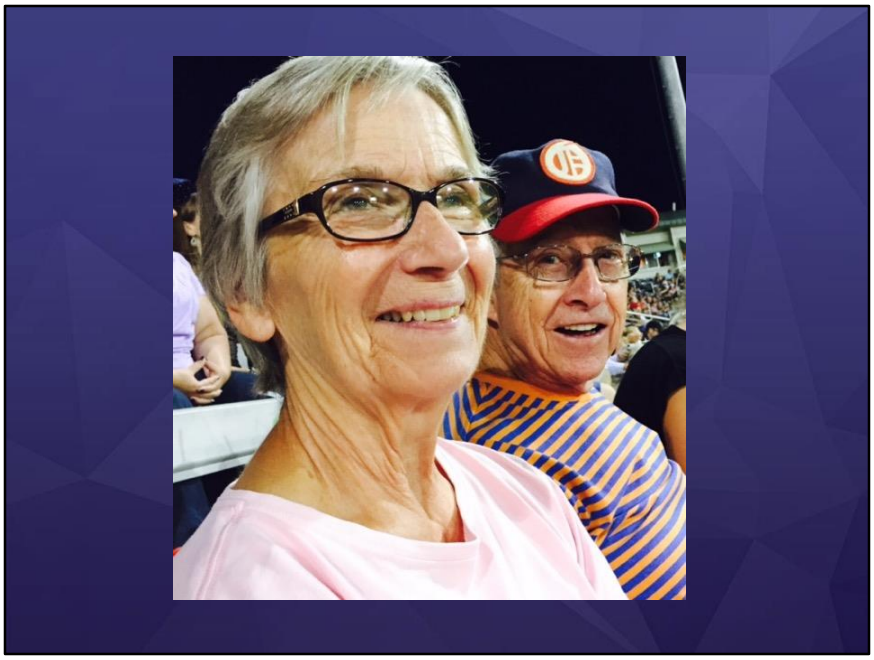
Setting up the tone:

The most important task before beginning is to engage the participants. Only engaged learners are open to information, and only engaged learners will change behavior as a result of information. Remember that we are modeling exactly what we want participants to do with patients, so the task before beginning is to make a genuine connection to the participants (even if you already know them) and also connect them to the material at hand.

Introducing yourself: First, introduce yourself if participants don't know you. You want to connect to them, regardless of how well you know them, so sharing some personal information is important.

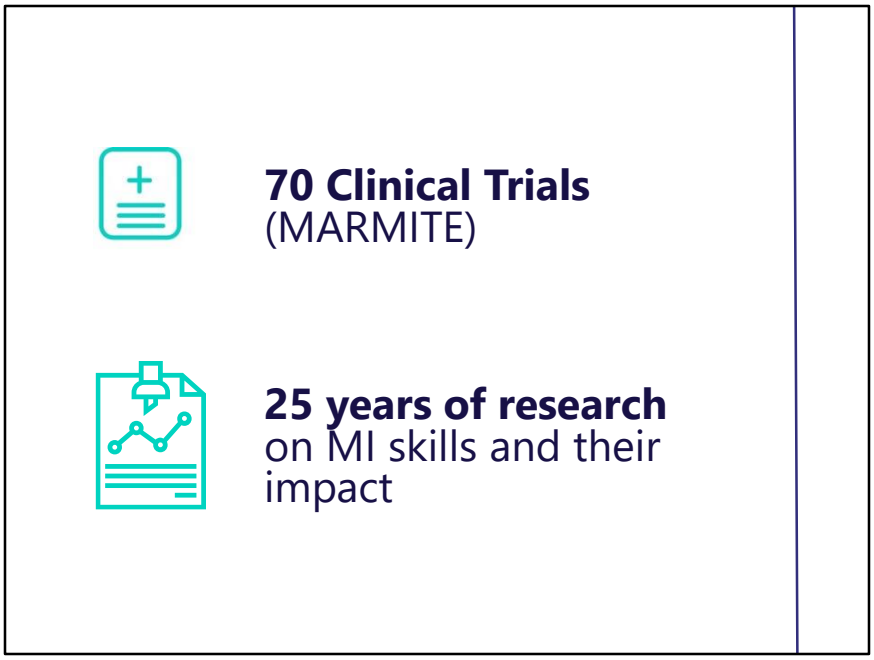
It is also usually important to qualify your own personal and professional connection with MI. What is it about MI that matters to you? How did you become acquainted with it? What
The group introducing themselves: It is important for everyone to introduce themselves, because feeling connected to you, the material, and each other will determine the success of the training. It is important to budget time for introductions, and to demonstrate listening skills when it is occurring (eye contact, mirroring, walking close to those who are talking, reflective listening, etc.). Depending on how large the group is, you might have to do just names/jobs, if it is a smaller group, you could ask them also to talk about something else, like what their experience is with MI, or what they hope to get from today's workshop. If everyone knows each other, you can skip names and possibly jobs, and just ask for their experience with MI, or hopes for the workshop.

Just a reminder, if you don't know everyone, this is the time you want to use your memory skills to memorize everyone's name, so you can use it in the workshop.



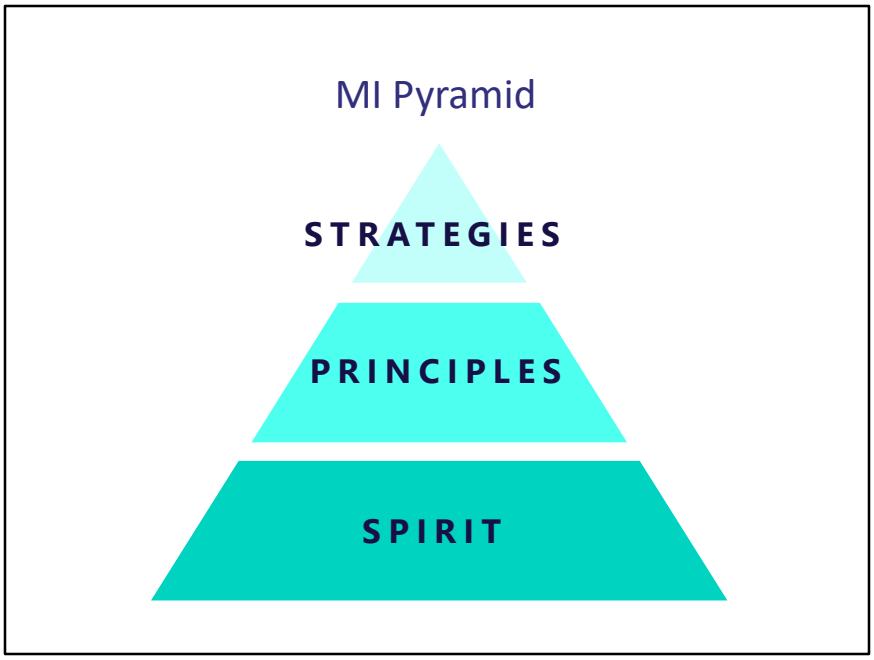
Replace here with your own picture that supports an opening story, of why communication matters to you. This can be a story about a patient, about your work, or something more personal, whatever you are comfortable with.

Briefly letting people know, there is a huge evidence base for MI, and during the workshop you will reference specific research on techniques. You can let them know you will refer them to a bibliography if they'd like, that you don't cite studies in these slides.



This is where you want to hit it out of the park in terms of ensuring that everyone knows, unequivocally, that the evidence base for MI is solid. Depending on your participant group, some respond stronger to the research case than others, so you can judge by the audience how much time to spend on this slide (or if you want to add a few slides of your own, highlighting research from the bibliography that matches your organization's mission or patients best). The important thing to convey on this slide is that the research base is enormous, and that MI is an evidenced based practice, and has been for about 20 years. I also think it can be useful to linger on the last 2 sentences here, that MI has been shown to have an impact on our own job satisfaction, it is a way to show your care not just for patients, for the employees in the room as well.

Just a reminder that 'MARMITE' is a meta analysis of MI done in 2011, showing evidence for MI effectiveness in a variety of settings, for a variety of behavior changes. This is not the only research (the whole bibliography is MI research) it is just a meta analysis, so easy to read if you'd like to review, and easy for others if you have someone in the audience that would like to read it.



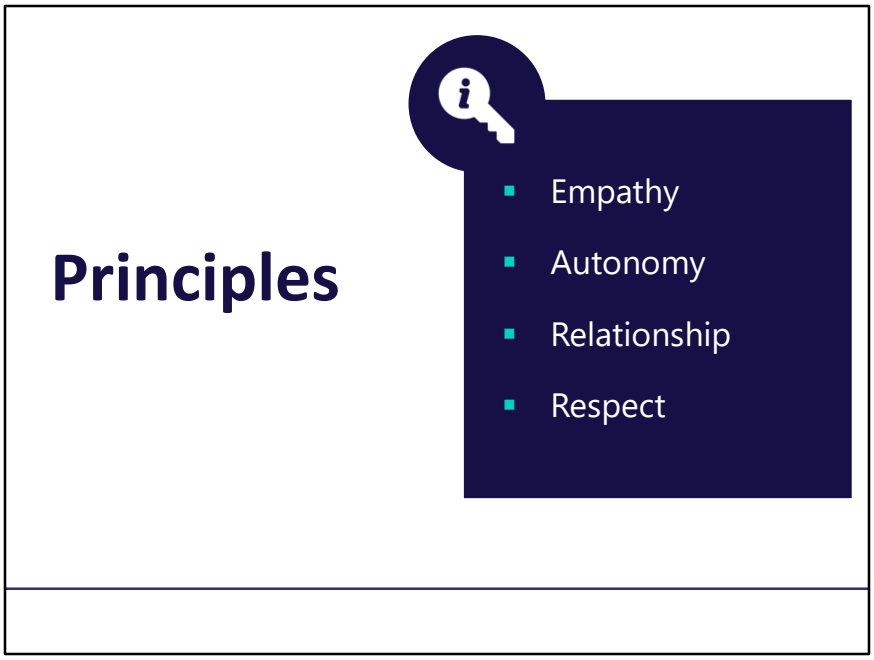
This is a slide to talk about the underlying **spirit of MI.** This is a place to really use your own style, and your own enthusiasm for MI to articulate what the 'spirit' is.

To really make sure the participants understand, this isn't just a set of tricks to get people to do what we want them to do; the **spirit** is actually a revolutionary way of thinking about our relationship with patients (and others in general), that really puts us as equal partners, not experts; that assumes the strengths and wisdom and good of others, and that rests on a foundation of unconditional positive regard for patients.

We could say something like, the true spirit of MI is collaborative, empathic, curious. It is truly believing that others have the answers to their deepest questions, and our role is only to help them listen to themselves, not to impart our own knowledge, beliefs or advice on them.

Principles are the main tenets of MI: the principle of deep listening, of evoking, or eliciting, and of valuing or prizing, the other person's preferences, wisdom and beliefs

Then mention that we will spend most of our time on **strategies**, so they will leave with something specific! Strategies are specific techniques to help us activate the spirit and the principles in an effective manner.



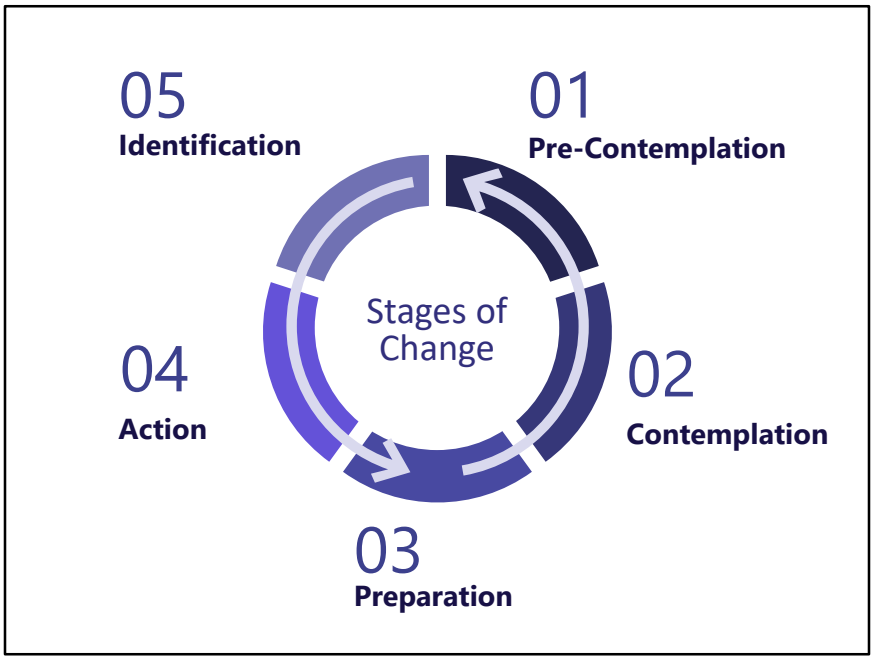
This slide explains, in brief, the main principles. You can say that we are focused primarily on the first 2 bullets in 'MI part 1'.

Express Empathy: This is THE primary principle of MI, the spirit of MI, the principle that all other principles are based on, and that all techniques are based on. This isn't about feeling empathy, it is about effectively conveying empathy, which takes a lot of practice (a lifetime of practice!)

Autonomy: This means the 'hero' is the story is the patient, (or our family member), we are not the 'hero' in the story who saves anyone, our job is to support, empower and help activate patients heroic efforts for themselves.

Relationship: This means that no correcting, imposing, arguing, or 'righting' patients (or others) will ever be effective, and in fact can be harmful; we instead use the relationship to allow for the person to share about themselves and their own concerns and motivations.

Respect: This is similar to 'unconditional positive regard', meaning, MI asks us to remain in the place of always respecting the other persons own wisdom and their own path.



This is a great slide to ask for participant input. You can ask who might want to define these (start with pre-contemplation and work clock wise. This is usually a chance to practice skillful reflective listening and also how to 'correct' without correcting, because often people wrongly define pre-contemplation as 'thinking about it' or 'ambivalence' which is contemplation.

It is important here that as a trainer you feel very competent and confident about your own understanding of each stage of change, so you can give examples of what happens during each stage. It is also very useful to share examples from your own life, or an example from one of your patients (no names of course).

Here are some basic explanations:.

Pre-contemplation: Do not think it is a problem. No thought about changing. Sometimes called 'denial'

Contemplation: also called 'ambivalence'. Considering change; one step forward 1 step back, etc.

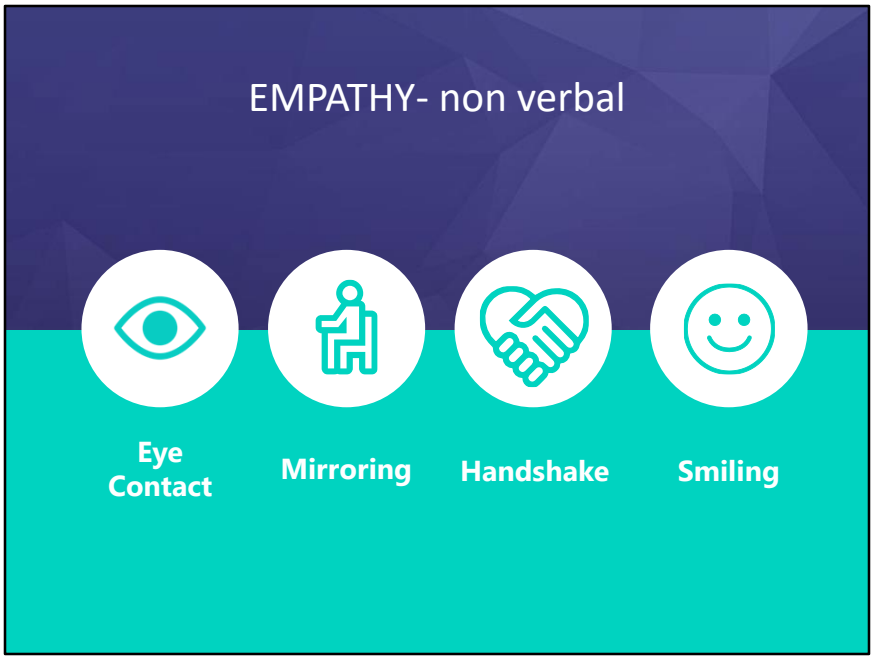
Preparation: no change yet, however the decision has been made, and preparations are happening, such as telling people (that the diet will start in 2 weeks, that the quit date for cigarettes is next month, etc.), buying supplies, looking for apartments (in the case of leaving a relationship, etc.). This is a good place to use an example from your own life or one of your patients.

Action: self explanatory

Identification: so identified with the change, relapse is very unlikely. It is important to give an example here.

You can add that relapse can happen after action, and often does for any behavior change.


Principle Techniques of
Motivational Interviewing
Non-Verbal Empathy Conveyance



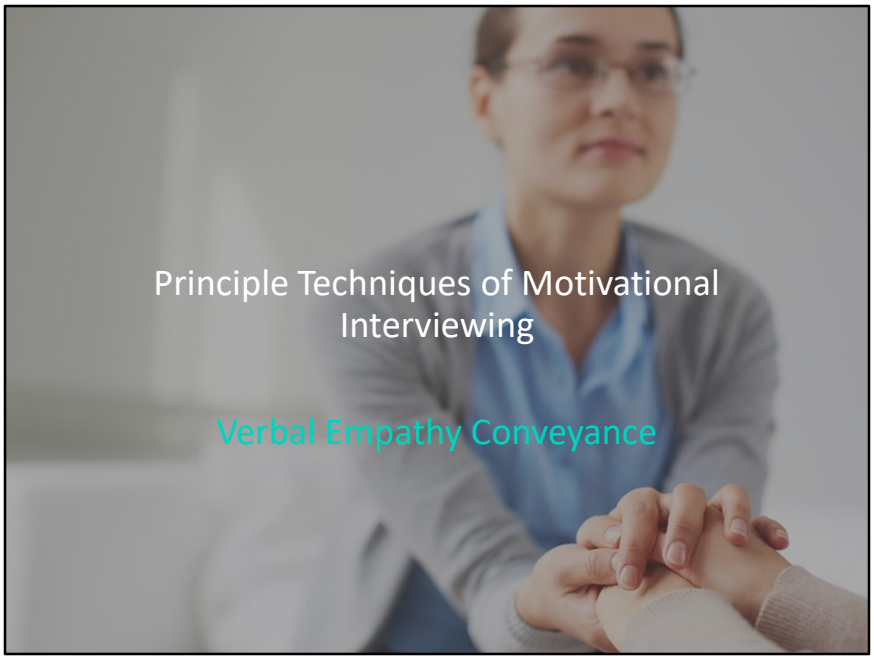
The important thing about this slide is to mention that these are research based techniques, they are indeed evidenced based. I often ask which one people think is the most important, in the literature. The answer is eye contact (lots of research on this in the bibliography).

Often a participant mentions that eye contact is moderated by culture in terms of how appropriate it is. This is true, although there have not been any differences found in the importance of initial eye contact (only sustained eye contact). In terms of responding to participants, remember we want to always preserve adult learners sense of self, and we want to encourage engagement, so we don't want to 'correct' anyone, we can thank someone for bringing cultural considerations to the forefront, and agree with them that there are differences, and then share it is in sustained eye contact.

This is slide where it is useful to have participants reflect on a time they didn't get these non verbals, especially in a healthcare situation, so they can viscerally recall how badly it feels. You might also ask them to remember a time they did get these non verbals.

Facilitators demonstrate.

This is where you and your co-facilitator demonstrate non-verbal empathy. It is often helpful to have planned in advance what you will say, and who will do what. Remember to pick something 'real', since we are modeling this for participants when we ask them to pick something real to practice on.



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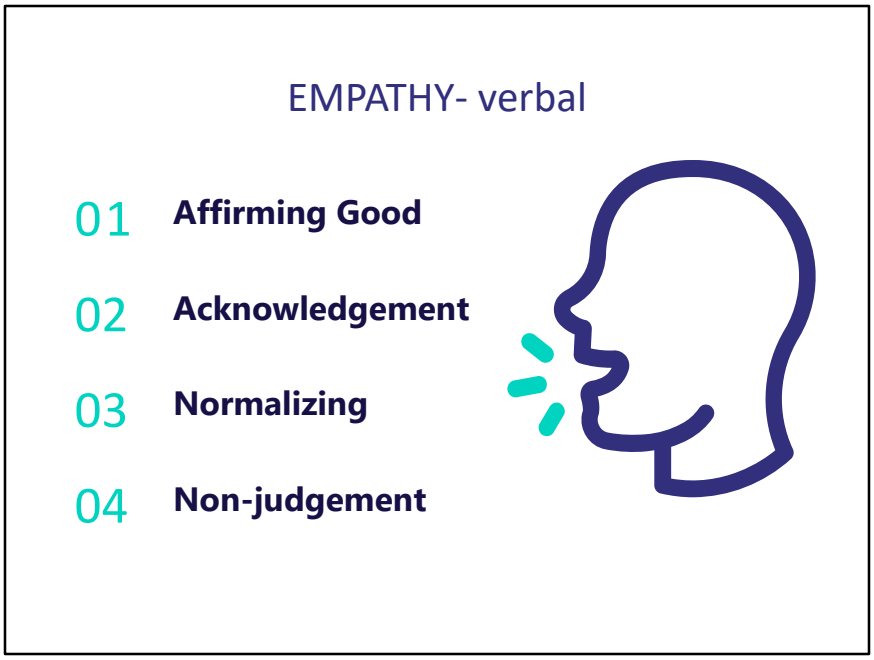


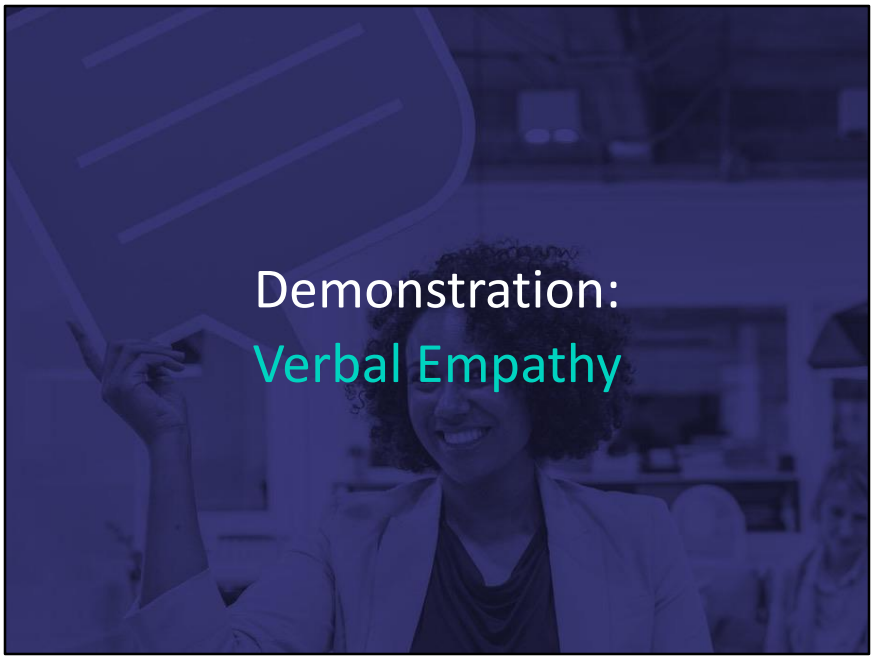
This is where you define each of these things. It is necessary to have examples for each for participants to understand what they really mean, so if having some examples in your pocket is important.

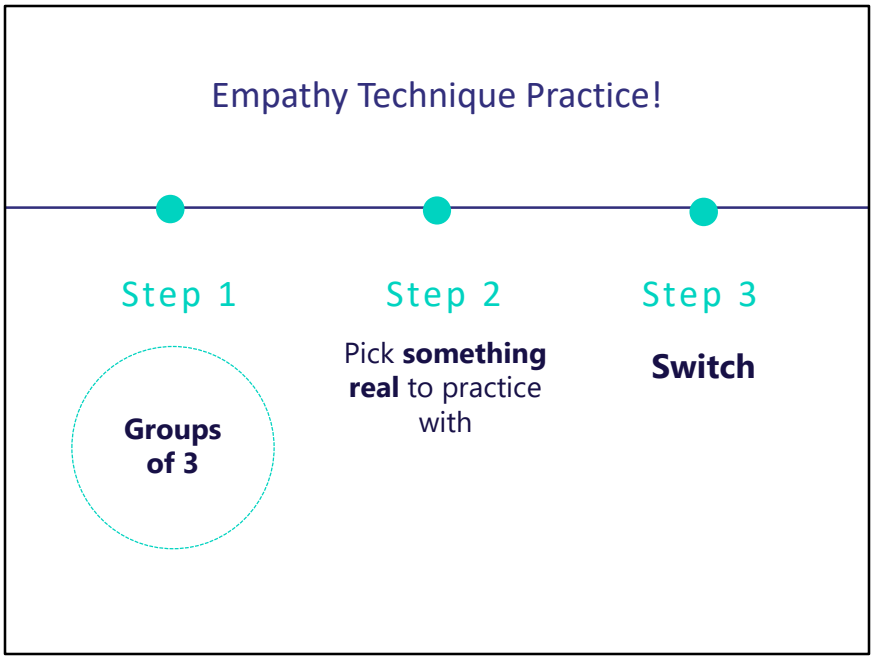
Affirm: noticing and articulating someone's strengths. Often starts with 'I'm impressed with your…' 'I'm inspired by your....',' I appreciate your....' (in giving examples, need to finish the sentence)

Acknowledgement: this is acknowledgment of feeling, whetther someone said it or just 'showed' it. 'I hear you are feeling.....' or 'that sounds really tough'

Normalizing: Letting someone know they are normal 'Anyone would feel that way' 'I'd feel the same' 'relapse is so common with this disease' 'most of us struggle with our weight...'

Non-judgment: All of the above demonstrate non-judgement, this is a technique where we directly say it 'I'm not judgeing you' 'i don't have judgments about that, I just wanted to reassure you'


Demonstration:
Verbal Empathy



Triads are preferred. Avoid 'counting off', it causes movement and commotion, and we want people just practicing with those next to them, as they usually are more comfortable with those they sat by.

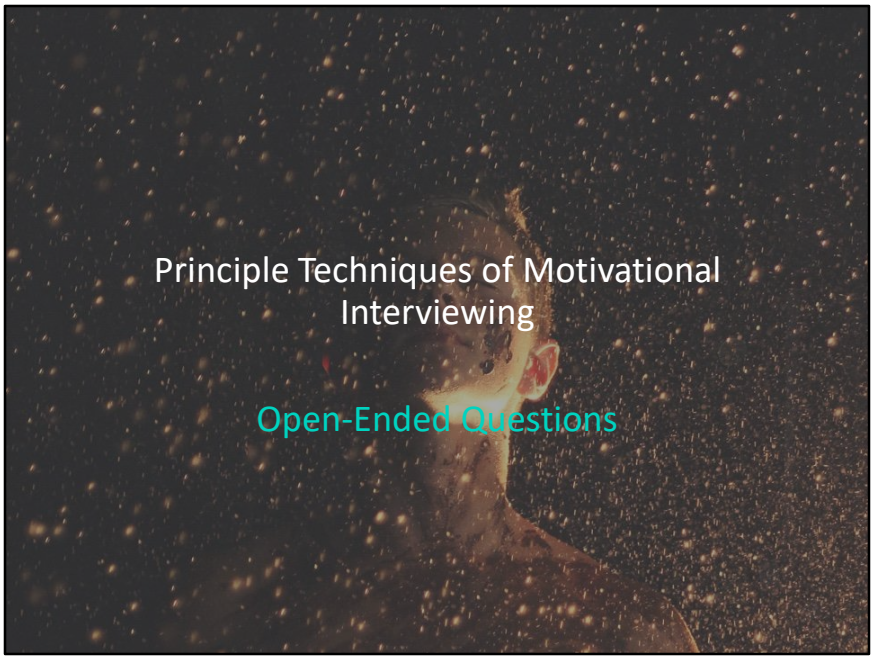
Give roles: 1. Person practicing 2. Person being practice on and 3. Observer.

Let the groups know to avoid any questions or advice. They are only practicing empathy techniques talked about previously.

The person being practiced on thinks of something they are willing to share, that they are having feelings about. They can use what they did before, in the previous exercise, or they can use something new.

The person practicing, responds with non-verbal empathy, and then at least one empathy technique (normalizing, akcnowledgment, non-judgement, affirming).

The observer names the non verbal and the verbal empathy techniques used.



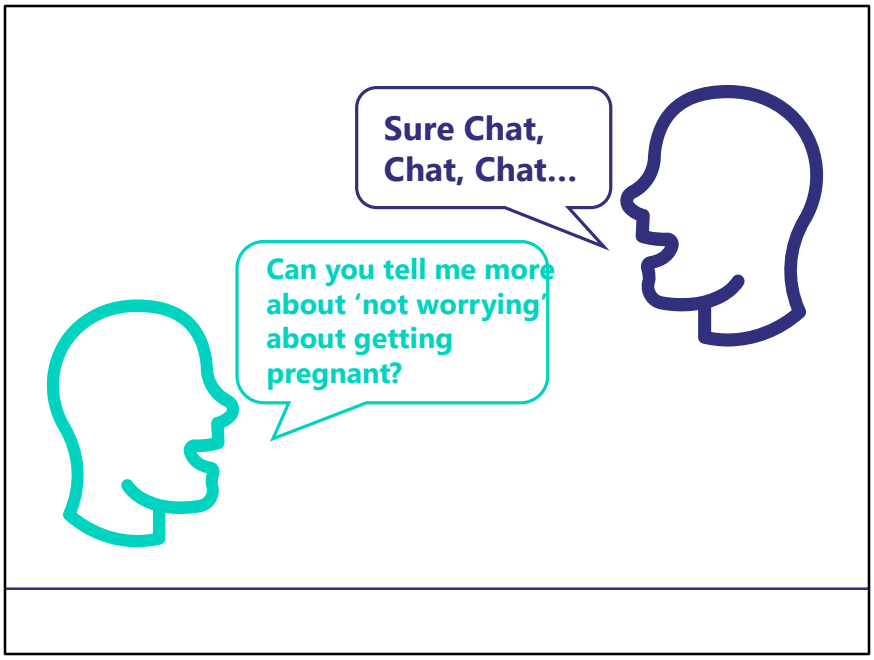
Ask participants to define open ended questions (can't answer yes or no). Expand the definition to include any one word or one phrase answer, and give examples 'when did that happen?" 'where did you go?' 'who went with you?'

This is a slide to share research. Looking through the bibliography at some of the open ended question research is useful. Here are a few highlights:

The Institute of Medicine called open ended questions the 'gold standard' of communication over 15 years ago, and since then there has only been more research to support this.

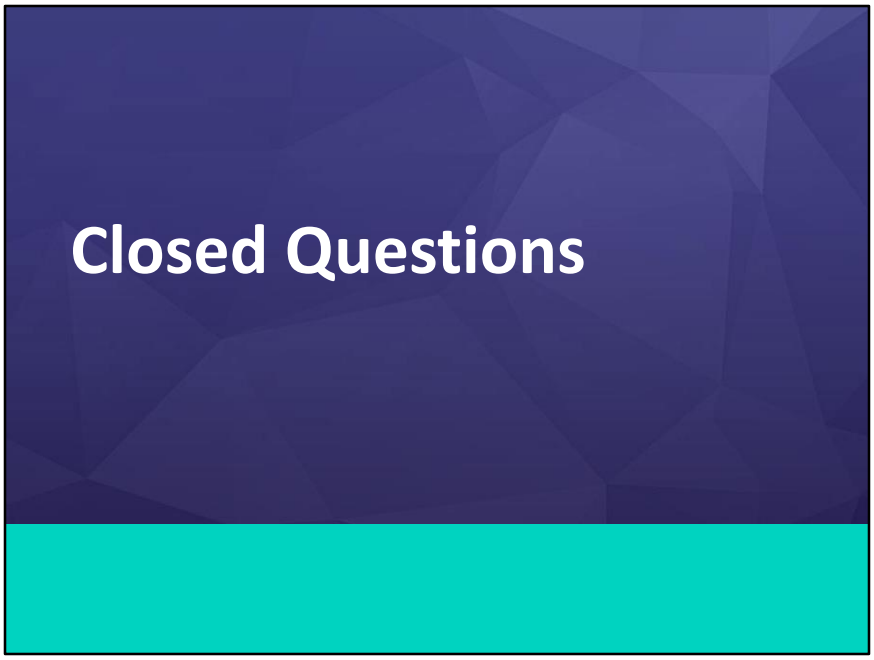
Diagnostic accuracy is related to how many open ended questions clinicians (physicians and BH clinicians) ask. Inaccurate diagnosis is related to the number of closed questions
asked.

Open ended questions effectively convey empathy; closed questions do not, they convey an agenda.



In this slide, you can ask participants to change these questions into open ended questions.

This is where you can share about not starting open ended questions with ‘Why’; and instead use the stems ‘What’, ‘How’ and ‘Tell me more about…’



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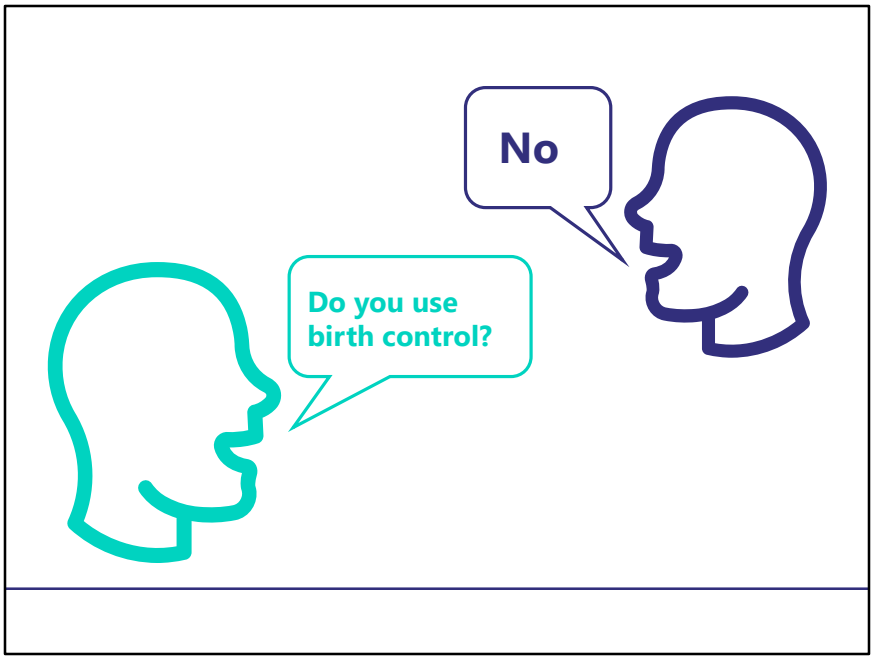
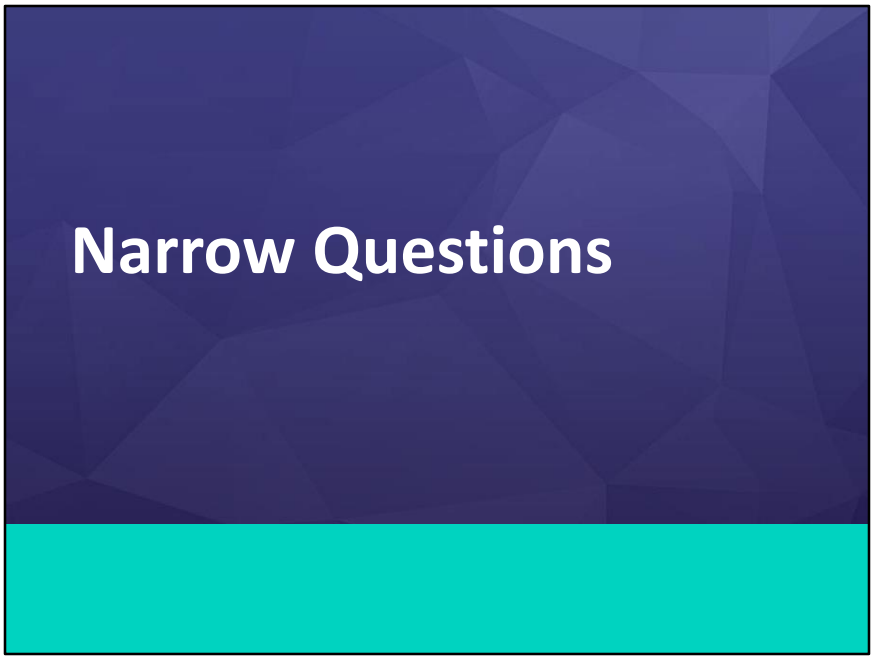

No
Do you use birth control?



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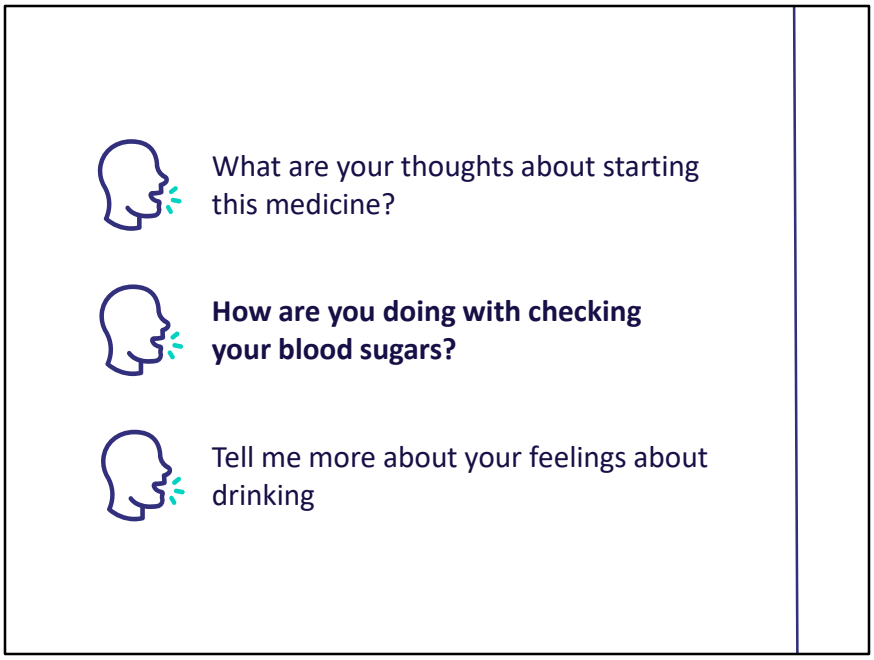
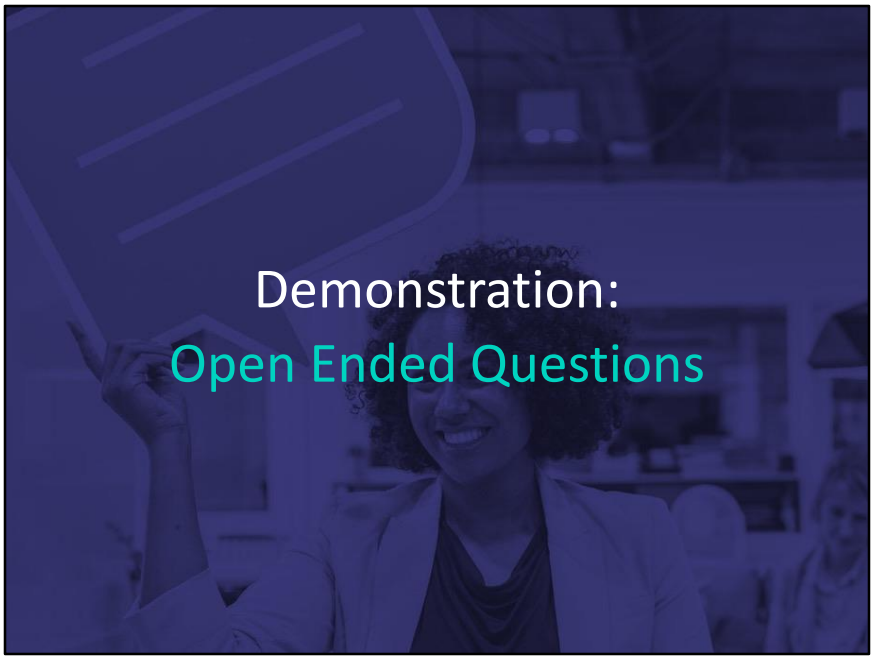
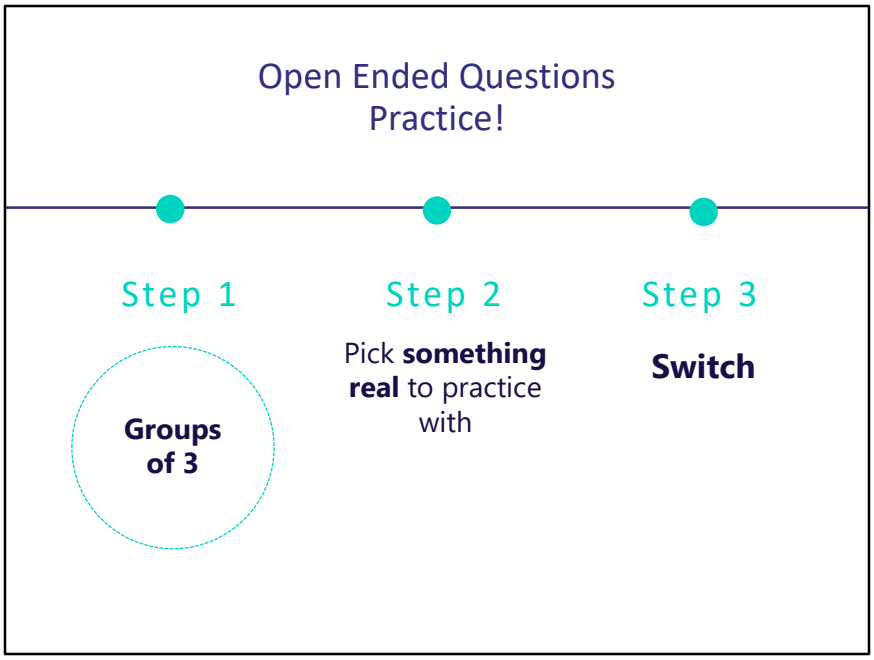


Here you are giving examples of how the questions on the previous slide could be changed to be open, and still be specific and to the point. I usually share that there is no one right way to ask open ended questions, these are just helpful stems



Facilitators demonstrate. Open ended questions are hard, so if you make a mistake during the demonstration, and ask a closed or narrow question, you can just normalize how hard it is and try again to do an open question. Remember to use something real, no role playing ☺



Set up the exercise. The basic directions are:

Triads are preferred. Keep the same triad.

Give roles: 1. Person practicing 2. Person being practice on and 3. Observer.

Let the groups know to avoid any questions or advice. They are only practicing empathy techniques talked about previously.

The person being practiced on thinks of something they are willing to share, that they are having feelings about. They can use what they did before, in the previous exercise, or they can use something new.

The person practicing, asks at least 2 open ended questions (1, then let the person talk, then another)

The observer names whether a question is open or closed, after the person practicing asks. If it is 'closed' the practitioner stops and tries again..

Switch.


Principle Techniques of MI:
Reflective Listening

Define reflective listening. If you have been engaging in reflective listening during the workshop in the last few minutes, you can use those examples.

Again, it is useful hear to cite some research. There are many research articles about reflective listening in the bibliography, here are some highlights:

Reflective listening conveys empathy

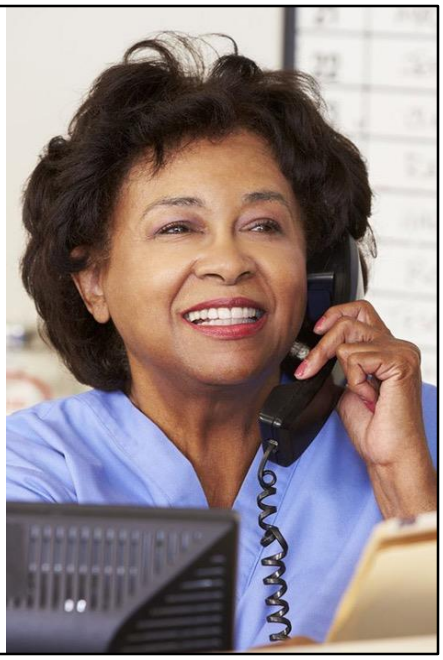
Reflective listening saves time in a visit (an average of 2-3 minutes)

Reflective listening increase patient safety and decreases medical errors

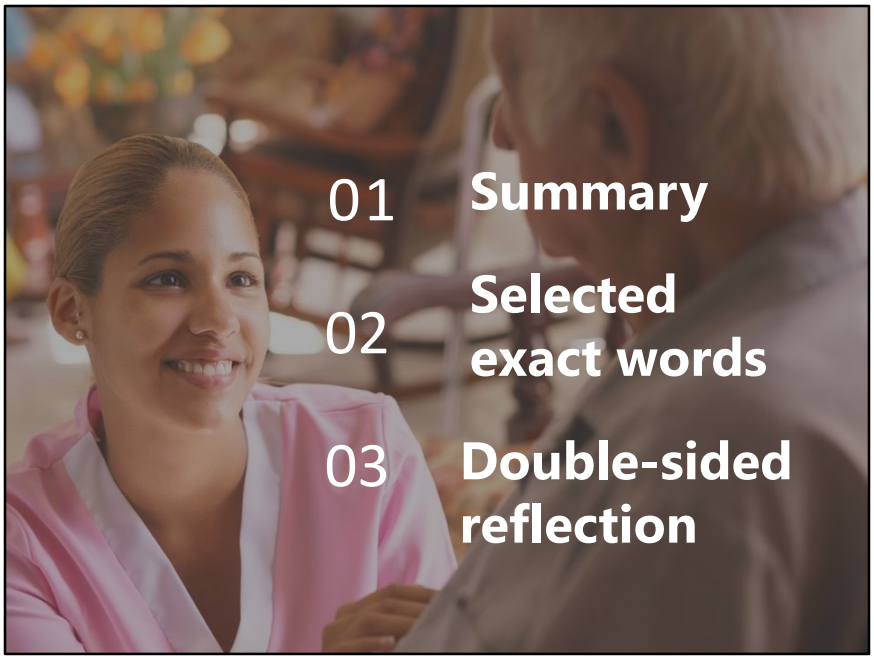
Reflective listening increase important self disclosures

Reflective Listening Demonstrates:

- Listening
- Understanding
- Acknowledgement
- Value



Types of Reflective Listening



Define these 3 types of reflective listening.

Giving examples of these three makes them concrete.

Basic definitions:

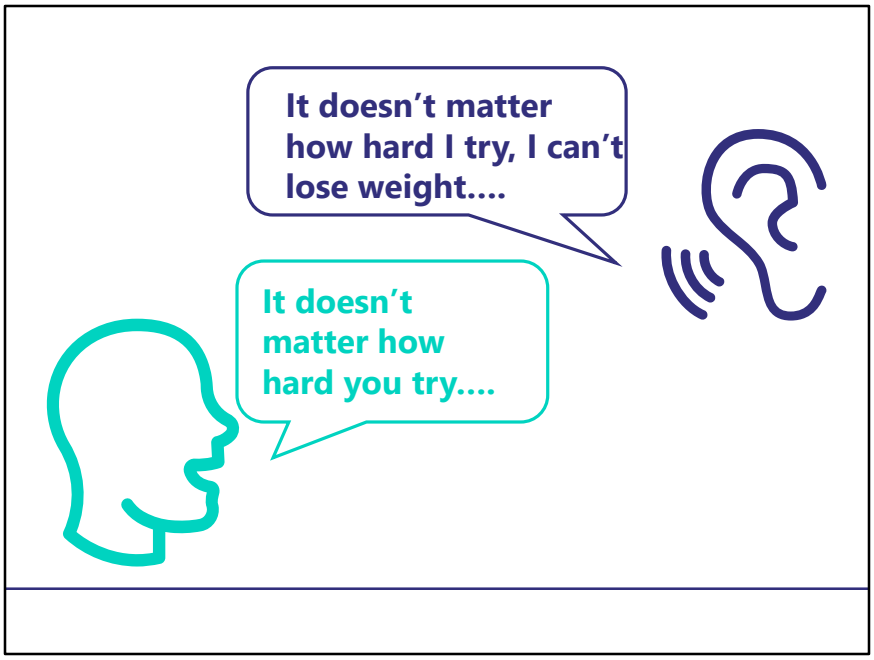
1. **Summarizing** is when you respond to what has been said with a general summary: 'It sounds like you have had such poor experiences with our healthcare system' or 'you've had so many losses recently'

2. **Exact words** means selecting the high impact words that the other person used: patient: I just feel like I can't take it any more, my head feels like it is in a vice' practitioner: 'like it is in a vice'.

3. **Double sided reflection**: capturing both sides of ambivalence 'I hear you saying you want your old body back, and I also hear that you feel like the dieting and exercise was punishing back then'

Reflective listening, more than most MI techniques, elicits push back from participants. People often share about when others have done it with them and it felt forced, or manipulative; often people share that they've done it to others, and been chastised 'didn't I just say that?!'.

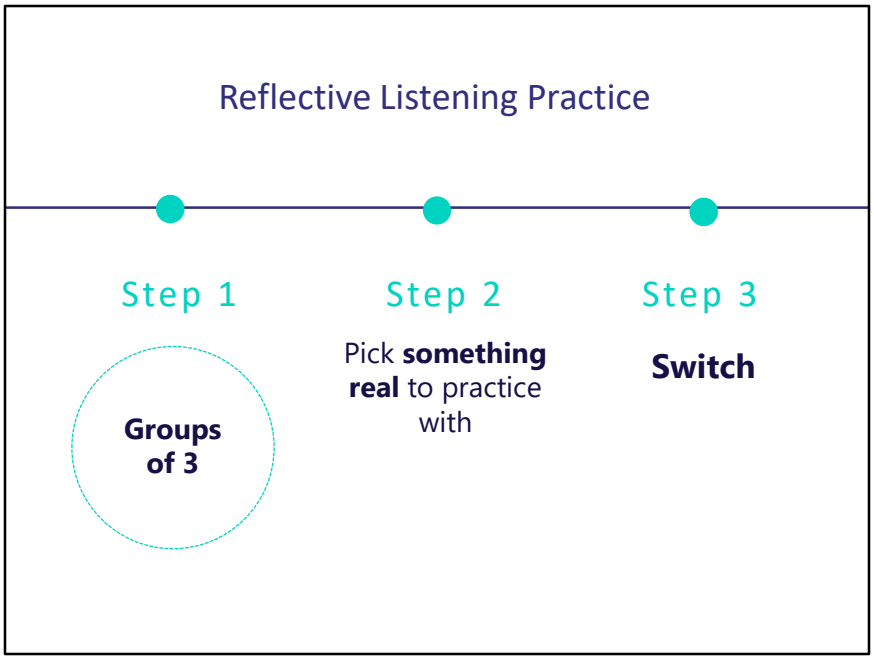
The best response to this is to, well, use reflective listening and just repeat back, so they know they are heard. We can also reinforce that reflective listening, like all of these techniques, is highly skilled, and takes a lot of practice to be proficient at it, and we are never perfect!



Exact word reflection, as an example

Facilitators demonstrate reflective listening. It is helpful to demonstrate 3 times; exact words, summary and double sided reflection, so have your partner share something they are ambivalent about (wanting to exercise, not having time, for example….something real)

Set up the exercise:



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Give roles: 1. Person practicing 2. Person being practice on and 3. Observer.

Let the groups know to avoid any questions or advice. They are only practicing empathy techniques talked about previously.

The person being practiced on thinks of something they are willing to share, that they are having feelings about. They can use what they did before, in the previous exercise, and build on it, or they can use something new.

The person practicing, uses reflective listening statements, twice. Encourage them to try 2 different types (exact words and summary, for example)

The observer names what type of reflective listening was used.

Most Common Pitfalls

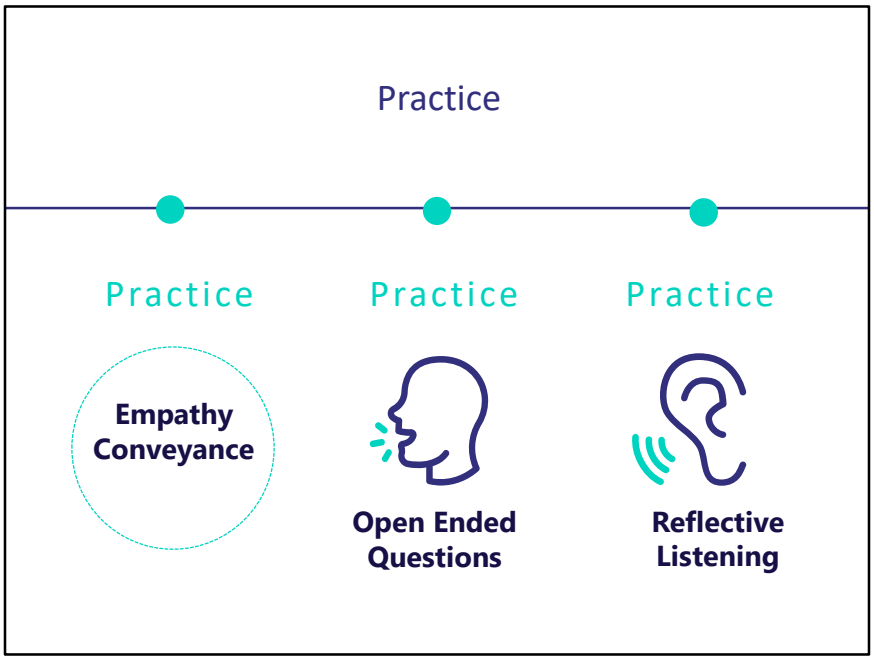
This slide is to give a brief explanation of each. It can be helpful to review some research in the bibliography on advice giving and righting reflex. Here are some basics:

Advice giving is not correlated to behavior change. It also does not convey empathy, and is not part of motivational interviewing. Giving advice is different than giving information. You can ask participants, what the difference is.

Giving advice: Uses 'you' pronoun, tells others what they 'should do, need to, must do, or have to'; is given even when others have not asked for it; is given before asking others their own thoughts.

Giving information: Uses third person pronouns, avoids lack of autonomy words like 'should, need to, must, have to', is only given after asking if someone wants it; is giving after the other is asked their own thoughts on the subject.

Righting reflex: The normal human tendency to set another person straight when they say something wrong. Example: 'My family is just big boned, he isn't obese' response ' actually, he is in the morbidly obese category, this isn't 'big boned'. This is the opposite of the MI principle 'rolling with resistance'.



One last practice session, using all three.

1. Triads are preferred. Keep the same triad.
2. Give roles: 1. Person practicing 2. Person being practice on and 3. Observer.
3. Let the groups know to avoid **any questions or advice**. **Add to avoid any cheerleading.** They are only practicing empathy techniques, open ended questions and reflective listening.
4. The person being practiced on thinks of something they are willing to share, that they are having feelings about. They can use what they did before, in the previous exercise, and build on it, or they can use something new.
5. The person practicing, uses the skills from these three techniques.
6. The observer names what type of techniques were used.
7. Switch.
8. Use your phone to time exercises; 3 minutes for each person, and each person should go, so 9 minutes or so for the exercise.
9. When everyone has gone, pull the group back together, and ask a general question to process, like 'how was that'? Or 'who would like to share their experience with practicing?' and let 1-3 people share.