Socratic Questioning Notes

The author opened the article by talking about her process rationalizing through what qualifies as a good question. Some examples of good questions include “Have you ever been in similar circumstances before? What did you do? How did that turn out? What do you know now that you didn’t know then? What would you advise a friend who told you something similar?” These kinds of questions are very helpful because they are extremely reflective, but they can’t be asked again and again, so the author re-examines the goal of therapy to understand patterns in therapeutic questioning. I agree with the author’s point that the goal of therapy is not just about correcting illogical beliefs. Therapists must always take an empirical approach and I love the phrase that the author uses to describe this “collaboratively empirical” Thus the author shows two cognitive vignettes to illustrate the difference between changing a client's beliefs and guiding discovery (shown below in the table)

Changing Client’s Mind	Guiding Discovery
Example 1: Changing Stuart's Mind S: I'm a complete failure in every way. Th: You look defeated when you say that. Do you feel defeated? S: Yes. I'm no good. Th: You say you are no good. Is it true that you haven't done anything at all good? S: Nothing of importance. Th: How about for your children this week -- did you care for them at all? S: Of course, I helped my wife put them to bed and took them to soccer practice. Th: Do you think that was important to them? S: I suppose so. Th: And did you do anything to make your wife happy this week? S: She liked the fact that I came home from work on time. Th: Would a "complete failure" be able to respond to his wife's request in such a successful way? S: I guess not. Th: So is it really accurate to say you are a complete failure in every way? S: I suppose not. Th: So how do you feel now? S: I guess a little better.	***Example 2: Guiding Discovery*** S: I'm a complete failure in every way. Th: You look defeated when you say that. Do you feel defeated? S: Yes. I'm no good. Th: What do you mean when you say, "I'm no good?" S: I've completely screwed up my life. I haven't done anything right. Th: Has something happened to lead you to this conclusion or have you felt this way for a long time? S: I think I see myself more clearly now. Th: So this is a change in your thinking? S: Yes. (Pause) I went to that family reunion and I saw my brother and his kids and wife. They all looked so happy. And I realized that my family's not happy. And it's all my fault because of my depression. If they were in my brother's family, they'd be better off. Th: And so, because you care about your family, you then decided you were a complete failure, that you've let them down. S: That's right. Th: You also indicated this was a change in your thinking. You've been depressed many times. And you've seen your brother and his family many times. How did you think about this in the past?

	S: I guess I used to always think I was OK because I tried to be a good husband and father. But I see now that trying isn't enough. Th: I'm not sure I understand. Why is trying not enough? S: Because no matter how hard I try, they still are not as happy as they'd be with someone else. Th: Is that what they say to you? S: No. But I can see how happy my brother's kids are. Th: And you'd like your kids to be happier. S: Yes. Th: What things would you do differently if you were less depressed or a better father in your own eyes? S: I think I'd talk to them more, laugh more, encourage them like I see my brother do. Th: Are these things you could do even when you are depressed? S: Well, yes, I think I could. Th: Would that feel better to you -- trying some new things as a father, rather than simply doing the same things? S: Yes. I think it would. But I'm not sure it would be enough if I'm still depressed. Th: How could you find that out? S: I guess I could try it for a week or so. Th: And how will you evaluate whether or not these changes are making your children feel happier?

In the first example, the therapist's questions seem like they are leading towards making the client realize that he is not a failure. Moreover, it seems like the therapist wants to 'prove' to the client that he is not a failure. However, in the second example it is unclear where the therapist is headed. The therapist seems to just confirm and openly question the client's statements, and the main approach to this guided discovery seems to be asking open questions instead of closed questions. The therapist is just trying to understand the client instead of changing or leading the client towards something.

With the first method of changing the clients minds, the author highlights that although this method is quicker and a direct route, the client will lose the long-term benefits of therapy because we lose collaborative empiricism. The author beautifully explains that "The goal of cognitive therapy is not simply to make our clients think differently or feel better today. Our goal as cognitive therapists is to teach our clients a process of evaluating their goals, thoughts, behaviors, and moods so that they can learn methods for improving their lives for many years to come" Thus guided discovery is a method through which therapists don't fix problems but rather teach ways to find solutions.

Although it may seem bad that the therapist doesn't know where the client is headed, the author clarifies that it's actually not a bad thing because sometimes if therapists are confident about leading the client to think a certain way, they may miss detours that might have been better options. Using guided discovery, the therapist can 1) understand how the client is feeling, 2) discuss with the client how they want things to be different/set goals 3) decide how to evaluate progress/success. This method also helps keep the client active because the therapist and client are working together to discover the problem and address it.

The author does clarify that this doesn't mean that therapy has no coherent structure or form. Within this structure "we can ask questions which either imply there is one truth the client is missing or which capture the excitement of true discovery". This leads to a solid definition of guided discovery/socratic questioning

Socratic questioning involves asking the client questions which:

a) the client has the knowledge to answer

b) draw the client's attention to information which is relevant to the issue being discussed but which may be outside the client's current focus

c) generally move from the concrete to the more abstract so that

d) the client can, in the end, apply the new information to either reevaluate a previous conclusion or construct a new idea.

Question	Flaw	Socratic Question
"What are you feeling right now?"	Doesn't help client who's confused about their emotions	"Are you aware of any tension or changes in your body as we talk about your father?"

The second part of the definition addresses relevancy of the question. The question must always help the client discover something that they may be missing. Sometimes relevant information may be outside the client's focus. According to many empirical studies we remember things that match our current thoughts/feelings. For example, if we view ourselves as successful, we will remember mostly our successes. Thus therapists can be memory retrievers if they ask good socratic questions and help highlight things that may be outside the client's focus.

The third part of socratic questioning involves progressing from concrete to abstract. This starts with being specific first. For example, if a client says that he is no good, then the therapist can ask what the client means by that to gain a specific understanding of what "no good" means.

Then, the author re-clarifies the goal of socratic questioning, stating that "when using Socratic questioning to guide discovery, our final goal is to help the client use the information we've uncovered to reevaluate a previous conclusion or to construct a new idea"

Lastly, the author clarifies the 4 stages of asking socratic questions which include asking informational questions, listening, summarize and finally synthesizing or analytical questions.

Stage 1 - Question	Stage 2 - Listening	Stage 3 - Summarize	Stage 4 - Synthesize/Analytical
- Ask questions that follow the	- While trying to change the clients mind, the	- Summarizing is key because when	- This is extremely important as it helps

definition and guidelines of Socratic Questioning. - Questions will bring into awareness relevant concepts for clients, and also make the concepts concrete for client and therapist to work with.	therapist may unintentionally only listen to answers that help them prove their point. However, with guided discovery, the therapist will be more open to listening to everything trying to make a discovery. The therapist must be open to finding new and unexpected information. - Therapists should also listen for idiosyncratic words, unexpected words, metaphors, emotional reactions and sudden info to help them fully experience and notice new things in the client's story.	making a discovery, the therapist and client may be inclined to just focus on where they are headed but it's crucial to take a pause sometimes and recap where they are. Plus, clients may be in a highly emotional state to be able to interpret what they are saying so summarizing is key. - It also helps the therapist and client make sure they are on the same page	the client and the therapist tie things together in a meaningful way. This is the time when the therapist asks the client if their initial statements/judgements match their thoughts now. - This is also like the last chance for the therapist and client to discover something meaningful. - The ideal response that would make a therapist's day "I just realized that I came here to feel happy and instead I've learned that sometimes it is healthier for me to be sad."

I loved this article because I got to learn so much and gain a deep understanding of socratic questioning. I will implement this not only as a future therapist but also in my daily life as I help friends with problems :)

A brief guide to
MOTIVATIONAL INTERVIEWING

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Year 3 Motivational Interviewing Workshop
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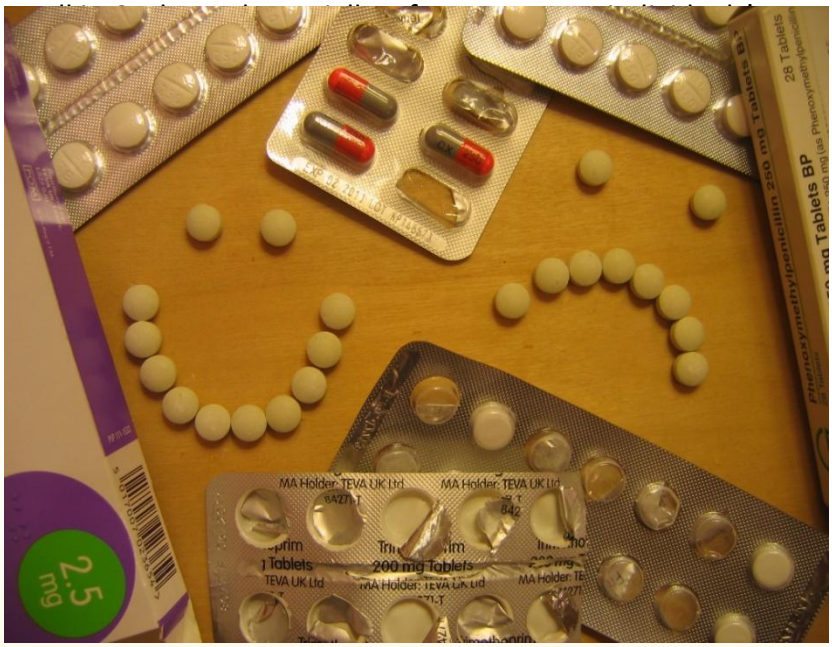
Adherence



Health professionals are often very worried for those under their care who are not adhering; concerned for the risks they are taking and often feeling responsible for not being able to help. Why do some people struggle so much with adherence? Actually, a better question might be 'why do so many people **not** struggle with adherence?' After all, many healthy behaviours such as dental flossing or avoiding fatty foods are much less difficult to adhere to than the treatment regimen in many conditions and yet so many in the general population struggle with them.

Our starting point, then, is that adherence can be tricky. This doesn't mean that we accept it if people don't adhere without trying to intervene, but it does mean that if we are to stand a chance of influencing people so that they have better adherence we need to know what's going on.

We know that adherence in a whole variety of medical conditions is poor (time and again research has indicated that 30–50% of patients with chronic conditions do not take their medicines as directed). It does depend a little on how we define adherence – for example keeping to all the treatment recommendations every day without fail versus having some fully adherent days and other poorly adherent days. Patterns of non-adherence can actually have important effects. In general, most people with chronic conditions that require an active treatment regimen are only partially adherent.

So what affects rates of adherence, and what can be done about different causes? We suggest a general framework below, but it is inevitably crude compared to the complexities of the individual - in reality there is, of course, no substitute for talking to someone to find out their own individual circumstances.

Potential problems

Lack of knowledge

Sometimes people are genuinely unsure about what they need to do. Although it may have been explained in the past, it's wise not to assume that this necessarily means that the information has been understood. Research has clearly shown that there are helpful and unhelpful ways of conveying information – information exchange would be a good way of giving someone information tailored to their situation - more on this below. Remember, too, that there are many reasons that people may not ask for clarification – they may not realise that they have misunderstood, or may be too embarrassed or shy to ask, for example.

Problems putting adherence information into practice.

Sometimes a patient may agree on the need to improve adherence but not be sure how to make changes in practice. They need to find a way to incorporate treatment into their daily routines, and find ways around possible barriers. Problem solving approaches may be ideal in helping someone find a solution.

Problems taking on board the importance of adherence

Sometimes a patient may not appear to be aware of the importance of improving adherence. Occasionally this may be lack of knowledge but is often more complex - you may find that just providing information has little or no effect. Instead, many patients find themselves in the situation in which they have poor adherence and when they think about this it generates such anxiety that they try not to think about it, which means in turn that change becomes unlikely. This vicious circle can continue for years, and poor adherence behaviours become part of a daily routine. In such situations the best way forward is to engage the patient in a conversation about this, and to help them consider their options (to change or stay the same). Motivational interviewing is a good way to do this, and ensures that thoughts about changing and improving adherence become a central part of the conversation.

Deliberately choosing not to adhere.

Some patients may make a decision not to adhere, in order to enjoy life in the here and now. Whilst we always have to respect the right of every patient to make their own decisions about their life and their treatment, we also ought to be mindful that it is important that this is an informed decision and that the patient has freely chosen, rather than, for example, felt so afraid of their condition that it has been easier to choose to ignore it. Sometimes people see non-adherence as a way of "not letting it beat me", seeing non-adherence as a way of leading a 'normal life'. Again, MI is a good way to have a conversation about this, and revisit this decision, considering good adherence as an alternative way of minimizing the intrusions of the condition into life, and taking control of it.

Tackling adherence and the importance of collaboration

Hopefully by now we've conveyed the key principle that changing behaviour is tricky for most of us, even when we know, deep down, that we should do it. Ironically, this is especially true if we have potentially strong feelings about it or the stakes are high – the many dangers of smoking are well known but smokers are ingenious in the ways they can ignore worrying information about it and justify carrying on. Similarly, adherence is obviously a major worry for the patient and family. In order to help, then, you have to build up a relationship of trust. If you haven't got this, then someone is unlikely to be honest with you if they are struggling. Instead, it's likely that they will tell you what they think you want to hear.

A good way to think about this is that you develop collaboration with your patient. This doesn't mean that the two sides in the relationship are the same – you will have specialist knowledge that may be of vital use to your patient, your patient will have knowledge of what it's like trying to adhere in the real world outside of the clinic. what it does mean is that you trust each other to be open about what's going well and what's not, and that you agree to work together to solve any problems that arise. Your goals are clear and there is nothing wrong with being upfront about them - you want good adherence and for your patient to be medically stable. You need to be mindful that your patient may not be on the same page, however, and patient in your attempts to help them resolve the problems holding them back.

Giving information: a guide to information exchange

As we have argued above, sometimes poor adherence is a function of simply being unsure what to do. It is easy to underestimate the skill required in conveying complex information, and the barriers to someone taking on what is required of them.

There are many occasions when you may need to give information to a patient. Sometimes you may discover that it is lack of information – or a misunderstanding – that is contributing to poor adherence. The temptation is then to put this right by giving out all the information you think they might need. The problem here is that this can sometimes not work if the person isn't ready to receive the information and is overloaded by it. They simply won't be able to recall what you've said afterwards.

Think about your favourite novel, perhaps one you read many years ago. Did you have any trouble finishing it? Could you tell someone what it was about? Now think about a book you were told to read at school but didn't enjoy. Was it easy to read or did you find it hard going? Could you explain what it was about? The difference is that you were engaged with the first book – you were interested in it and thinking about it, so you remembered it!

The elicit-provide-elicit cycle

The key when presenting information, then, is to engage the person first. The simplest way of doing this is to ask them what they already know about the topic first (elicit). This helps you shape up the information you are to present, and also starts the person thinking about it. You then need to present the information (provide). Following this, you need to check that they have understood what you have said by asking them (elicit). There are many reasons why they may not tell you if they haven't – they may wrongly believe they have understood, or they may be too embarrassed to admit that they haven't heard.

So, the routine to adopt when giving any piece of information is to:

1. Understand what the patient already knows, and what they would like to know, by asking.
2. Provide information in as neutral a way as possible.
3. Check their understanding of what you have just said - "what do you make of that information?"

In this way the patient is engaged in the process before you give the information. They are therefore more likely to think about the meaning of what you say, process it, and integrate it with their own experience and beliefs.

Personal integration is always best done by the patient.

Sometimes the questions you ask after you have presented information can really aid this process, such as:

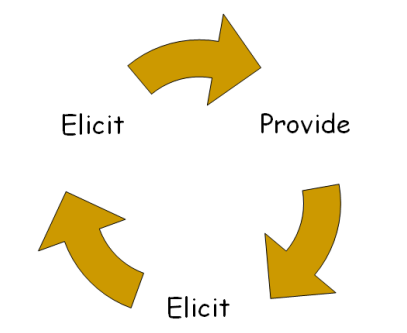
- *"What do you make of that?"*
- *"So, where does that leave you?"*
- *"What would you like to do next?"*

There are some other general rules for giving information.

The most important is to **always ask permission first**. If you do not, it could feel like a lecture and the patient may not be receptive, even if you are presenting useful information.

This can be done quickly, simply by saying:

"Is it OK if I tell you a little more about that?"



There are other helpful guidelines for presenting information. If you are saying a lot, be careful to break up information into manageable chunks. You need to watch the pace as you present it, and don't be afraid to keep "checking in", to make sure the other person is listening and understanding.

Another useful strategy is to find opportunities for small summaries of what you've said so far, or reflections on it, from yourself or the patient. And don't forget the importance of affirmation: if it is a lot of information, reflect this:

"I guess this might be a lot to take in"

We also know that other factors can influence how much information people can remember. In particular, if people are anxious they usually do not remember what they are told at the time. You may need to repeat information several times. On such occasions it is important to break larger pieces of information down, and if at all possible give written material too.

Remember that some information is easier to understand than others. Remember, too, that if someone asks for information they may actually be indicating a need to talk and for emotional support, rather than just information.

Lastly, the words you use are, as ever, extremely important and can convey your feelings about the situation. They can influence the consultation to be a useful and receptive one, or am unhelpful and potentially antagonistic one.

For example, avoid using "I" or "you". In particular, don't say:

"I want you to do…" Or *"You should do…"*

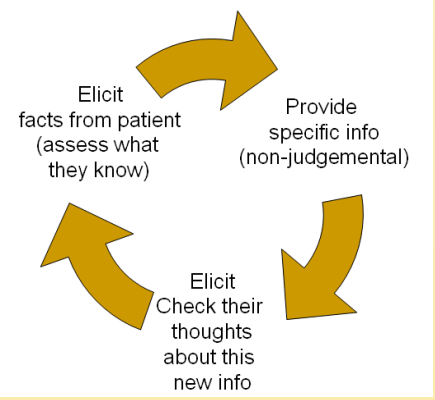
Remember, someone will change if <u>they</u> want to do it, not if <u>you</u> want them to do it

Instead, use more neutral language wherever possible:

"You might consider…" or *"we could do it this way…"*

And if you want to pass on an opinion, a more effective way might be to say:

"Other people have found that…"



Motivational Interviewing: principles and practice

Motivational interviewing is an intervention designed for situations in which a patient needs to make a behaviour change but is unsure about it, sometimes to the extent of being quite hostile to the idea. It builds on the idea that the first step in any consultation is actually to get a conversation going. It then uses particular strategies to focus this conversation on behaviour change, and to ensure that the patient is helped to consider change as an option.

The background to MI lies in the treatment of people with alcohol problems. The traditional approach had been to confront the person with their drink problem, the belief being that unless they admitted they had a problem, they would never get better.

When this was done, however, people who were being confronted fought back by denying they had a problem. This shouldn't really be a surprise. It's not an easy thing to hear yourself being called an alcoholic who has ruined their life, and many responded by not hearing it, and coming up with reasons why their counsellor was wrong ("I don't drink any more than the next guy…"). It was tempting for those providing counselling to then blame the patient, seeing them as having "no will power" and "no motivation".

The first paper on MI, written by a psychologist in New Mexico called Bill Miller in 1983, tackled this issue, and was rooted in his own clinical practice – basically he reflected on his own clinical work with his students and came up with an alternative viewpoint. In contrast to the prevailing view, he suggested that rather than seeing denial as poor willpower or lack of motivation to solve the problem, it might be more helpful to see this outcome as a product of the situation in the counselling session. Basically, when we confront anyone with something, we are likely to increase their resistance and hear them argue the opposite side.

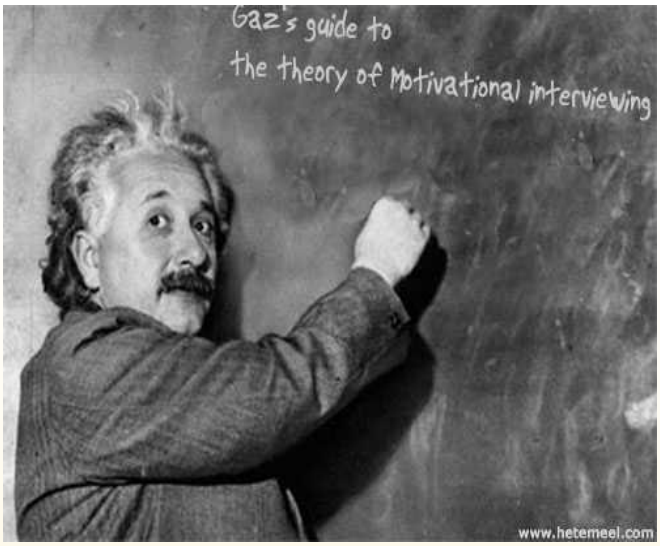
Bill Miller went on to suggest a number of ways that a counsellor might try and avoid a confrontation, and this laid the foundations of MI. These idea started to circulate, and came to the attention of Stephen Rollnick, a clinical psychologist originally from South Africa but then working in Addictions in the UK, who saw the relevance of this approach to physical health settings, especially adherence. They went on to collaborate on the first book on MI, and many publications since.

A commonly used definition of MI is:

> *'A directive, patient-centered counseling style for eliciting behaviour change by helping patients to explore and resolve ambivalence.' (Rollnick and Miller, 1995)*

It sometimes seems strange to see MI described as both person centred and directive, since person centred approaches are traditionally not directive at all. Its' a good description, though, as the aim of the intervention in to encourage the patient to change their behavior.

The theory and main principles of Motivational Interviewing



Although MI clearly has its roots in clinical practice, it is now clear that the principles behind MI – why it works- have a very long history in terms of theory.

They can be briefly summarised as six general principles:

Principle 1: don't tell people what to do

…because it usually doesn't work, even if you're right. Basically, if people don't feel they have a choice, they feel a real need to do whatever it is they've been told not to - to prove they still have free will. It can be summarised in the phrase "No one tells me what to do" and seen in its purest form in most teenagers! This was the basis of Reactance Theory by Jack Brehm in 1966.

Principle 2: listen

If you can't listen and engage someone in conversation, they are <u>never</u> going to change. This part of MI has its roots in patient centered counseling, proposed by Carl Rogers in 1951, who argued that change can be facilitated by providing someone with a therapist who adopts a non-directive style, who is empathic, genuine in their attempts to understand, warm in their responses but who mostly listens. If someone is expecting to be persuaded or told off about not adhering, this is unexpected!

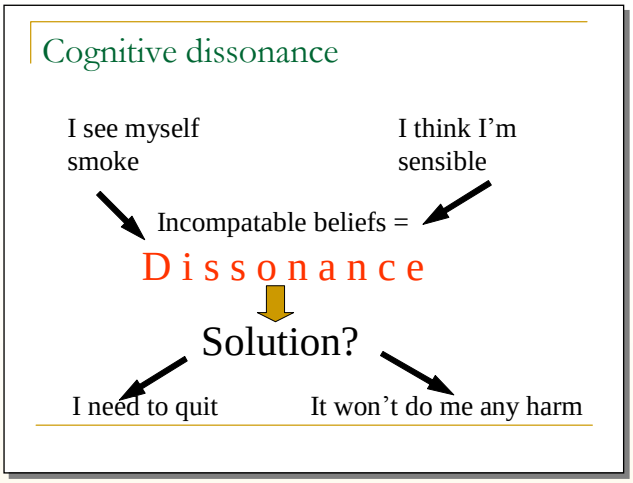
Principle 3: let the patient tell <u>you</u> they need to change

The very best thing that can happen is for someone to tell <u>you</u> why they should change. If someone says it themselves without you saying it first, it's <u>much</u> more powerful. Basically, '*People believe what they hear themselves say'.* Also, the reasons tend to be more powerful too – if you do something because you think it is right you are more likely to carry through than if you are doing it because you are trying to please someone (like your mom or your doctor!).

This was investigated scientifically by Daryl Bem in 1966 but actually goes back much further – to 1670 and the French mathematician and philosopher Blaise Pascal who noted that people are much better persuaded by reasons they think up themselves than those thought up by others. People are very good at convincing themselves, but alert to other people trying to do the convincing. No doubt advertisers have a pretty good understanding of this, which is why modern adverts are much more subtle!

Principal 4: cognitive dissonance

This was cited by Bill Miller in his first paper. He's not so keen on this now, but we rather like it. Basically, Cognitive dissonance was proposed by Leon Festinger to be a feature of situations in which people are struggling with a choice about changing which is making them feel uncomfortable – such as when there is something someone feels they ought to do but they are not doing it (such as filling out a tax return, giving up smoking, taking medication). This conflict itself makes people uncomfortable and produces a momentum towards change if handled in the right way.



Cognitive dissonance is a very powerful phenomenon that every one of us has experience of. MI refers to this and aims to use an understanding of the principles to encourage change. Basically, if the contrast between the two choices is brought out, people feel an urge to resolve the conflict by choosing. With your help, they can choose to change.

Principle 5: people need to feel confident before trying to change

Even if someone is convinced of the need to change, if they don't feel confident they are unlikely to try. Worse, they can feel depressed since they realize their predicament. Albert Bandura captured this with the idea of self-efficacy (self belief). If this is high, someone will feel confident and are much more likely to succeed. Mi is explicit about the need to keep morale high.

Principle 6: is ambivalence is normal

It's normal for human beings to be unsure about what to do, especially if the choice is tough, or involves a change which would be difficult.

How to do Motivational Interviewing

> "Motivational interviewing has been *practical* in focus. The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative. The motivational interviewer must proceed with a strong sense of purpose, clear strategies and skills for pursuing that purpose, and a sense of timing to intervene in particular ways at incisive moments" (Miller and Rollnick, 1991, pp. 51-52).

The four principle strategies of MI are:

1. Get a conversation going - express empathy through reflective listening.
2. Develop discrepancy between a patients' goals or values and their current behavior.
3. Avoid argument and direct confrontation and adjust to resistance rather than opposing it directly.
4. Support self-efficacy and optimism.

Clinicians who adopt motivational interviewing as a preferred style have found that the following five strategies are particularly useful in the early stages of treatment:

1. *Ask open-ended questions.* Open-ended questions cannot be answered with a single word or phrase. For example, rather than asking, "Do you like to drink?" ask, "What are some of the things that you like about drinking?"
2. *Listen reflectively.* Demonstrate that you have heard and understood the patient by reflecting what the patient said.
3. *Summarize.* It is useful to summarize periodically what has transpired up to that point in a counselling session.
4. *Affirm.* Support and comment on the patient's strengths, motivation, intentions, and progress.
5. *Elicit self-motivational statements.* Have the patient voice personal concerns and intentions, rather than try to persuade the patient that change is necessary.

In using MI in practice, you initial goal is to engage the patient in conversation. Without this, of course, nothing will happen.

A practitioner using MI will be able to:

- Express empathy through reflective listening.
- Communicate respect for and acceptance of patients and their feelings.
- Establish a non-judgmental, collaborative relationship.
- Be a supportive and knowledgeable consultant.
- Compliment rather than denigrate.
- Listen rather than tell.
- Gently persuade, with the understanding that change is up to the patient.
- Provide support throughout the process of recovery.
- Develop discrepancy between patients' goals or values and current behavior, helping patients recognize the discrepancies between where they are and where they hope to be.
- Avoid argument and direct confrontation, which can degenerate into a power struggle.
- Adjust to, rather than oppose, patient resistance.
- Support self-efficacy and optimism: that is, focus on patients' strengths to support the hope and optimism needed to make change.

Expressing empathy and getting a conversation started

The first aim when working with someone is to get the conversation going. If you are concerned about someone, if it is urgent that they change a behavior, if you have many things to tell them, all of this may make you feel that you cannot waist time in addressing these things, but will count for nothing if they do not listen. It doesn't matter if a service has access to the best medical treatments in the world; if the patient never comes back they won't be of any help. You may feel under tremendous pressure of time – you are aware of the things you need to say, and how little time you have. This is a difficult situation, but most times it's still more important to engage with the patient so that they are more likely to respond to what you are saying and come back, rather than go through a list of things you need to say.

Conversations may be thought of as operating on two levels. On the first, or surface level, we never get past polite, formal or stunted interactions. At this level you may ask how someone is to be told they are alright, even when the truth is very different. On the second, deeper level, we tell others what we really think and feel. The second level typifies the conversations we have with people close to us, who we trust. The first level typifies most consultations that occur in clinic. The problem is, if there is a significant issue preventing adherence, it will never emerge in clinic unless the conversation moves to a deeper level.

We are all skilled in having conversations at a deeper level, and all have them from time to time. When in clinic, however, we usually adopt a way of interacting that keeps things as a more surface level. This is often a very good idea and keeps us focused. At times, however, we need to give ourselves permission to use some of our natural skills in opening up a conversation with a client to the deeper level, in order to help them solve a problem with adherence.

You need to be careful that you don't fall in to the expert trap – telling someone what you think they need to do. The danger here is that they will switch off. Instead, you need to put the patient at ease and attempt to understand their frame of reference, all the time encouraging a conversation about change. Let the patient do most of the talking. You are trying to foster collaboration between patient and practitioner and create a climate for change. Don't be afraid to acknowledge what might be on your agenda, but don't forget to ask for their agenda too.

You can use a number of skills to make someone feel at ease, able to open up with you, and understood if they confide some difficult emotions. The tools you need to use to achieve this can be remembered as the OARS:

- Open Questions
- Affirmations
- Reflective Listening
- Summaries

Open questions

Open ended questions are very useful for getting a conversation going. You probably use these a lot, and they are great for opening up a conversation. They also prevent you from making the mistake of assuming you know what's going on for someone or how they feel. Some examples of open and closed questions are given below:

Closed Question	Open Question
So you are here because you are concerned about not taking your medicines?	Tell me, what is it that brings you here today?
Do you agree that it would be a good idea for you to take your medicines regularly?	What do you think about the possibility of taking your medicines regularly?
First, I'd like you to tell me about the medicines you take. On a typical day, what do you take?	Tell me about the medicines you take during a typical week.
Do you like to smoke?	What are some of the things you like about smoking?
How has your use of medicines been this week, compared to last: more, less, or about the same?	What has your use of medicines been like during the past week?
How long ago did you take your medicines?	Tell me about the last time you took your medicines

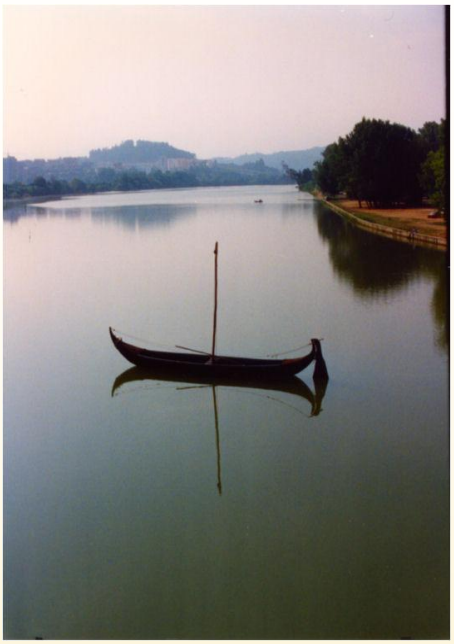
Affirmations

These help to keep the conversation positive. It's important that your encouragement and support is genuine, and this can have a significant effect on the course of the conversation. One way of doing this is to make statements of recognition of patient strengths:

E.g. *"not everyone manages to give up smoking as you have"*

Reflective listening and summarising are the cornerstones of your techniques. They help the other person to feel that they are being heard and open the conversations into areas necessary for change to occur.

Reflective listening



Reflective listening refers to reflecting back what a patient has said. Reflection can be simple and intuitive – such as reflecting back the main content of a statement (**Content Reflection**). This is the simplest response to resistance: nonresistance - repeating the patient's statement in a neutral form. It acknowledges and validates the patient's voice and shows you are listening. For example:

- Patient: This has been a rough few weeks for me
- Interviewer: It sounds like things aren't going well.

Reflection can also be complex and powerful, however, such as reflecting back a meaning from earlier in a conversation which has a bearing on what someone has just told you (**Meaning Reflection**). You won't be surprised to hear that as with most skills, this get easier with practice! This is a powerful way of helping someone to talk, and to think about something, such as changing their behaviour. For example:

- Patient: I've been so good at taking the medication then I got fed up and missed them all weekend.
- Interviewer: You feel upset because you feel as if you've let yourself down.

Meaning reflections give you the opportunity to help move the conversation on to more meaningful topics, showing you are listening and also showing that you understand. It may seem quite a risky thing to attempt, but if said in the right way will almost always result in a deeper understanding, even if you are wrong – your patient will tell you what is really going on!

Another form of reflection is **Amplified Reflection**, where you exaggerate what someone has just said. This is more risky, but very powerful when done right, and can lead to a re-appraisal by the patient.

There is another form too, which when used right can be very useful: **double sided reflection**. Basically, this entails reflecting back what a patient has said but in the same sentence also stating contrary things they have also said – in this or past appointments. The trick is to think about the order in which you reflect them back – if you conclude with a positive statement the conversation is more likely to stay positive. The tendency is to reflect information back in the order you have heard it. This tends to be with a positive statement first, followed by a negative one, often quite general. For example:

- *Patient: "I know I need to get on top of my medicines, but I just can't imagine changing".*

The tendency is to reflect is back like this:

- *Health professional: "So, you're saying that you do see the need to get your medicines sorted out, but at the moment you can't see yourself doing it"*

What do you think the next thing spoken might be? Perhaps something like:

- *Patient: "No, not at the moment, it's just too difficult."*

So the sequence goes like this:

- *Patient: "I know I need to get on top of my medicines, but I just can't imagine changing".*
- *Health professional: "So, you're saying that you do see the need to get your medicines sorted out, but at the moment you can't see yourself doing it"*
- *Patient: "No, not at the moment, it's just too difficult."*

Now consider the order in which you reflected the two statements back. What would happen if you reversed them and finished on the more positive one? Perhaps something like this:

- *Patient: "I know I need to get on top of my medicines, but I just can't imagine changing".*
- *Health professional: "So, you're saying that you can't see yourself changing just yet, but you really do see the need to get your medicines sorted out"*
- *Patient: "yes, I know it's really important and I need to do something about it."*

It's possible, then, to alter the whole tone of the conversation that follows. One way to practice this is to use the phrase *"So, on the one hand"* and *"and on the other hand"* when you start to use double sided reflections, until you get used to it!

- *"So, on the one hand you're saying that you can't see yourself changing just yet, but on the other hand you really do see the need to get your medicines sorted out"*

Summaries and reframing

Summaries seems such a simple technique, but it is surprising how powerful it is for a listener to actively pull together what someone has been saying and reflect it back to them. Sometimes this really does produces novel insights. It refers to pulling together things the patient has said and presenting them back in a brief summary.

Finally, **reframing** offers the possibility to go beyond reflecting back what someone has said, and reframing it with a different perspective – perhaps pointing out the positives for someone who has taken a very negative view of their past achievements.

> *"reframing acknowledges the validity of the patient's raw observations, but offers a new meaning for them*". (Miller and Rollnick, 1991)

Developing Discrepancy

Once the conversation is going, your task is to help them think about change. You may wonder whether it's necessary to use techniques to focus on change – won't this come up in conversation anyway? Perhaps, but in situations where the change is charged with emotion – for example, where thinking about increasing adherence to a medication triggers thoughts about the consequences of the disease and not adhering – our natural tendency is usually to try not to think about it.

In a sense, then, your job is to "level the playing field" – to try to ensure that there is an honest discussion about the consequences of not changing and changing. Remember:

> *"Given a choice between changing and proving that it is not necessary, most people get busy with the proof."* (John Galbraith)

Many of the techniques that may be helpful here are designed to raise awareness of the problem, and to focus on the discrepancy between beliefs and goals - what they would like to be doing (or what they think they should be doing) and what they actually are doing. People often know this already, but try not to think about it.

Mostly you can achieve this by talking, using summaries. With permission, you might integrate objective assessment such as test results or diaries, but if doing this take your time to explore the meaning, and be sure you have permission to focus on this first. One technique used in addictions is to complete a 'drink diary' with the patient: you share a sheet of paper with the days marked on, and together fill in the amount the patient thinks they have drunk in the previous week. You then ask them to add it up, and ask if the total surprises them. This technique can be adapted for many other situations, including adherence.

MI uses scaling questions - a simple assessment technique that can be useful too. These focus on the two things that are crucial to change: Importance (*" I know I ought to change") and* Confidence ("*I know I can change"),* which together produce 'readiness':

So, you first ask about importance – how important do you think it is for you to change right now, on a scale from 0 to ten?. This is followed by a similar question about confidence in being able to change.

Thinking about change

The behaviour you are thinking about changing:

Importance

How important is it for you to change this behaviour right now?

Please rate how important you feel it is to change on the following scale with an X, where 0 is 'not important at all' and 10 is 'the most important thing'.

0 _____ **10**

Confidence

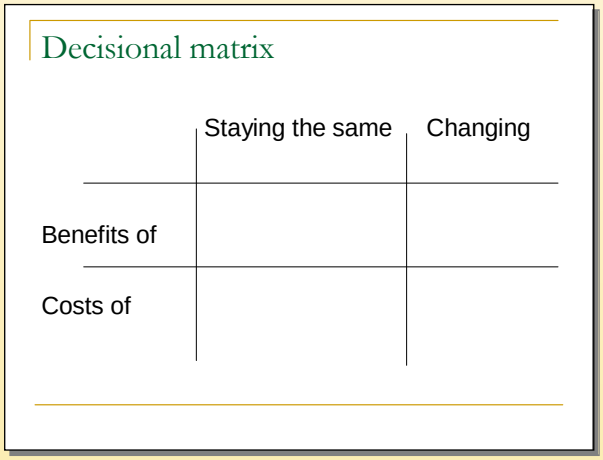
If today were the day you decided to change the behaviour, how confident are you that you could do it?"

Please rate your confidence on the following scale with an X, where 0 is 'not confident at all' and 10 is 'very confident'.

0 _____ **10**

Scaling questions can be incredibly useful: they immediately focus the conversation on the here and now, and can highlight potential barriers to change long before they disrupt the work. After asking your patient to rate their importance and confidence, you can ask "what would it take for you to be at X?", where X is a rating a little higher than the one they have given.

In some ways, MI can be thought of as a decision aid for those deciding whether or not to change a behavior. The metaphor of scales is a useful one: your job is to help your patient weigh up the pros and cons of changing, and hopefully encourage them to be open and honest when placing weights on the side of change. A useful technique is to make the pros and cons explicit using a grid (a decisional matrix) that can be filled in with your patient, which lists the benefits and costs of staying the same and changing. Using this grid, the benefits of not changing and the costs of changing can be discussed. This is important, and honest. If you do not discuss them, the patient will think them anyway – remember, most people have very good reasons for not changing. The grid also enables the benefits of changing to be discussed, however. The suggested way of moving through the grid is to discuss benefits of staying the same first, then costs of staying the same, then costs of change and finishing with the benefits of changing.



Remember cognitive dissonance? There's a tendency in all of us to close down a difficult choice as quickly as possible, and MI aims to keep this discussion going, which makes change much more likely, This should be done sensitively, and a nice analogy is with the style used by the old TV detective Columbo, with his gentle line of questioning – "there's one thing I don't understand – perhaps you can help me"

Rolling with resistance

When the topic of change comes up in conversation, you need to be prepared for a certain amount of resistance. This is an understandable and common reaction. Avoiding confrontation certainly reduces it, but it doesn't disappear altogether.

An important factor here is to pay attention to the words that are used. After practice, it's easy to spot words which indicate someone is thinking about change and words which indicate someone is not – or resisting. Examples of resistance - or status quo - talk include: arguing, interrupting, denying, and ignoring.

Research shows that strong change talk, particularly towards the end of a session, is associated with change afterwards. You need to look out for DARN - words that indicate desire, ability, reason and need.

It may well be, however, that instead of DARN words you are confronted with resistance. Poor adherence can also be intentional, though this may not be explicit – someone may be aware of the need to change but too scared of this to fully consider it as an option. In such cases, once you have built a good rapport, you need to talk about the problem behaviour (i.e. poor adherence). Its' fine to be upfront about this, as long as you don't start to tell someone what to do:

> *"Is it OK if we talk about the medication now?"*

Once this conversation starts, you will likely be confronted by some well worn thoughts and phrases that represent resistance to change. This is to be expected: this is a difficult topic that someone is likely to have considered many thousands of times before. It's also very sensitive, and they are likely to have become very skilled at keeping any very worrying thoughts at bay.

Handling this resistance is one of the most useful skills you can develop. Resistance at some level is a feature of many consultations. After all, very few people enjoy coming to a hospital to be briefed about things they have to do, and resistance to the idea of a long term intrusive treatment regimen is clearly understandable. More than that, if adherence is poor the patient may well be primed for an argument – resistance is ready before you even say anything!

There are many examples of resistance talk, many of which you will be familiar with:

Disagreeing. *"Yes, but..."*
Discounting *"I've already tried that."*
Interrupting ***"but..."***
Sidetracking *"I know you want me to do my airway clearance, but did you notice I gained 5 pounds? You have to admit I've been doing a great job with my weight!"*
Unwillingness *"I don't want to have to do that as well"*
Blaming *"It's not my fault. If only my parents..."*
Arguing *"How do you know?"*
Challenging *"Well Pulmozyme doesn't make a difference to MY lung functioning"*
Minimizing. *"I'm not that underweight"*
Pessimism. *"I keep trying to do better but nothing seems to help."*
Excusing: *"I know I should eat more calories, but with my job I'm always on the go and it's hard to prepare and then sit down for a big meal"*
Ignoring

One of your jobs is ensure that resistance doesn't stop the discussion about change prematurely. Most people's natural reaction to hearing resistance statements is to argue back, try to persuade, or, conversely, drop the issue totally. Dealing with resistance is like a car skidding on ice. You have to fight the natural tendency to jam on the breaks and jerk the wheel and instead gently ease off the gas and roll with resistance.

How should we respond to resistance? It's common - but unhelpful - to respond by trying harder to convince someone they are wrong. There is a very handy way of thinking about this: you need to avoid 'the righting reflex'; this is the compulsion we all have to correct someone when they are wrong, to give them advice when we feel responsible for them. In clinical situations it is very powerful. Unfortunately, it almost always results in very unhelpful responses (especially 'yes but…'). It's not a good way to encourage change.

'Rolling with resistance' is the term MI uses for not responding with persuasion, but to side step an argument and encourage conversation. MI suggests that you acknowledge ambivalence about a decision – and therefore some resistance to change – as perfectly normal. Doing this immediately lowers resistance. Instead, you can use reframing and reflective listening to encourage discussion, and point out alternatives.

The key principles behind rolling with resistance are:

- Don’t respond to resistance with confrontation - no matter how frustrated you are!
- Use empathy and reflective listening
- Reframe statements
- Acknowledge ambivalence as normal

Remember not to talk of some people as resistant, as this invites confrontation. Instead, you need to try to steer the conversation towards considering the alternatives, and letting the person see the incompatibility. Our job is to give “airtime” to the two sides of the internal struggle.

When people are indicating a willingness to consider change, you can discuss alternatives with them. Even after someone has decided to change, there are usually still many alternative ways of achieving it.

Strategy	*Example*
Simple reflection	**Patient:** I’m not going to start using taking my medicines anytime soon. **Clinician:** You don't think it would help you right now.
Amplified reflection	**Patient:** I don't know mum is worried; I take most of my medicines. **Clinician:** So your mum shouldn’t worry at all?
Double-sided reflection	**Patient:** I know you want me to start taking all my medication, but I'm not going to! **Clinician:** You don’t want to talk about the medication, though you can see it’s a big concern.
Shifting focus	**Patient:** I can't stay in and use my nebulizer when all my friends are going out! **Clinician:** You're ahead of me – we were exploring your concerns about the medication. Shall we talk about how the nebulizer fits into your life later?
Agreement with a twist	**Patient:** Why is everyone so stuck on my not using the nebulizer? You'd go out all the time, too, if your family were nagging you. **Clinician:** That’s a good point. It's not as simple as you not using the nebulizer. I agree with you that we shouldn't be trying to place blame here. It sounds like it involves the whole family.
Reframing	**Patient:** My mum is always nagging me about my medicnes. **Clinician:** It sounds like mum is really worried, although she expresses it in a way that gets to you. Maybe we can help her learn how to tell you she is worried in a more helpful way.

Supporting self efficacy

When someone is committed to making a change, a lack of confidence in their ability may cause them great frustration – they now appreciate the need to change but don't feel able to. At worse it can increase distress. MI therefore explicitly aims to increase confidence and self efficacy – someone's belief that they can achieve a particular goal. One way of achieving this is to consistently treat the patient and their choices with respect. If the decision to change comes from the patient, they are immediately more secure in their own judgments than if it is imposed from outside.

It is a central principle of MI that individual stake responsibility for their own actions. This is important if change is to be firmly rooted, but can be difficult in clinical settings, especially where there is concern for a patients welfare. In truth, though, if someone doesn't own a decision to change a behavior, any behavior change tends to be short lived. Respect for a patient contributes to increasing self esteem, and may enable a discussion about the actual goal of a behavior change to take place.

When discussing the goal, there are many ways of enhancing self efficacy and the chances of success. One technique is to look for past successes. If someone has low mood or anxiety, they can often see past events in a very negative way, and reframing these can be helpful. When practical considerations concerning the behavior change are discussed, you can use techniques to enhance the creativity of the process such as problem solving and brainstorming:

- Generate a list of possibilities together (You may add some suggestions, such as what other patients have tried)
- Encourage patient to evaluate the list
- Patient picks best option

It's also important to be realistic, and build bridges into real life from your session – it's no good coming up with a plan together if it is hopelessly unrealistic. Set smaller targets rather than big ones, for example. If the patient chooses, they may bring in to the session people who may be important to change, such as friends or relatives.

The scaling questions we discussed earlier can be useful tools, as can goal setting: making explicit, realistic targets, and breaking them down large goals into smaller, more manageable steps. Using a simple goal – strategy – target formula can be useful. Writing these down makes a difference – they act as a reminder and foster a greater sense of commitment to change.

Sometimes there may be some practical help that someone needs: perhaps some knowledge that you can help them to access, perhaps a new skill that they need to work on.

Eliciting self motivational statements is an important part of enhancing self efficacy. Four types of motivational statements can be identified (Miller and Rollnick, 1991):

- Cognitive recognition of the problem (e.g., "I guess this is more serious than I thought.")
- Affective expression of concern about the perceived problem (e.g., "I'm really worried about what is happening to me.")
- A direct or implicit intention to change behavior (e.g., "I've got to do something about this.")
- Optimism about one's ability to change (e.g., "I know that if I try, I can really do it.")

Some strategies for eliciting self-motivational statements include:

- Problem Recognition (e.g. what things make you think that this is a problem?)
- Concern (e.g. what is there about your use of medication that you or other people might see as reasons for concern?)
- Intention to Change (e.g. If you were 100 percent successful and things worked out exactly as you would like, what would be different?)
- Optimism (e.g. what makes you think that if you decide to make a change, you could do it?)

The following page has an example worksheet you can use.

Change Plan Worksheet

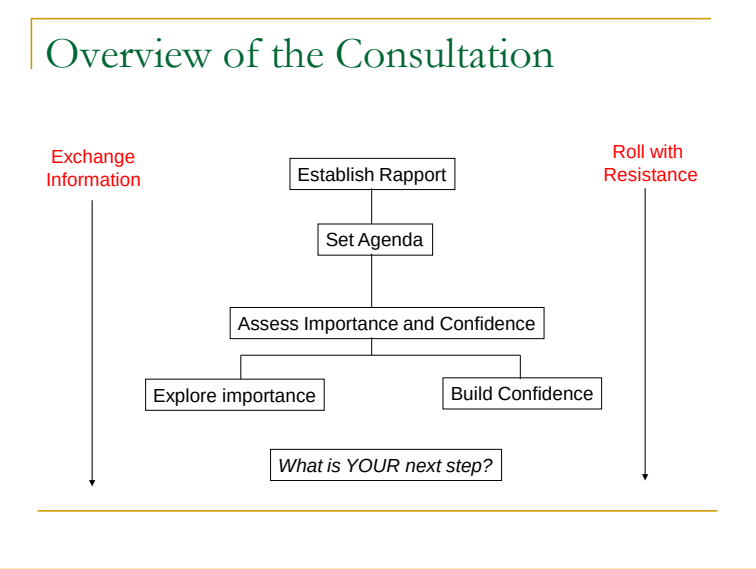
The changes I want to make are:
The most important reasons I want to make these changes are:
My main goals for myself in making these changes are:
I plan to do these things to reach my goals: *Plan of Action* *When*
The first steps I plan to take in changing are:
Some things that could interfere with my plan are:
Other people could help me in changing in these ways: *Person* *Possible ways to help*
I hope that my plan will have these positive results:
I will know that my plan is working if:
Source: Miller and Rollnick, 1991

Using MI in practice

The spirit of MI is often referred to by Miller and Rollnick, and is crucial to understanding the approach. Basically, it refers to the fact that MI is not just a collection of techniques; it's the spirit of how you talk to the patient that is most important:

- Motivation to change elicited not imposed
- Patient's task is to articulate and resolve their ambivalence
- Health professional's task is to be directive in helping patient examine ambivalence but using a quiet and eliciting style
- Readiness to change is not a trait, but a fluctuating product of the interpersonal interaction
- Any therapeutic relationship is a partnership not expert/recipient

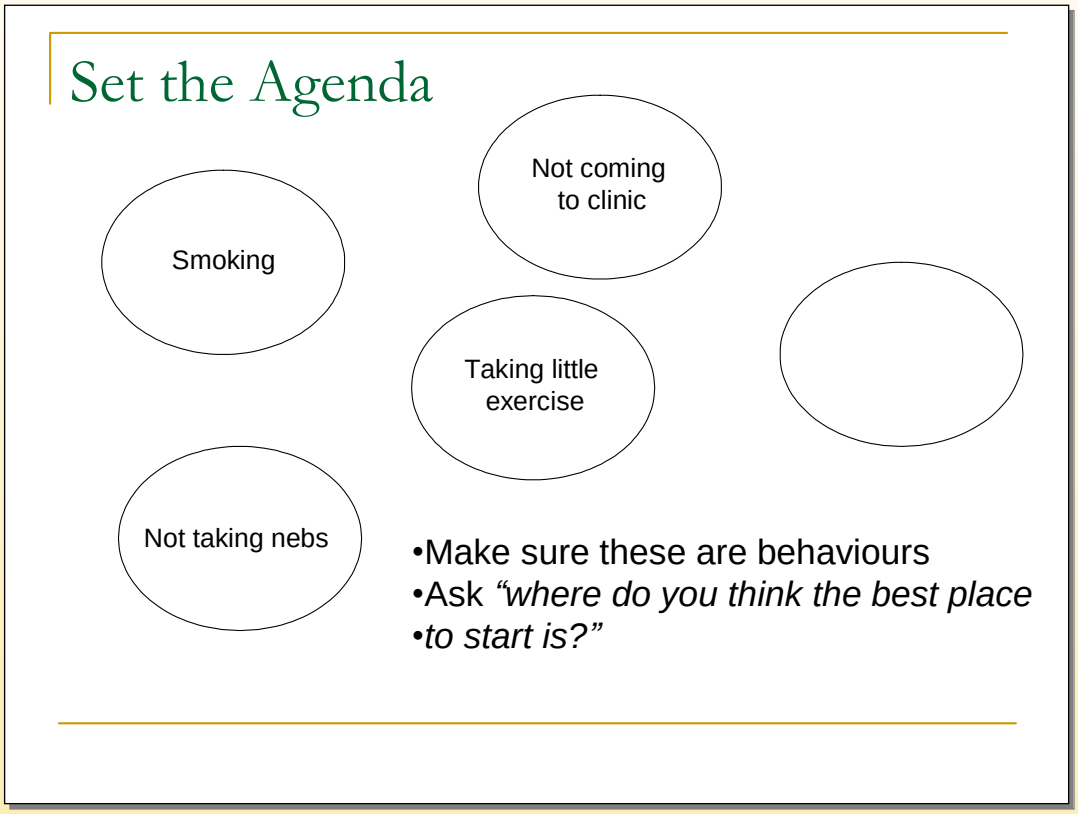
There are many ways of integrating MI into your routine practice. A reasonable plan for an MI session would be:



1. Create safe environment & build rapport
2. Set agenda
3. Assess readiness:
   "How important is it for you to change?"
   "How confident are you that you could do it?"
4. Explore importance & build confidence:
   Acknowledge status quo talk
   Invite discussion about not changing
   …and changing

It's crucial to get the beginning right. If you start the session on the wrong note, it can be hard to recover. One useful technique is to use an agenda setting menu. This is given to the patient and features some items which are known to be important, and some blank areas for the patient to write in what they think is important. The patient is then asked to choose the topic for discussion. This isn't always appropriate, but can be an excellent way of both conveying important information (what's in the boxes) and giving some control over the conversation to the patient.

The next step after agreeing on an agenda is to assess importance and confidence concerning change. You then need to facilitate a discussion centered on change, and if appropriate look at ways of building confidence. At the end of the session you need to have a discussion about where to go next. If your patient is ready and willing to make a change, you can help them to plan this. If they are unsure, there are more conversations to have. If they are making it clear they are not ready to change just now you need to respect their decision, but keep the options open - it's fine to express your own view and leave it open to have further conversations in the future.



One common concern for practitioners learning MI is that it sounds impossible to do in a short time. Although there are ways of tailoring MI to suit short sessions, this can be a problem. The only solution is to aim to do less in a single session. If a session covers many topics but change is very unlikely afterwards, it makes sense in the long run to cover less but get a better chance of at least one change. Sometimes using MI can plant seeds of change that many not come to fruition until sometime later.

FRAMES

An approach that may be useful was again initially developed for the use of MI with addicted patients - the FRAMES approach - which has the following components:

- ***F****eedback* regarding personal risk etc is given and usually includes normative data/discussion of implications

- ***R****esponsibility* for change is placed squarely and explicitly with the individual. Patients have the choice to either continue their behavior or change it.

- ***A****dvice* about changing is clearly given in a non-judgmental manner. It is better to *suggest* than to *tell.* Asking patients' permission to offer advice can make patients more receptive to that advice.

- ***M****enu* of self-directed change options is offered.

- ***E****mpathic* counseling, showing warmth, respect, and understanding, is emphasized. Empathy entails reflective listening.

- ***S****elf-efficacy* or optimistic empowerment is engendered in the person to encourage change.

Research has shown that simple motivation-enhancing interventions are effective for encouraging patients to return for another clinical consultation, return to treatment following a missed appointment, stay involved in treatment, and be more adherent.

Developing and Maintaining MI skills

MI is harder than it looks. Avoiding inadvertent and well meaning advice giving – and even confrontational interactions – is difficult in an area like CF where the stakes are high and concern for patient's wellbeing can be a powerful influence. In addition, the skills involved in successful MI may seem deceptively simple, but take practice and application to do well. We know from many years studying learning and behavior change in staff that attending a workshop or reading a book does not lead to long term changes in behavior, even when people are enthusiastic!

The stages of learning MI have been described by Bill Miller and Theresa Moyers:

1. Overall Spirit of MI
2. OARS: Patient-Centered Counseling Skills
3. Recognizing Change Talk and Resistance
4. Eliciting and Strengthening Change Talk
5. Rolling with Resistance
6. Developing a Change Plan
7. Consolidating Commitment
8. Transition and Blending

They go on to consider the implications for how MI is taught, and suggest six levels or types of training:

1. Introduction to MI – Experience the bases of MI and decide level of interest in learning more
2. Application of MI: To learn one or more specific applications of MI
3. Clinical Training: To learn the basic clinical style of MI and how to continue learning it in practice
4. Advanced Clinical Training: To move from basic competence to more advanced clinical skillfulness in MI
5. Supervisor Training: To be prepare to guide on ongoing group in learning MI
6. Training for the Trainers: To learn a flexible range of skills and methods for helping others learn MI

There are many people offering short courses on motivational interviewing. Some will be general introductions, some focused on specific areas of practice, and some covering advanced skills. Those running such courses come from a variety of backgrounds. Many will have specific training in how to teach motivational interviewing. Completing such training allows the trainer to join a remarkably friendly group with members across the world that communicate via an e-mail discussion list and a website. This is known as the Motivational Interviewing Network of Trainers (members are known as 'MINTIES'). Bill Miller and Stephen Rollnick are members of the group and often contribute to the discussion. The website is at:

http://www.motivationalinterview.org/

The page has a section on training which is well worth a look. Training is usually face to face, but some is offered via the internet or teleconferencing. The events take place all over the world, but get booked very early so be quick.

There is, in fact, a wealth of resources on MI available on the internet. There is a free on-line training course in using MI in addictions available vie the MINTIE website at:

http://www.motivationalinterview.org/mionlinefree/index.html

A variation of MI called Motivational Enhancement Therapy (MET), designed for a large scale trial of treatments for alcohol problems has now been made available for free download. You can get the manual for free here:

http://casaa.unm.edu/manuals.html

A manual for applying MET to people with Diabetes has been put together for an intervention at the Institute of Psychiatry in London, UK, and is available here:

http://www.iop.kcl.ac.uk/iop/Departments/PsychMed/EDU/downloads/pdf/DiabetesManual.pdf

More relevant to CF, there is an illustrated guide to using MI (Duff, Latchford & Reikart, 2008) which is available for free download from Advancmed at: http://www.advancmed.org/839mi

As we know, a workshop doesn't insure skill retention or further development. Miller and Mount (2001) found that participants in an MI workshop tend to over estimate their skills after taking part in a workshop, and that without "booster" sessions MI skills are likely to fade over time.

We would suggest, then, that those interested in using MI read through some of the material that we suggest in this handout. If interested to find out more, we would recommend further training, perhaps following the suggestions we have outlined. To improve the chances of skills consolidating, however, we would also recommend continued supervision in the techniques. Ideally this would be with someone skilled in MI, but peer supervision – getting together with one or two colleagues with similar interests – can be incredibly useful. This can be supplemented by further courses, reading (and sharing useful books and articles with colleagues).

Previous research has looked at the long term effects on skill retention and competency in MI of a range of method including videotape training, teleconferencing, and live coaching. Although the studies tend to feature small sample all methods examined show some promise though there is a clear need for further research.

Perhaps the best method to improve your own personal practice is to listen to audiotapes of your clinical sessions. There are several self assessments available that can give you some guidance on how you are doing. They are free and easy to complete, and you can track your skill development in private or with a peer group.

The MITI (Motivational Interviewing Treatment Integrity) version 2, developed by Theresa Moyers, Tim Martin, Jennifer Manuel & Bill Miller, contains two elements: a global rating (of empathy and MI spirit) and behavior counts of a number of MI consistent and MI inconsistent behaviors:

- Giving Information
- MI Adherent (Asking permission, affirm, emphasize control, support.)
- MI Non-adherent (Advise, confront, direct.)
- Open Question
- Closed Question
- Simple reflection
- Complex reflection

There is a manual to help you understand these categories, and the manual and coding sheet can be downloaded here: http://casaa.unm.edu/codinginst.html

The BECCI (The Behaviour Change Counselling Index) is an alternative coding system, developed in Cardiff in Wales by Claire Lane, and was designed specifically for health settings. It uses global ratings of a number of MI behaviours used in a session, rated from “not at all “to “a great extent”. It focuses on four domains and eleven behaviours:

1. **Agenda Setting and Permission Seeking**
    - Practitioner invites the patient to talk about behaviour change
    - Practitioner demonstrates sensitivity to talking about other issues

2. **The Why and How of Change in Behaviour**
    - Practitioner encourages patient to talk about current behavior or status quo
    - Practitioner encourages patient to talk about behaviour change
    - Practitioner asks questions to elicit how patient thinks and feels about the topic
    - Practitioner uses empathic listening statements when patient talks about the topic
    - Practitioner uses summaries to bring together what the patient says about the topic

3. **The Whole Consultation**
    - Practitioner acknowledges challenges about behaviour change that the patient faces
    - When practitioner provides information, it is sensitive to patient concerns and understanding
    - Practitioner actively conveys respect for patient choice about behaviour change

4. **Talk about Targets**
    - Practitioner and patient *exchange* ideas about *how* the patient could change current behaviour

It is very easy to use. The manual and scale can be downloaded here:

http://www.motivationalinterview.org/library/BECCIForm.pdf

http://www.motivationalinterview.org/library/BECCIManual.pdf

We suggest using the record sheet provided on the next page to record your use of MI, and to flag up areas to work on.

Finally, the importance of getting supervision cannot be overestimated: there is good evidence that this greatly enhances study skills and reflection on skill development. Ideally this would be with someone skilled in MI, but as we said above, peer supervision – getting together with one or two colleagues with similar interests – can be incredibly useful. Probably the best way to do this is with your team.

BECCI record sheet

Session Date	Domains											Total BECCI score
	Invite talk about behaviour change	Demonstrate sensitivity	Encourage talk about current behaviour	Encourage talk about behaviour change	Ask questions to elicit thoughts/feelings	Empathic listening statements	Summaries	Acknowledge challenges	Provide info in sensitive way	Respect for patient choice	Exchange ideas	

Does MI work?

Those involved in developing MI have been interested in evaluation from the beginning. Since it began as a treatment for alcohol problems, much of the early work was in this area. A review of 11 clinical trials of motivational interviewing published in 1997 concluded that this is a "useful clinical intervention...[and] appears to be an effective, efficient, and adaptive therapeutic style worthy of further development, application, and research" (Noonan and Moyers, 1997, p. 8). More recent trials have confirmed this early promise (a list of recent reviews may be found in the further reading list). Interestingly, it has been shown to be effective for patients who were not previously thinking about change (pre-contemplators), as well as those in the contemplation stage.

It's worth mentioning that a variation on MI, Motivation Enhancement Therapy (MET), was used in one of the arms of Project MATCH, a large scale trial of interventions for alcohol abuse. They found that MET produced comparable overall outcomes at lower cost when compared with two longer treatment methods.

MI is still very widely used in addictions, but has also been adopted by clinicians in a wide variety of other areas, including health promotion, forensic populations and adherence in chronic illness, in nations all across the world.

The evidence base is, then, steadily growing. Interestingly, there is now enough evidence to enable meta-analysis (a computational method in which the results of different trials may be pooled statistically to produce an overview). A recent one is known as MARMITE (Meta-Analysis of Research on Motivational Interviewing Treatment Effectiveness) (Hettema et al, 2005). They included 72 trials drawn from the following areas: Alcohol (31), Drug Abuse (14), Smoking (6), HIV Risk (5), Treatment Compliance (5), Water purification (4), Diet and exercise (4), Gambling (1), Eating disorders (1), and Relationships (1).

Altogether, the trials featured 14,267 participants treated with MI. The average length of MI offered in these trials was just 2.2 hours. Unsurprisingly, they found the effectiveness of MI varied widely between the different studies, but were able to conclude that there were "robust and enduring effects when MI is added at the beginning of treatment". They noted that MI increased treatment retention, treatment adherence and staff-perceived motivation.

Research has more recently turned to MI as an intervention to increase adherence. This has been reviewed by Duff and Latchford (2010), who found that there are now many high quality studies covering adult and child populations in a number of clinical areas, including diabetes and HIV, and work is ongoing in CF. It seems clear that MI is a highly promising intervention.

Further Reading

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Socratic Questioning:
Changing Minds or Guiding Discovery?

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Why did you choose to come and hear this talk?

What am I going to say?

What do you already know about Socratic questioning?

Don't you think it is a mistake to ask questions without a goal in mind?

These are all questions. Are they equally useful questions? I don't think so. When I first began doing cognitive therapy fifteen years ago, I thought the Socratic questioning process was the most intriguing part of the therapy. I still do. Today you will hear the best questions I've been asked about Socratic questioning and the paths I've followed to answer them.

I will assert that some questions are better than others, that it is possible to develop guidelines to help therapists and clients learn to use Socratic questions more effectively, and that it is important we answer the question, "Is the primary purpose of Socratic questioning to change minds or to guide discovery?"

My thinking for this talk actually began in 1986. By then I had attained sufficient skill as a cognitive therapist that therapists began asking me, "How do you know what questions to ask?" Somehow, responding that the questions just intuitively "popped into my head" did not seem a satisfactory answer. And yet, for me and, I suspect, for many other skilled therapists, it was hard to articulate how I thought of the questions I asked.

This question posed to me seven years ago, "How do you know what questions to ask?" has guided my own learning as a therapist and teacher of Cognitive Therapy more than any other. It is a tribute to the power of a well-timed question that I have been stimulated by this simple query to engage in extensive observation of myself and other therapists for seven years in search of a satisfactory answer.

Of course, therapists studying cognitive therapy with me continued to pose the question. For awhile, I answered my students' curiosity by providing lists of questions that could be asked in therapy. Then we would develop rationales in our training programs for why one question would be better to ask first and another later and yet another not asked at all. This collaborative process between us led to the development of a list of good Socratic questions that were generic in nature and generally led the client to discovering useful information. Typical Socratic questions on the "good" list included:

Have you ever been in similar circumstances before?

What did you do? How did that turn out?

What do you know now that you didn't know then?

What would you advise a friend who told you something similar?

This strategy of listing good questions to ask was a useful one. I discovered that it was not only helpful to therapists learning cognitive therapy, but I began giving these questions to clients and found that these same questions helped clients generate alternative responses on their written automatic thought records. So, as I became more aware of what questions I tended to ask again and again, this knowledge could be shared with other therapists and clients.

But the question asked in 1986 continued to roll around in my mind. "How do I know what questions to ask?" Although beginning students of Cognitive Therapy were quite satisfied with my list of "good questions to ask," more advanced therapists were quite aware that these generic questions were not enough. I didn't simply ask these questions over and over again. I asked hundreds of different questions and different questions with each client. Where did these questions come from? And was there any pattern to the questions I asked when I was doing therapy well?

Approximately 100,000 therapeutic questions later, I have discovered some patterns in my own questions. Watching myself and other experienced cognitive therapists on videotape, I think these simple patterns might serve as a beginning to a clearer articulation of what is involved in good Socratic questioning within a cognitive therapy context. Therefore, I will offer guidelines tonight for therapists who wish to improve their Socratic questioning skills.

But before doing that, I'm going to digress to discuss the purpose of Socratic questioning. I began thinking about this in 1990 when a therapist wrote me after a large workshop and asked for written references on Socratic questioning. In particular, he wanted some written descriptions of how Socratic questioning was defined in Cognitive Therapy and some examples and guidelines of how to do it.

I quickly turned to my library of Cognitive Therapy books to find some references on Socratic

questioning so I could respond to his letter. I began with Cognitive Therapy of Depression and proceeded through books published in 1990. To my surprise, there was almost nothing written on Socratic questioning. There were hundreds of references to this questioning process as a cornerstone of cognitive therapy, but little had been written describing or defining the process.

Others, including Tim Beck, Melanie Fennell, and Gary Emery had also come up with "good questions" lists like we had devised but no one described the process in great detail. In fact the two articles written by Overholser and published in the 1993 spring issue of Psychotherapy are the first papers I've read written specifically on the Socratic method.

But back to 1990. Next, I turned to the clinical vignettes in these books. I thought, "Well, I'll send him vignettes from several different books and the process will at least be clearly illustrated." To my chagrin, I discovered that many of the published vignettes did not seem to illustrate what I considered good Socratic questioning.

Clearly I had some notion of the purpose and process of Socratic questioning which was being violated in these vignettes. I suddenly wanted to define standards that could be used to judge "Socratic questioning" as "good". Furthermore, I realized for the first time that not all Cognitive Therapists were in agreement on what constituted good questioning.

As I read therapy vignettes in various Cognitive Therapy texts, I noticed they varied considerably in therapist style. In some examples, the therapist seemed to know exactly where he or she was headed. In these examples, the therapist would ask a series of factual questions "one-two-three" and then say to the client (almost triumphantly) "well, then how can you think thus and so?" The client in these vignettes would invariably say, "Oh, I see what you mean."

In these clinical examples, the client would report a change in mind, but I felt disappointed in the therapeutic process. Perhaps my disappointment was fueled by my clinical experience in which few clients undergo lasting change because a therapist has shown their thought processes to be illogical. And yet there are many clinical vignettes in the literature that imply cognitive therapy consists primarily of a therapist and client revealing logical flaws in the client's thought process: “One-two-three-aha!”

Theoretically, I can't accept that the goal of Socratic questioning is to change client's beliefs. Why not? Isn't change in beliefs one of the primary goals of cognitive therapy. Yes... and no. While changing beliefs is often very therapeutic, I worry about the therapeutic costs if belief change by any means is the goal. Our theoretical underpinnings in cognitive therapy are that we are to be collaboratively empirical.

Can a therapist who sees a flaw in a client's thought process and sets out to change the client's mind be collaborative and empirical? Yes, but often we are not. Let me give you two clinical vignettes of my own which illustrate the difference between changing minds and guiding discovery. In these vignettes, a depressed client named Stuart (S) believes he is a failure in every way. I will be the therapist in both examples.

Example 1: Changing Stuart's Mind

S: I'm a complete failure in every way.

Th: You look defeated when you say that. Do you feel defeated?

S: Yes. I'm no good.

Th: You say you are no good. Is it true that you haven't done anything at all good?

S: Nothing of importance.

Th: How about for your children this week -- did you care for them at all?

S: Of course, I helped my wife put them to bed and took them to soccer practice.

Th: Do you think that was important to them?

S: I suppose so.

Th: And did you do anything to make your wife happy this week?

S: She liked the fact that I came home from work on time.

Th: Would a "complete failure" be able to respond to his wife's request in such a successful way?

S: I guess not.

Th: So is it really accurate to say you are a complete failure in every way?

S: I suppose not.

Th: So how do you feel now?

S: I guess a little better.

In this example, I am trying to show a relatively good example of questioning to change a client's mind. This is not bad therapy. The therapist engages in a reasonable line of questioning and it seems somewhat helpful to the client.

However, I believe we can do better. And I believe many therapists would do better if we had better descriptions of the Socratic questioning process. Compare this first example, with the following example of Socratic Questioning where the purpose is not to change the client's mind, but to guide discovery.

Example 2: Guiding Discovery

S: I'm a complete failure in every way.

Th: You look defeated when you say that. Do you feel defeated?

S: Yes. I'm no good.

Th: What do you mean when you say, "I'm no good?"

S: I've completely screwed up my life. I haven't done anything right.

Th: Has something happened to lead you to this conclusion or have you felt this way for a long time?

S: I think I see myself more clearly now.

Th: So this is a change in your thinking?

S: Yes. (Pause) I went to that family reunion and I saw my brother and his kids and wife. They all looked so happy. And I realized that my family's not happy. And it's all my fault because of my depression. If they were in my brother's family, they'd be better off.

Th: And so, because you care about your family, you then decided you were a complete failure, that you've let them down.

S: That's right.

Th: You also indicated this was a change in your thinking. You've been depressed many times. And you've seen your brother and his family many times. How did you think about this in the past?

S: I guess I used to always think I was OK because I tried to be a good husband and father. But I see now that trying isn't enough.

Th: I'm not sure I understand. Why is trying not enough?

S: Because no matter how hard I try, they still are not as happy as they'd be with someone else.

Th: Is that what they say to you?

S: No. But I can see how happy my brother's kids are.

Th: And you'd like your kids to be happier.

S: Yes.

Th: What things would you do differently if you were less depressed or a better father in your own eyes?

S: I think I'd talk to them more, laugh more, encourage them like I see my brother do.

Th: Are these things you could do even when you are depressed?

S: Well, yes, I think I could.

Th: Would that feel better to you -- trying some new things as a father, rather than simply doing the same things?

S: Yes. I think it would. But I'm not sure it would be enough if I'm still depressed.

Th: How could you find that out?

S: I guess I could try it for a week or so.

Th: And how will you evaluate whether or not these changes are making your children feel happier?

In this second example, the therapist asks a series of questions but it is not quite so clear where the therapist is headed. As the therapist in this example, I must confess, I had no idea when I started the questioning process where we would end up. And I will assert to you that I think this is a good thing. What? A good thing if the therapist does not know where she is going? Yes. Because sometimes if you are too confident of where you are going, you only look ahead and miss detours that can lead you to a better place.

A cognitive therapist can guide without knowing where she and the client are going to end up. In this second example, the therapist asks questions to understand the client's view of things, not to simply change the client's mind. As a result, the client is more active. After a period time in which the therapist and client look together to discover what is in the client's mind and experience, the therapist begins asking how the client would like things to be different and what the client could do to bring about this change. Finally, the therapist begins to wonder aloud how the client will evaluate and measure the success of these efforts.

In this more empirical process of (1) gathering data, (2) looking at this data in different ways with the client, and (3) inviting the client to devise his own plans for what to do with the information examined, there is discovery going on.

There is also discovery in the first example, but compare the nature of this discovery. In the first example, when the therapist's goal was changing the client's mind, the therapist had "the answer" and directed the client to find it. In the second example, when the therapist's goal was guided discovery, the therapist didn't have an answer, just genuine curiosity. The discovery that the client makes is owned by the client and not the therapist. As an added benefit, Stuart's "answer" to his dilemma is quite different than one I would have constructed for him and undoubtedly fits him better.

There are many examples in the literature of Socratic questioning to change minds. I realize now, that these written examples partly prompted the

original question, "How do you know what questions to ask?" When students of cognitive therapy read these vignettes in our cognitive therapy texts, it is clear to them that these therapists know the answer. And so students were asking me, "How do you know what the answer is so you can properly change your client's mind?" In the best cognitive therapy, there is no answer. There are only good questions that guide discovery of a million different individual answers.

Does this mean that cognitive therapy will have no coherent structure, shape or form? Of course not. Empirically, the body of evidence suggests cognitive therapy leads to best results when we are structured in the therapy hour and teach our clients specific skills. What I am suggesting, however, is that within this structure, we can ask questions which either imply there is one truth the client is missing or which capture the excitement of true discovery.

Therapists ask me if I get tired of doing thought records with clients or of teaching clients the panic model or of any one of a number of cognitive therapy tasks that I have done hundreds or even thousands of times. And I can honestly say that when I do get tired of these tasks, it is usually because I have stopped doing them well. To do cognitive therapy well is to do each repeated task a little differently with each client because, while the initial guiding questions are often the same, the answers are almost always a little different and so there is always the chance of ending up in a new place.

Several years ago a therapist in one of my training programs raised his hand after a clinical demonstration early in the year, and said with some frustration, "I don't see the point in asking all these questions. I could have pointed out the flaws in this client's thinking and changed her mind much more quickly by taking a more direct route." This is undoubtedly true. But in most cases I think a direct challenge of beliefs is not as therapeutic as guided client discovery. Why not?

If we lose the collaborative empiricism of cognitive therapy, we lose its long-term benefits. The goal of cognitive therapy is not simply to make our clients think differently or feel better today. Our goal as cognitive therapists is to teach our clients a process of evaluating their goals, thoughts, behaviors, and moods so that they can learn methods for improving their lives for many years to come.

We are not simply fixing problems but also teaching ways of finding solutions. In outcome studies, many therapies do well in the treatment of depression, anxiety and other problems. Cognitive therapy shines at lowering relapse and, so far, it is the learning of specific concepts and skills that appear to predict lower relapse rates, not merely a change of mind.

There is a vast difference between the client who exits therapy saying, "I was depressed because my thinking was negative," and the client who says "I learned how to reevaluate my negative thinking when it's distorted and how to problem solve when it is accurate."

Among therapists, there is a vast difference between one who thinks cognitive therapy involves changing distorted thinking and a therapist who thinks cognitive therapy is a process of teaching clients to evaluate their thoughts, behaviors, moods, life circumstances, and physiological reactions to make choices that are adaptive.

Clearly, I want therapists to learn to do Socratic questioning as guided discovery. To this end, I offer some guidelines for what we should teach therapists when they are learning to use questions in cognitive therapy.

As a starting point I offer a definition of Socratic questioning which incorporates guided discovery.

> ***Socratic questioning involves asking the client questions which:***
>
> ***a) the client has the knowledge to answer***
>
> ***b) draw the client's attention to information which is relevant to the issue being discussed but which may be outside the client's current focus***
>
> ***c) generally move from the concrete to the more abstract so that***
>
> ***d) the client can, in the end, apply the new information to either reevaluate a previous conclusion or construct a new idea.***

Let's examine each part of this definition. First, the client should have the knowledge to answer your question. One of my opening questions to you this evening violated this rule and thus, would not be a good Socratic question for guiding discovery. I asked you, "What am I going to say?" You couldn't know the answer, so it is a poor Socratic question.

This example may seem obvious, but as therapists we do sometimes ask our clients questions they couldn't possibly answer. We ask a client who is completely unaware of his emotions, "what are you feeling now?" It weakens collaboration to ask questions we are pretty certain our client can't answer. A better question would be "Are you aware of any tension or changes in your body as we talk about your father?" This question guides discovery rather than underscoring deficits.

The second point of this definition is that good questions draw the client's attention to information which is relevant to the issue being discussed but which is outside the client's current focus. Relevancy

is important. Sometimes as therapists we ask a series of unrelated questions that have doubtful relevancy to the client's concerns. Or we ask questions because a part of the client's history interests us even though it may not be important to addressing the issue at hand.

What relevant information would be outside the client's current focus? Many different types of empirical studies suggest that we think about things related to and supportive of our current thoughts and emotions. When depressed we recall depressing memories. If we think of ourselves as successful we can recall successes more easily than failures. And yet we are able to retrieve information and memories contradictory to our current mood and beliefs if we have a stimulus which asks us to find this information.

Good Socratic questions can trigger retrieval of information which has relevance for the client once prompted into awareness. In this way, we as therapists serve as an additional memory bank retrieval system for the client. To the extent we have different beliefs and emotions activated than the client, we can be aware of important information currently outside our client's awareness.

Third, good Socratic questioning generally moves from the more concrete to the abstract. When a client makes an initial statement that therapist and client decide to explore, the therapist has a world of questions to choose from. Many questions are good questions to ask. In general, it is helpful to begin with concrete questions that help define the client's concern or which request a specific example of it. Making an issue concrete can help insure that therapist and client are both talking about the same thing.

When Stuart says he is "no good", it is important he and the therapist share an understanding of what he means. Does he mean he is evil? Does he mean he never does anything right? Does he mean he has failed in some specific way? Generally, Socratic questioning will begin with several questions which make the client's concern more specific.

Another advantage of picking a very specific illustration of the client's concern is that therapist and client can more easily test out beliefs and conclusions as well as understand emotional responses when a particular situation is described. When Stuart says he is "no good" the therapist notes his defeated tone. But when the family reunion is described, Stuart recreates a situation which the therapist can enter.

After exploring a specific situation, good Socratic questioning will lead to some learning or discovery. It is at this point that the questioning proceeds from the concrete to the more abstract. The therapist will ask questions to help the client learn something from the discussion and figure out how to experiment with this idea in his or her life. In this way, Socratic questioning can help the client develop his or her own therapy assignments such as making further observations or trying a behavioral experiment to test out a new idea.

The therapist asked Stuart what interactions made a good father-child relationship and encouraged him to evaluate whether he could do these things. This discussion led to a concrete plan to experiment with specific changes in his life for a short period of time and then to evaluate the results. In this way, Socratic questioning in reality often goes from the abstract ("I'm no good") to the concrete (the family reunion) to the abstract (qualities of a good father) to the concrete (a behavioral experiment). As therapists we err if our discussions with clients do not include both the concrete and more abstract levels of learning.

When using Socratic questioning to guide discovery, our final goal is to help the client use the information we've uncovered to reevaluate a previous conclusion or to construct a new idea. Although this goal is implicit in the discovery process, many therapists, including myself, ask dozens of good questions in a session without ever helping the client put the answers together in some meaningful way.

To increase the likelihood that all this questioning leads to both discovery and application in the client's life, I propose to you four stages of the guided discovery process.

Stage One: Asking informational questions

The questions asked will follow the guidelines in the definition above. The client will know the answers, they will bring into awareness relevant and potentially helpful information, and these questions will initially strive to make the client's concerns concrete and understandable to both client and therapist.

Stage Two: Listening

It is critical that the therapist not just ask questions. She or he must also listen well to the answers. In Socratic questioning with a goal of changing minds it often seems that the client's answers to single questions are irrelevant. The therapist is building a case and as long as most of the questions are answered in the expected direction the case will be proven.

In contrast, if Socratic questioning is done to guide discovery, the therapist must be open to discovering the unexpected even if she or he anticipates a specific answer. Many times I ask the client a question and am startled by the answer. If I am not regularly surprised by my

clients' answers, I suspect I am either not asking interesting questions or not listening to the replies.

Is there a function to the listening beyond understanding your client? Yes. Listen for idiosyncratic words and emotional reactions. Listen to your clients' metaphors and recreate in your own mind their images. Listen for a word that seems oddly placed in a sentence. Listening for these unexpected pieces of your client's story and reflecting these parts back instead of the expected parts will often intensify client affect and create new and faster inroads to core schema and life themes.

Listening is the second half of questioning. If you are not truly curious to know the answer, don't ask the question.

Stage 3: Summarizing

Socratic questioning often occurs over several or more minutes in a session. Often a number of pieces of new information are retrieved and discussed. While this is going on, the client may be in a highly charged emotional state or uncertain why you are asking about particular parts of their experience.

One of the most common mistakes I notice therapists making in the Socratic questioning process is that they don't summarize enough. In the portions of the session where you are using Socratic questioning, there should be a summary every few minutes. When a summary is particularly relevant or meaningful to the client, he or she should write it down for later review.

The summary is also another chance for therapist and client to discover if they are understanding things in similar or different ways. Finally, the summary gives the client a chance to look at all the new information as a whole which sometimes has a greater impact than considering each bit of data as a single piece.

Stage 4: Synthesizing or Analytical Questions

Finally, after new information has been discovered, idiosyncratic meanings have been heard and explored, and a summary has been constructed, the therapist completes the guided discovery process by asking the client a synthesizing or analytical question which applies this new information to the client's original concern or belief. In it's simplest form, this question might be, "Stuart, how does all this information fit with your idea, "I'm no good?"

Again, therapists often stop short of this critically important final stage of guided discovery. As a beginning cognitive therapist I remember worrying so much about thinking up questions that I forgot to help the client tie the answers together in a meaningful way at the end. And yet the synthesizing questions are one last chance for the client to discover something unexpected. I once asked a client how she thought a particular set of information applied to her problem expecting her to come up with a plan for coping with her sadness in the coming week. Instead, she began laughing and said, "I just realized that I came here to feel happy and instead I've learned that sometimes it is healthier for me to be sad."

In Conclusion

After seven years of pondering the question "How do you know what questions to ask?" I still am not satisfied with my answers. But the ongoing discovery process is exciting. Like all discovery, I've sometimes been surprised by what I've found. As the years go by, I find myself even more intensely interested in the question than when it was first asked.

Today my interest is also fueled by concern. As cognitive therapy becomes more widespread and accepted, I am afraid it's empirical roots could be lost and the therapy could be watered down into a weaker form of a technology for changing minds. With economic pressures on psychotherapists in the US and Britain and many other countries, we are asked to do therapy in briefer and briefer formats. As therapists, we are going to feel the pressure to just change clients minds more quickly.

Without specifications for what constitutes good Socratic questioning, there can be no research to empirically evaluate whether guided discovery has any more positive long-term effects than simple questioning to change minds. This research could be an important part of the next stage of empiricism in cognitive therapy as we begin to sort out what are the critical components of therapies that have been shown to be effective. I hope some of you here will be intrigued enough by my remarks to help test out these ideas.

For my own part, I will continue to help define and describe the process of Socratic questioning in its best forms so that therapists use questioning to guide client discovery as part of genuine collaborative empiricism. And until I'm asked a more compelling question, I'll continue to try to figure out, "How do you know what questions to ask?"

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