PCSS Providers Clinical Support System

Motivational Enhancement Techniques: Working with Patients with Substance Use Disorders or High Risk Use

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Disclosures

- **Dr. Colistra has nothing to disclose**

Note: If AAAP is the CME provider for this training, please complete our COI form here: http://www.cvent.com/d/ntqcxz.

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

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Target Audience

- The overarching goal of PCSS is to train a diverse range of healthcare professionals in the safe and effective prescribing of opioid medications for the treatment of pain, as well as the treatment of substance use disorders, particularly opioid use disorders, with medication-assisted treatments.

Educational Objectives

- At the conclusion of this activity participants should be able to:

- Discuss and apply the basic principles of motivational enhancements techniques such as expressing empathy, developing discrepancies, rolling with resistance, and supporting self-efficacy.
- Review the *styles* and *traps* of using the motivational enhancement techniques and how to recognize and avoid falling into the common practitioner traps with patients.
- Explore and understand integration of these skills into primary care practices.

Note: When writing your educational objectives, please reference the link below to access recommended leading verbs for formulating objectives:

https://www.phscpd.org/resources/pdf/list_of_verbs_for_formulating_objectives.pdf

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Enhancing Patient Motivation

- It is ***not*** a technique so much as a style of engaging or counseling
- It is a ***facilitative*** way of being with people
  - As such it can be as useful in interpersonal interactions as counseling interactions
- It is client centered & empathetic yet directive
  - *Rogers with a twist*

Motivational Interviewing and Enhancement

- Designed to explore & reduce:
  - Natural ambivalence
  - Resistance to counseling/treatment
- Designed to enhance:
  - Self-motivation for (positive) change

Collaboration

- Provider must relate in a non-judgmental, collaborative way
  - Brief intervention is something done ***with*** a client not ***to*** a client
- Client's experience & personal perspective provides context for change that is facilitated, ***not coerced***

Evocation

- Interviewer's tone conveys, "What do you think?" rather than, "This is what you should know"
- Counselor draws out ideas, feelings, & wants
- Uncovering hidden motivation and drawing it out is what MI is all about
  - change becomes the client's idea

Autonomy

- Change is entirely the client's responsibility
- Individual autonomy is respected
- MI creates a safe & sheltered place for clients to, "Step back, look at the big picture, and consider the cost/benefit ratio of change"
  - Rule # 1 – no "in your face" confrontations
  - Rule #2 – acceptance of the client

Roll with Resistance

- Clients resist change, especially in the early stages of readiness
- Opposing resistance generally reinforces it
- Resistance can be reframe
- MI providers do not oppose resistance so much as "roll & flow" with it
- Reluctance to & ambivalence about change are natural

Acting on Resistance

- Interviewer does not impose new views or goals
- Invites different interpretations of existing facts
  - Reframing
- Facilitates ways for client to consider new information
- Encourages new perspectives on old facts

Traps that Prevent Motivational: "Question-Answer" Trap

- Easy to fall into…
- Use open ended questions & listen reflectively
  - ***Never*** ask more than 2 closed-ended questions in a row…***ever!***

"Labeling" Trap

- Diagnostic & other labels
  - No reason to use such labels as positive change is ***not*** dependent on them
- If a client wants to know "what do I have?"
  - Suggest, "*Labels are not important; you are*" or "*I'd like to hear more about…*"
- Avoid jargon, as it can become a label
  - "alcoholic," "addict," "substance abuser," etc.

“Premature Focus” Trap

- Insisting on discussing “your” conception of “the problem”
  - Especially when the client has other concerns
  - “*Some times you must give what the client wants to get the chance to provide what is needed*”
- Clients become defensive when they have to struggle to be heard/understood

“Taking Sides” Trap

- When counselor detects a problem and starts to tell client about how serious it is and what to do about it
- Facilitate resistance…
  - Clients become argumentative
- If you argue your view, the client will defend
  - The wedge gets driven further between you & client

"Blaming" Trap

- Blaming is historically viewed as denial
  - Confronting blaming as denial alienates the client
  - Sabotages consideration of *change talk*
- Diffuse blame instead of confront
  - Dismiss blaming as unnecessary; you don't label
- Use reflective listening
  - "*Who is to blame is less important than concerns are about the situation and which, if any, options you are open to considering*"

“Expert” Trap

- If you imply you have all the answers, clients become passive
  - Remember: The client is the expert on the client, e.g., his/her situation, values, goals, concerns, skills, etc
- Counseling is about collaborating and providing clients with the chance to explore and resolve ambivalence for themselves

Pick the trap

- The patient has been in suboxone treatment for 1 year and has been doing well with all negative urine drug screens and a recent return to full employment. She recently missed her appointment and at her next appointment she reported experiencing withdrawals of hot and cold sweats and body aches. She was given a urine drug test and when it returned it was positive for methamphetamine. When the nurse asked to discuss the UA the patient stated it was inaccurate. The nurse stated that she was lying and it was not surprising that she would be lying since she is an addict.

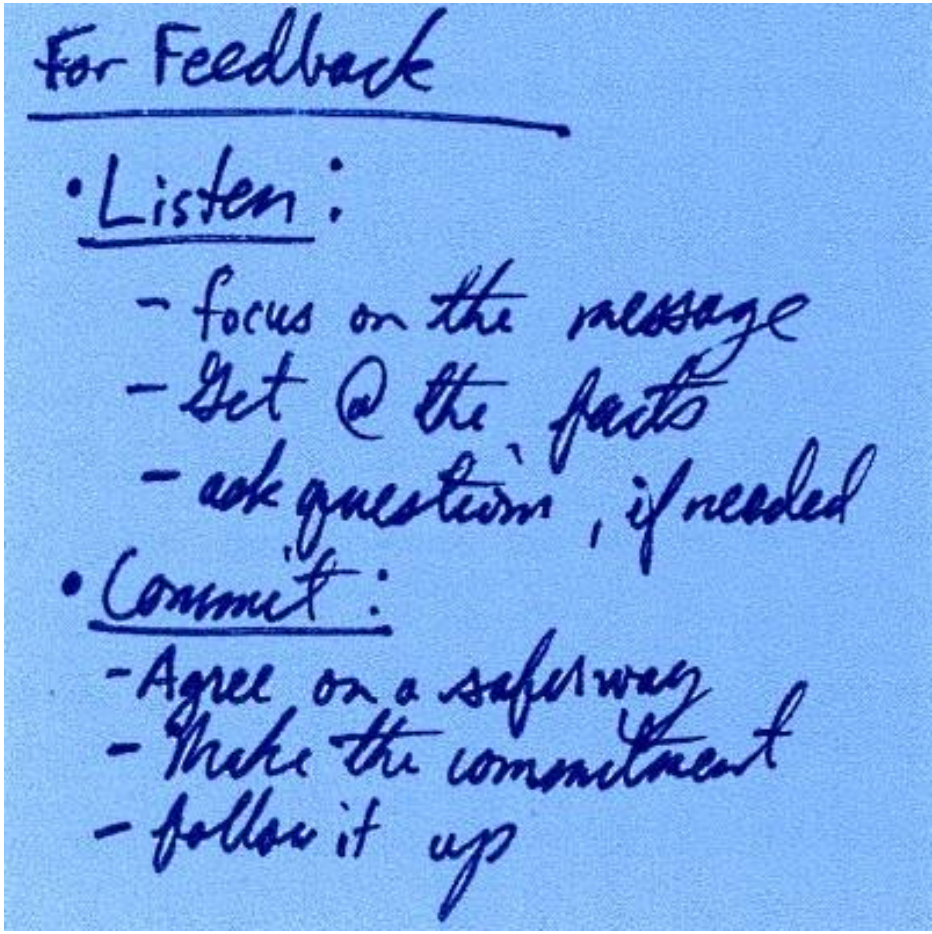
- Taking Sides
- Premature focus?
- Labeling trap?
- Expert Trap?
- Blaming Trap?

Pick the trap?

- The patients is on medication (Lortab) for back pain. He has been taking his Lortabs for five years for his back injury that he suffered as a result of a war injury five years ago. Back surgery is an option but he has not undergone surgery out of fear. He takes the medication as prescribed 2-3 times per day. His doctor has recommended he undergo the surgery and get off his long term pain medication regimen. As a result of this request, John has been reporting more back pain and last month he ran out of his medication 1 week earlier.
- The doctor tells John that he needs to come off of the medication and go for the back surgery and he feels that he is being resistant.
- Premature focus?
- Labeling trap?
- Expert Trap?
- Blaming Trap?
-

Providing Feedback

- Providing feedback is a staple of any Motivational Enhancement
- In MI this is *low-key* and it is expected that clients may be resistant
  - Avoid arguments
  - Present a warm, sheltered, accepting environment
- Non-judgmental, collaborative approach



Asking permission to provide feedback

A couple things occur to me as I listen to your views on this; do you mind if I provide some feedback?

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The Principles: An Overview

- Express empathy
  - *Listen to understand, not to reply*
- Develop discrepancy
  - Showcase client ambivalence
  - Point out inconsistencies in client thinking
- Roll with resistance
- Support self-efficacy

Express empathy

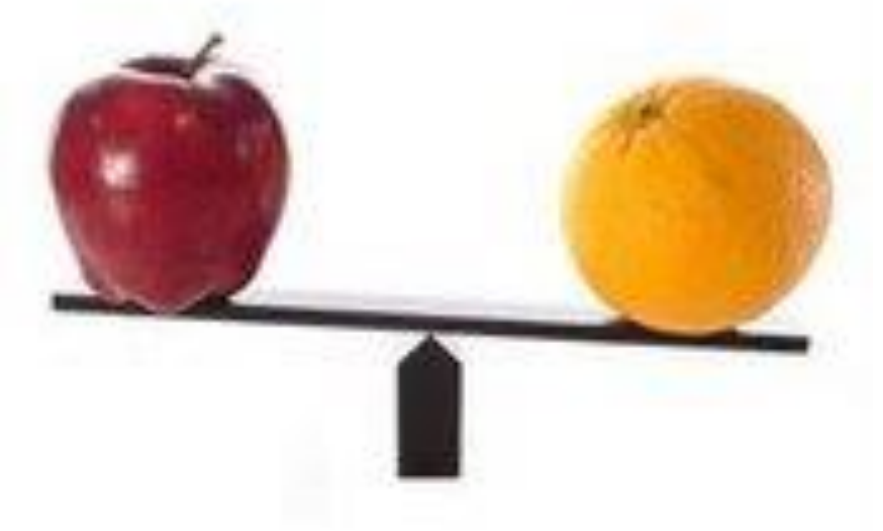
- This is the key or *defining principle* of MI
- Working definition:
  - Accepting & understanding another's perspective
  - Without judging or evaluating
    - *It's not about the nail!*
    -
- *Hate the sin, but love the sinner*

Empathy continued

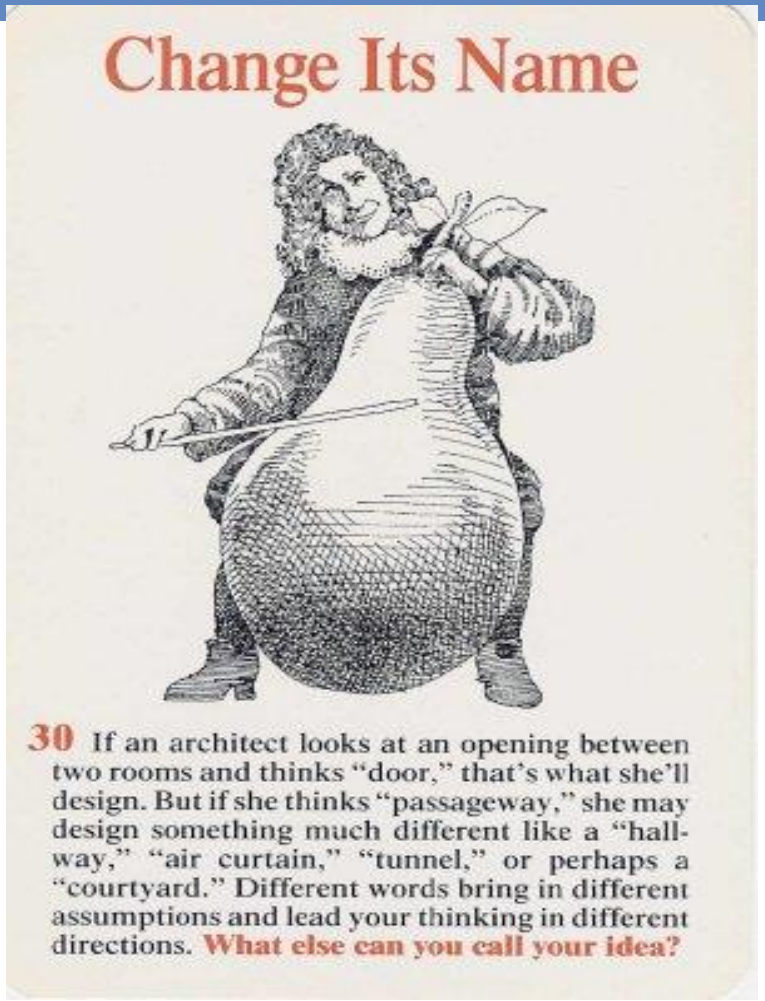
- Listening associated with empathy
  - Must *listen* in order to *hear*, that is
    - Understand
    - Accept
    - Empathize

Develop Discrepancy

- This is the *directive* part of MI
  - How it differs from traditional person-centered/ humanistic counseling
- Discrepancy between
  - The way things *are* and
  - The way the person would like them to be
- Help the client become *unstuck*
  - From ambivalent feeling



Discrepancy continued



- Developing the discrepancy enables person to see how important change can be
- Discrepancy *may* be sufficient to facilitate change
  - Rift between present behavior and stated values & goals
- Best for client to initiate change talk
- NOTE: Decisional Balance exercise

Roll with Resistance

- Arguing with client to change will necessarily force client to argue against it
  - This is traditionally viewed as resistance if not denial
- Resistance as a *clinical barometer*
- Examples of resistance
  - Client sounds disinterested
  - Unmotivated/unprepared to change

Roll with Resistance continued

- "Rolling" with resistance means getting out of its way and *not* engaging it
- "Psychological Judo"
  - Attack by another not met with direct opposition
  - Use attacker's momentum to one's own advantage

Types of Resistance

Arguing

Interrupting

Denying

Ignoring

Support Self-Efficacy

- Popularized by Bandura
  - Social Learning Theory
  - Definition: A personal belief in one's ability to do something
  - Similar to self-confidence, but more specific
    - Self-confidence is a belief in me, self-efficacy is a belief in my ability to do "X"
- Critical to MI
  - Change means action…can I or can't I do it?

Self-Efficacy continued

- If change is viewed as necessary, but client lacks the belief in an ability to make that change, it is not going to happen
- When the provider believes in the client and convey this, the client is likely to reflect this confidence
  - Works as a self-fulfilling prophecy

Self-Efficacy continued

- Providers cannot make changes for clients
  - Therefore clients must believe in the *ability to make the change*
  - Counselor can nurture & set the stage for self-efficacy
- Strategies to enhance S-E
  - Explore past successes
  - Skill building – *walk before you run*

Incorporating Motivational Enhancement Into Primary Care work and provider beliefs regarding the use of these skills

- Their beliefs and attitudes regarding counseling patients about health behavior change,
- Their self-efficacy to help support patients in making changes in health behavior,
- The extent to which they experience job-related burnout prior to learning motivational interviewing
- Time commitments

- Midboe et al. (2011).

References

- Midboe, A. M., Cucciare, M. A., Trafton, J. A., Ketroser, N., & Chardos, J. F. (2011). Implementing motivational interviewing in primary care: the role of provider characteristics. *Translational behavioral medicine, 1*(4), 588-94.
- Miller, W.R., & Rollnick, S. (1991). *Motivational Interviewing: Preparing people to change Addictive Behavior.* London.
- Substance Use and Mental Health Administration. Enhancing motivation to change in substance abuse treatment. TIP 35. Retrieved from https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Abuse-Treatment/SMA13-4212

Note: Please use the NIDA format for citations and alphabetize references.

PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medication-assisted treatment**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

For more information visit:

https://pcssNOW.org/mentoring/

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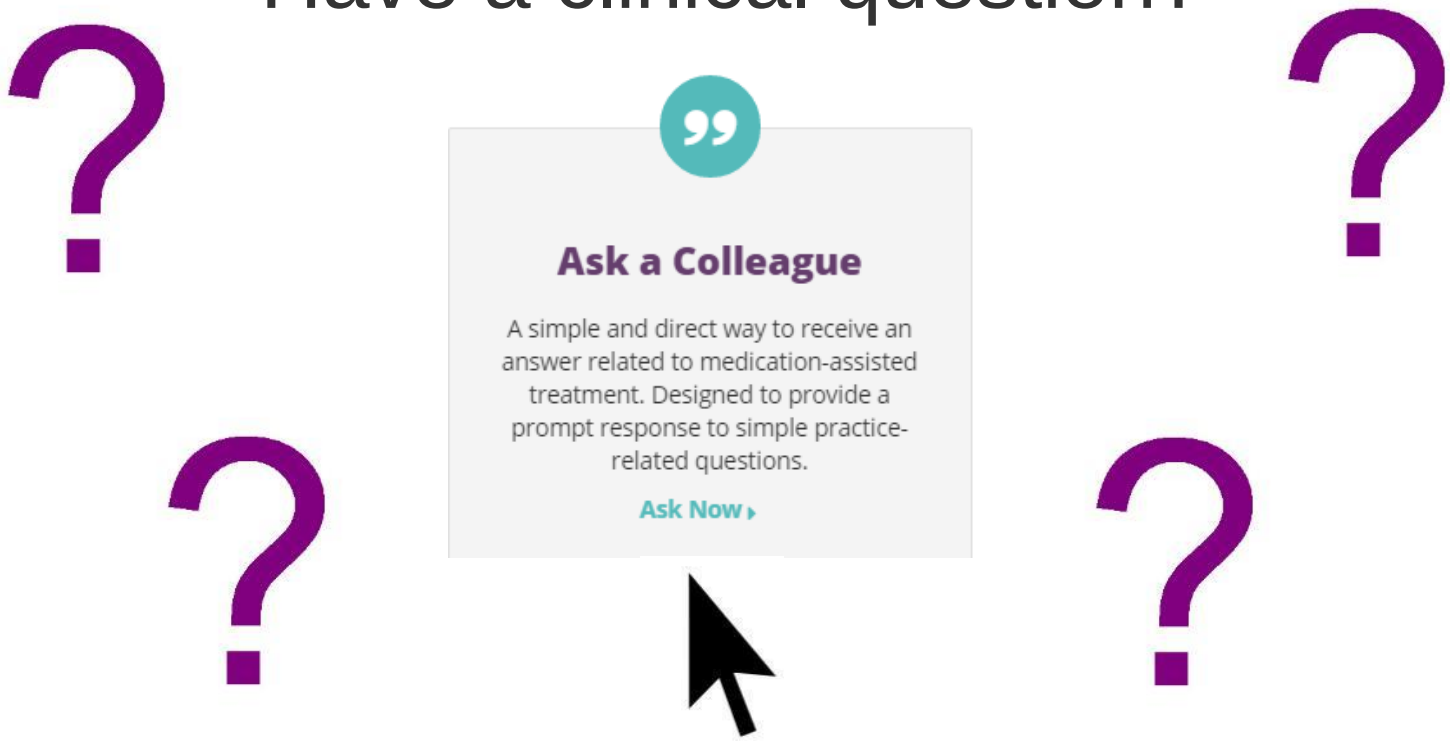
PCSS Discussion Forum

Have a clinical question?



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PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

American Academy of Family Physicians	American Psychiatric Association
American Academy of Neurology	American Society of Addiction Medicine
Addiction Technology Transfer Center	American Society of Pain Management Nursing
American Academy of Pain Medicine	Association for Medical Education and Research in Substance Abuse
American Academy of Pediatrics	International Nurses Society on Addictions
American College of Emergency Physicians	American Psychiatric Nurses Association
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