Allan Fohlmann

Something about the perspective and thoughts about others, communication and motivation

A man in a hot air balloon realized he was lost. He reduced altitude and spotted a woman below.

He descended a bit more and shouted:

"Excuse me, can you help me? I promised a friend I would meet him an hour ago, but I don't know where I am."

The woman below replied, "You're in a hot air balloon hovering approximately 30 feet above the ground. You're between 40 and 41 degrees north latitude and between 59 and 60 degrees west longitude."

"You must be an engineer," said the balloonist.

"I am," replied the woman, "How did you know?"

"Well," answered the balloonist, "everything you told me is, technically correct, but I've no idea what to make of your information, and the fact is I'm still lost.

Frankly, you've not been much help at all. If anything, you've delayed my trip."

The woman below responded, "You must be in Management."

"I am," replied the balloonist, "but how did you know?"

"Well," said the woman, "you don't know where you are or where you're going.

You have risen to where you are due to a large quantity of hot air.

You made a promise which you've no idea how to keep, and you expect people beneath you to solve your problems.

The fact is you are in exactly the same position you were in before we met, but now, somehow, it's my fault."

Much of this is about:

- What we say to each other and how we say it
- How we look at each other
- How we interpret the actions of others
- Our experiences with others
- Our experiences with people like the one in front of me
- Ulterior motives, bitter experiences and prejudices
- And many other things - which we will be looking at.

And much of this is often remaining unsaid and unreflected

What's your name?

Who are you?

Where do you come from?

Wishes?

Desires?

Thoughts?

Hopes?

What's in the stars?

Reasons?

Fears?

Needs?

Expectations?

Worries?

What's important for you?

” Where am I?”
MI-skills Ruler Lineup

Wright it down

Where would you place yourself on a scale from 0 to 10, describing how skilled you see yourself, where 0 means ‘not skilled at all’ and 10 means ‘exceedingly skilled’?

0	1	2	3	4	5	6	7	8	9	10
Not skilled at all										Excee-dingly skilled

” Where am I?”

- **Think about the following**
- Why are you here at (‘ your number’) and not (zero or a lower number)?.
- What brought you there?

  Since (almost) nothing comes for free

Interview each other using the following questions

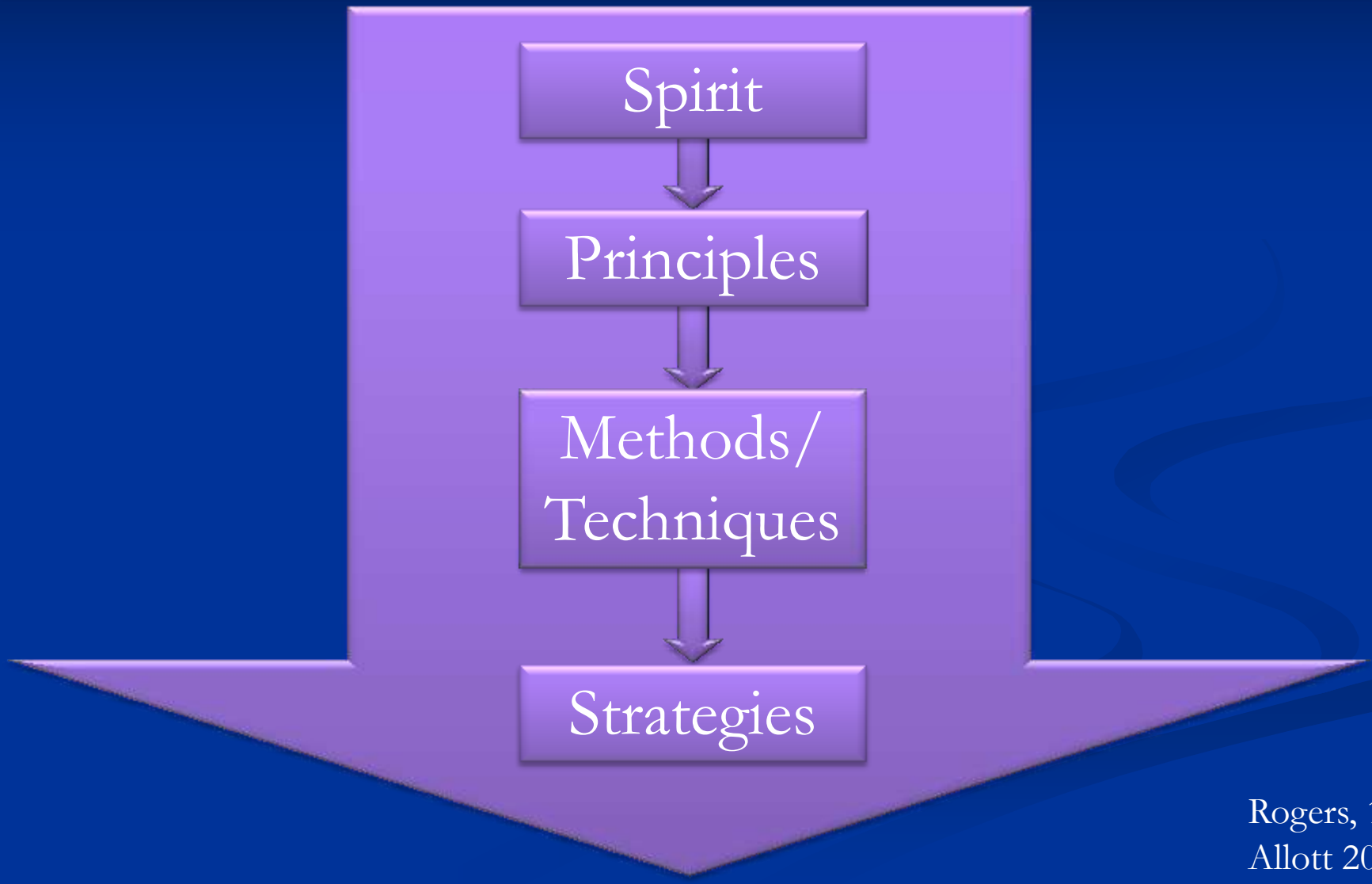
- **What did you become aware of when you did this? ?**

1. **What brought you there?**
   Qualities, Skills, Experiences, Mutual aid, Teamwork etc.
2. **What will it take to move up a step or more?**
3. **Where on the scale would you like to be?**
   - **Where it would be good enough?**
   - **Where it would be satisfying?**
4. **What can we learn from this?**

What Skills, Abilities, Experiences do you already have? Knowledge of MI?

Motivational Interviewing

*a way of being with and for people**



Rogers, 1980
Allott 2007

Motivationel interviewing

www.motivationalinterview.net/

How MI started

- Motivational interviewing began in a barber shop in Norway in 1982
- Bright Norwegian psychologist students was engaging in role-play enactment of therapeutic methods.
- And they asked; What are you thinking as you say that? Why have you taken this line of approach rather than another? Why that particular word? What underlying model is guiding your methods? etc.
- That required Miller to make his approach explicit.
- The approach he had learned from his clients

MI was not based on a theory

- Broadly grounded in Rogerian client-centered counseling approach
- Original based on implicit principles emerging from intuitive practice
- MI principles were stated before there was empirical support or theory (1983)
- Elaboration and the development of MI arose from Miller & Rollnick's interactions (1991)

Miller 2004

MI is logically linked to:

- Carl Rogers' theory of the change and motivation
- Leon Festinger's theory of cognitive dissonance
- Daryl Bem's self-perception theory
- Jim Prochaska and Carlo DiClemente's model whit transtheoretical stages of change

Hettema 2007 Miller 2004

Bem

I learned what I believe,

from what I hear myself saying

People develop their attitudes by observing their behavior and concluding what attitudes must have caused them

Motivational interviewing – the basic

- **A way of being with the client**
  - **Not a set of techniques**
  - **Not a school**
  - **Not a theory**
- You examine and resolve ambivalence in collaboration with the patient
- Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction
- The therapist's style is respectful and calm
- Themes are in focus, rather than solutions

Rollnick S, Miller WR. What is motivational interviewing? 1995. *Behavioural and Cognitive Psychotherapy*, Vol *23*, nr. 4, p. 325-334.

Jf. http://motivationalinterview.org/

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Jf. http://motivationalinterview.org/

Jf., Hesse 2006

Motivation; between confrontation and you lead the way, all the way

Client centered therapy

At the client's premises; also regarding themes, form, direction etc.

Unconditional acceptance and empathy

Motivational interwieving

The client decides but the focus is directed towards the problems and ambivalence.

Non confronting, non judgmental and empathical

Confrontational conversation

Controlling

Setting boundaries

Correctional

The therapist will determine focus an try to convince the client

What's the sign of an MI counselor?

Instructor	MI counselor
Instruct people	Encourage
Want people to change	Is patient
Is the expert	Is supportive
Tells	Listen

MI Spirit

A = Autonomy vs. authority

C = Collaboration vs. confrontation

E = Evocation vs. education

Carl Rogers:

When a person's view of himself changes, his behavior changes accordingly."

"The patient reacts in accordance with her belief, not necessarily in accordance with the doctor's belief –and certainly not against her personal belief."

‘People are generally better persuaded by the reasons which they have themselves discovered, than by those which have come into the mind of others’

Blaise Pascal: Pensees. *(tanker)* 1660

You think about your values, if you become aware of them

How we see ourselves

How we want to see ourselves

Its not a new problem

For what I do is not the good I want to do; no, the evil I do not want to do - this I keep on doing.

(Romans 7:19)

Try not to wrestle - Try to dance

What's important when you dance?

- Try to make it feel good
- Make it nice and smooth if possible
- Allow your partner to take the lead, to determine the music, the steps and the closeness etc.
- Only take the lead if your partner ask for it, wants it and allow it. Make sure not to overdo it
- Go with the music
- Make your partner want to dance again another time

The first step towards getting somewhere is to decide that you are not going to stay where you are.

John Pierpont Morgan

DEFINITION :

"Motivational interviewing is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence"

http://www.motivationalinterview.org/

But First …
Lets look at motivation

In a moment..
I will ask you the question:

What is motivation?

Motivation

- Motivation is the activation or energization of goal-orientated behavior
- Motivation is said to be intrinsic or extrinsic
- Motivation may be rooted in the basic need to minimize physical pain and maximize pleasure, or it may include specific needs such as eating and resting, or a desired object, hobby, goal, state of being, ideal, or it may be attributed to less-apparent reasons such as altruism, selfishness, morality, or avoiding mortality.

What is the components of motivation?

- Direction
  - What is the person trying to do?
  - Motivation to achieve? or
  - Motivation to avoid?
- Effort
  - How hard is the person trying??
- Stamina
  - How long does the person keep on trying?

Interview each other in pairs
One is the listener; active and interested and curious, and really wants to know:
What is important for you. What is fun, interesting, exciting to do, etc.

- **What's your coolest projects?**
- **What is your driving force?**

4 minutes for each one of you

What motivates you?

What conclusions did you reach?

- What was important, fun, interesting, exciting to do, etc.
- What was the coolest projects?
- What was the driving force?

- And Motivation is?

What conclusions would your patients reach?

- What would be important, fun, interesting, exciting to do, etc.
- What would be their coolest projects?
- What would be the driving force?

=

Do we forget this?
Why?
What can we do about it?

The radio station with most listeners?

WIIFM

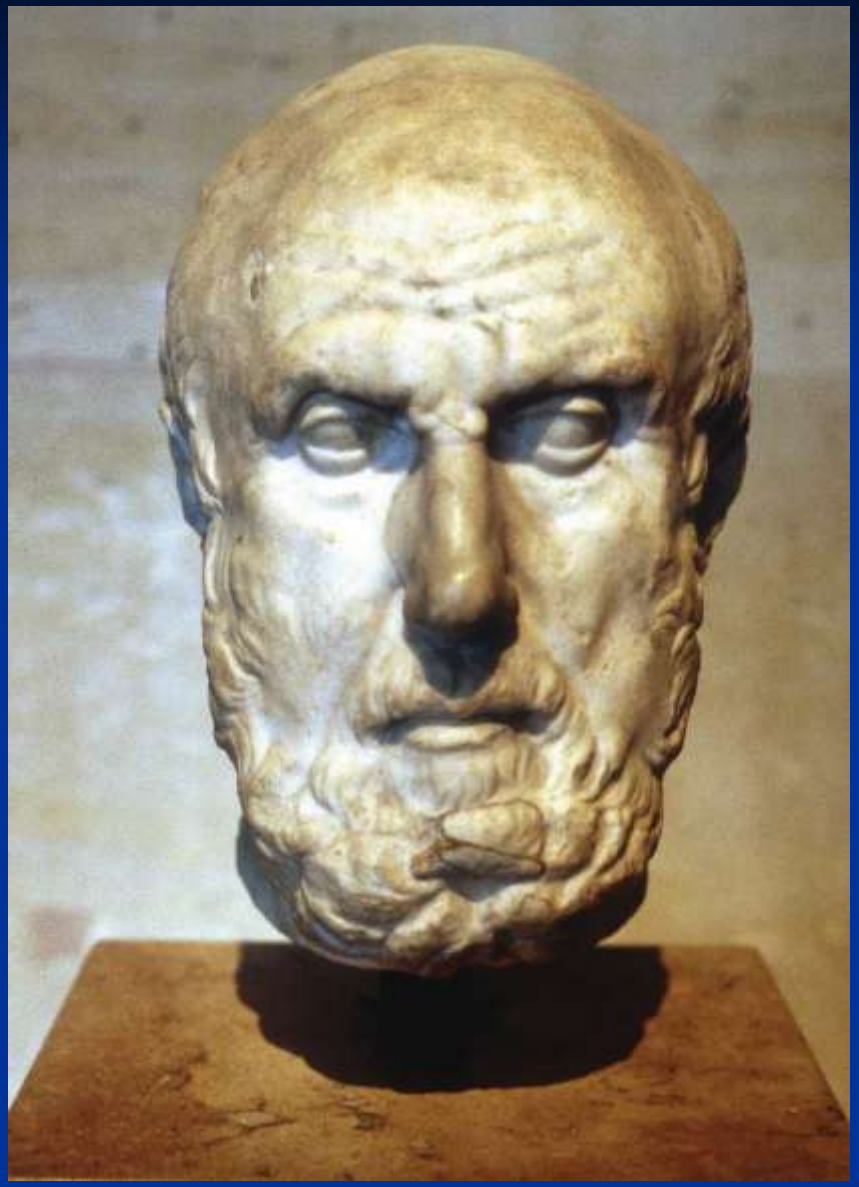
What's In It For Me?

But there is more to it!!

And then

Why don't I take my medication?

Motivation and medication



Hippocrates 460 BC – ca. 370 BC

Old problem!

"Keep a watch also on the faults of the patients, which often make them lie about the taking of things prescribed"

"Rule of three"

42-60% of first episode sufferers show poor adherence

1/3 takes the medication as prescribed
1/3 has such a low compliance / adherence, that the treatment is unlikely to be effective
1/3 is somewhere in between.

Institut for Rationel Farmakoterapi 2006,Urquhart1997; Osterberg & Blaschke 2005

Nature vs. Chemistry

I prefer nature rather than chemistry!

Cannabis - more than 66 active agents:

Chemistry is bad

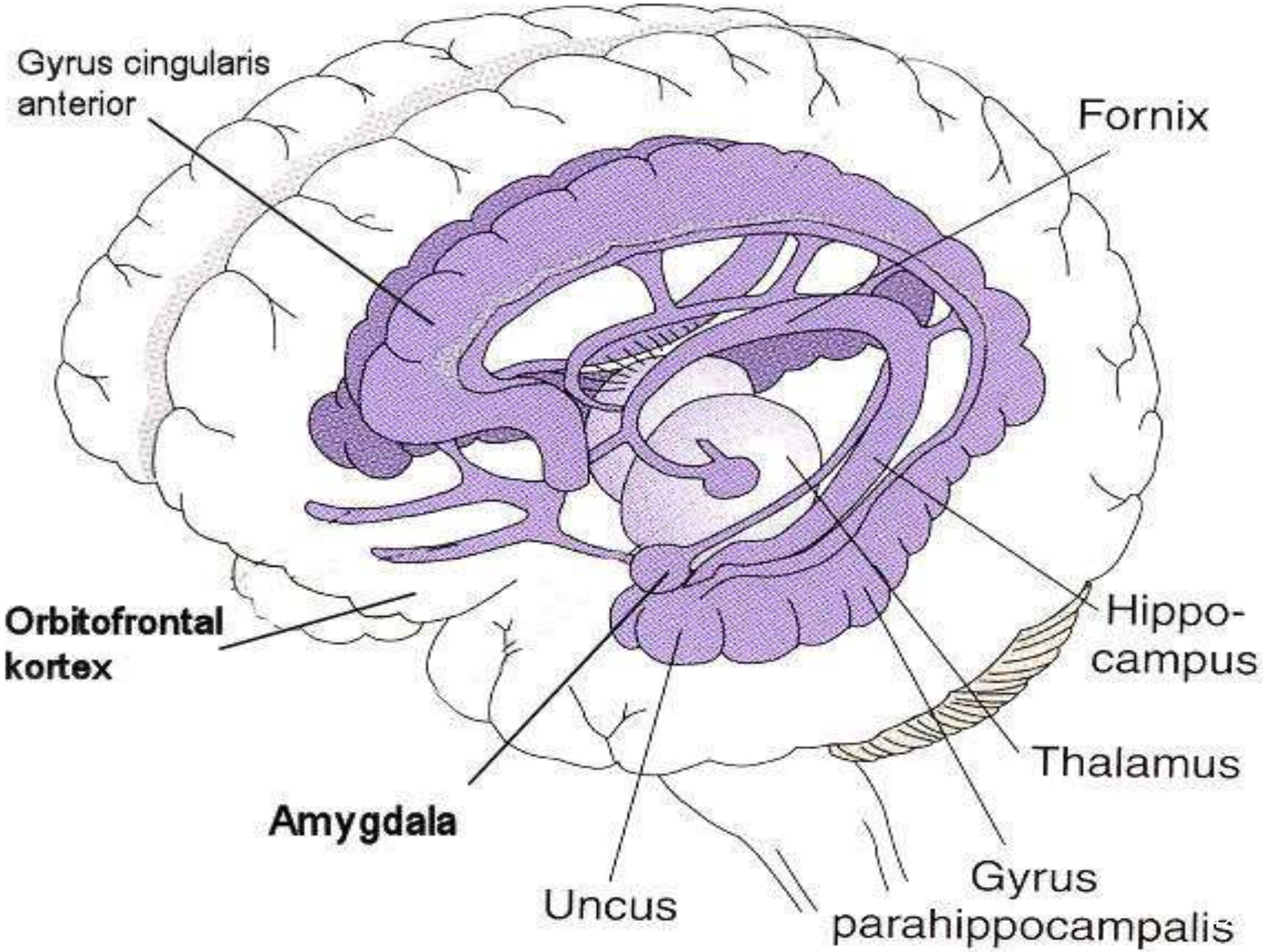
The brain is fragile

Why not take the medication?

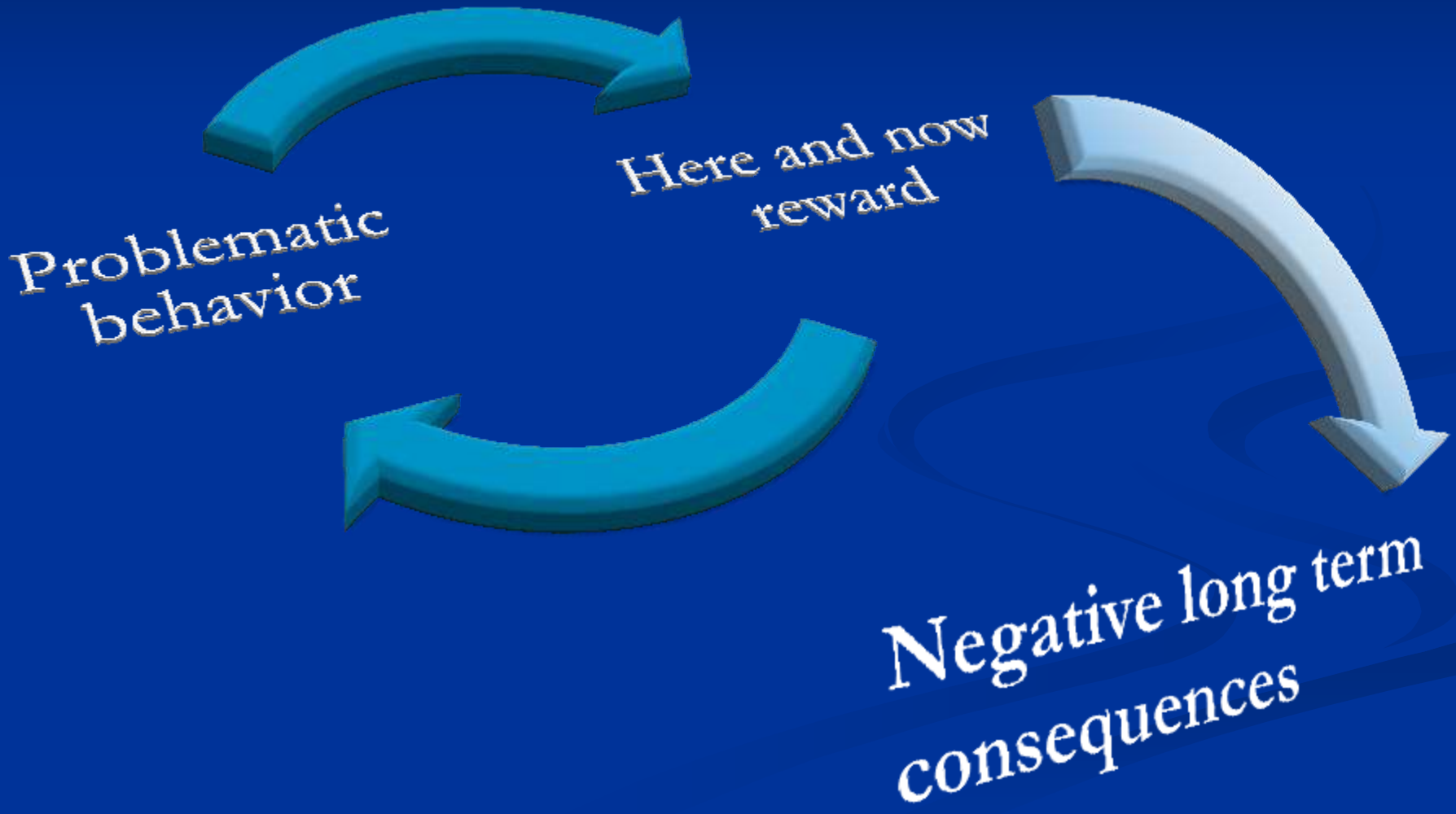
- Why do we take medication?
- Why don't we?
  - Something bad will happen
  - Something good will not happen
  - It makes no difference
  - I forget
  - Don't know
  - I'm ambivalent
  - ?

Decision balance

Change	No Change
Cons for not changing	Pros for not changing
Pros for changing	Cons for changing


Gyrus cingularis anterior
Fornix
Orbitofrontal kortex
Hippo-campus
Thalamus
Amygdala
Uncus
Gyrus parahippocampalis

Vicious circle - short term reward



And its not just the limbic system

- Psychology
- Sociology

- Media
- Hearsay
- Stigmatization
- And ?

If it wasn't like that..

We could use a rationalistic health ideology

- If we give people knowledge, they will want more
- If they get more knowledge, they will embrace the message
- If they embrace the message, they will understand
- If the understand, they will remember
- If the remember, they will change behavior
- If they change behavior based on knowledge, they will stick to that behavior
- If they stick to that behavior, there will be no relapse
- If there is no relapse, the problem is solved!

Good plans or ?

6 fruits per day

- Good for the ones that eats 5
- Bad for the ones that eats 0
  - Overwhelming
  - Unattainable
  - Unrealistic
  - To big leap between now and objectives
  - Defined by others ..

Motivational interviewing

www.motivationalinterview.org

Ambivalens and MI

Motivational Interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence

Rollnick & Miller 1995: ”What is motivational Interviewing?” Behavioral and Cognitive Psychotherapy, 23, p. 325-334

What is ambivalens?

- Is it a condition?
  - a constant companion?
- or a phase in a change process?
  - a recurrent stage of new insights and actions?

Ambivalence
what's the right word?

- Insecurity
- Hesitation
- Indecision
- Skepticism
- Irresolution
- Uncertainty
- Vacillation
- Mistrust
- Doubt
- Spinelessness
- Inconstancy
- Fickleness

Ambivalence – what is it?

- A capacity to experience, understand and cope with ambiguity and complexity ?
- A creative state, a creative space, with the possibility of mentally exploring and testing out different possible selves, different preferred selves?

Ambivalence – what is it?

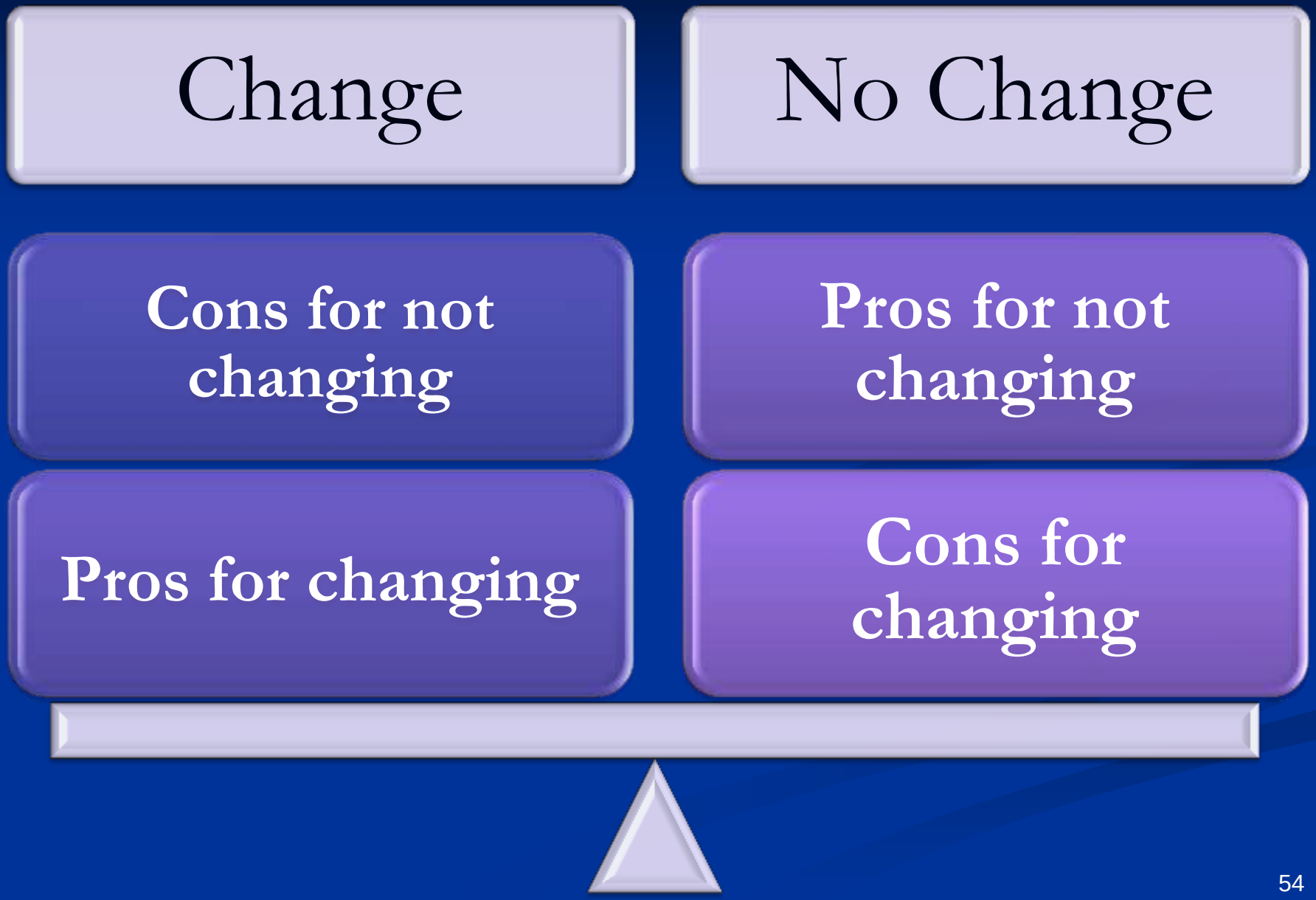
An important state or a stage in a change process, when the person starts and hopefully continues to think about, contemplates and explores the possibility of change

Ambivalence – what is it?

Ambivalence is not the same as being spineless or filled with resistance against what the therapist knows is right

Ambivalence is there, because there is something good, that you want but also something bad that you fear

Decision balance



Decision balance


Change
No Change
I don't have to remember pills
I can be my self
It spells it out; I'm mental
It will fuck up my brain
My psychiatrist is becoming tired of me
It helps me study math.

Common Reasons for Not Taking Medications? As you hear them!

Decision balance Exercise..

- Sit in groups of two
- One of you is the MI-provider
- One of you is the patient
  (a nice one, ambivalent about medication, but not the patient from Hell….)
- Talk about pros and cons
- Write it down

Decision balance Exercise..

Benefits/Pros of taking medication	Costs/Cons of taking medication
Costs/Cons of not taking medication	Benefits/Pros of not taking medication
All in all?	

Anxiety is proportional to the perception of threat:

$$\frac{\text{Likelihood / Probability}\ (+\ \text{to}\ -) \times \text{Awfulness / Danger}\ (+\ \text{to}\ -)}{\text{Coping}\ (+\ \text{to}\ -) \times \text{Rescue / Help from others}\ (+\ \text{to}\ -)}$$

Salkovskis 2010

MI – principals

Keywords

- Sympathy
- Empathy

  Evokes
- Synergy

MI principles - RULE

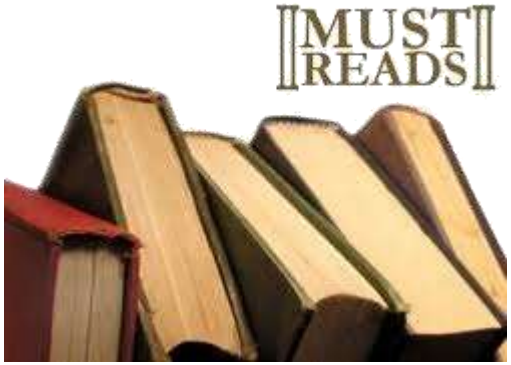
- **R** = Resist the righting reflex
- **U** = Understand your client's motivation
- **L** = Listen to your client
- **E** = Empower your client

MI principles - DRES

- **D** = Develop Discrepancy
- **R** = Roll with Resistance
- **E** = Express Empathy
- **S** = Support Self-efficacy *

*Bandura

R E A D S



- **R**oll with resistance
- **E**xpress empathy
- **A**void argumentation
- **D**evelop discrepancy
- **S**upport self-efficacy

R = Roll with Resistance

- Momentum can be used to good advantage
- Perceptions can be shifted
- New perspectives are invited, but not imposed
- The client is a valuable resource in finding solutions to problems

E = Express Empathy

- Acceptance facilitates change
- Skillful reflective listening is fundamental
- Ambivalence is normal

A = Avoid argumentation

- Confrontations result in defensive reactions
- Arguing can increase resistance to change
- Did they come for argumentative fights?

D = Develop Discrepancy

- Awareness of consequences is important
- A discrepancy between present behavior and important goals will motivate change
- The client should present the arguments for change

Jakabosky 2007

S = Support Self-efficacy

- Belief in the possibility of change is an important motivator
- The client is responsible for choosing and carrying out personal change
- There is hope in the range of alternative approaches available

Jakabosky 2007

DEARS

- **D**evelop discrepancy
- **E**xpress empathy
- **A**mplify Ambivalence
- **R**oll with resistance
- **S**upport self-efficacy

A = Amplify Ambivalence

- Acceptance facilitates change
- Skillful reflective listening is fundamental
- Ambivalence is normal

Take you pick

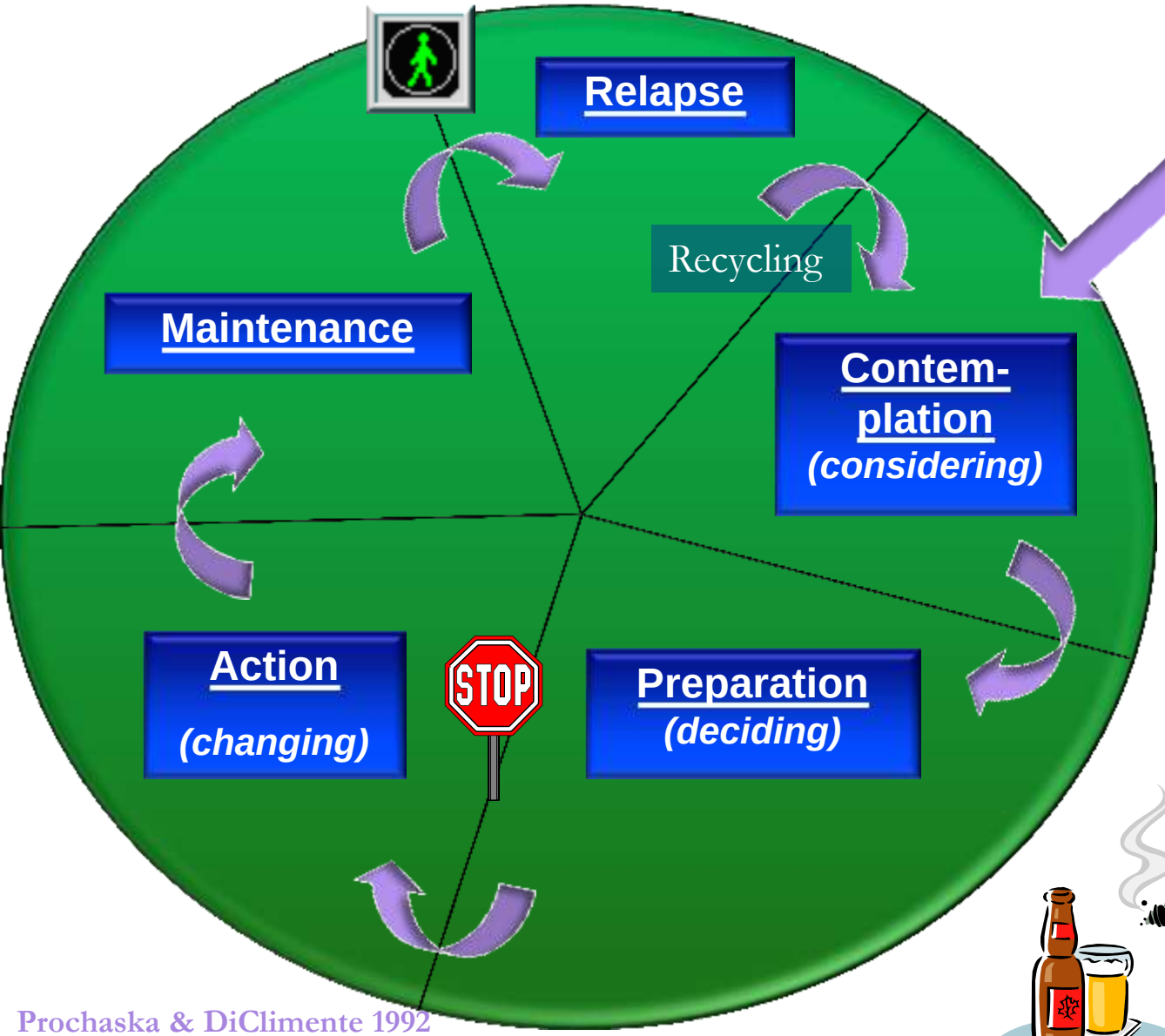
- DRES
- READS
- DEARS

The important things is behind the acronyms

Important - more important than techniques

- listen and be nice !!
- Think: there are good reasons for people's actions
- Empathy
- When in doubt: listen
- When not in doubt: listen
- Curious in a good way
- Confirming
- Respectful
- Non-judgmental attitude
- Non-confronting approach
- An inclusive atmosphere
- Friendly flexibility

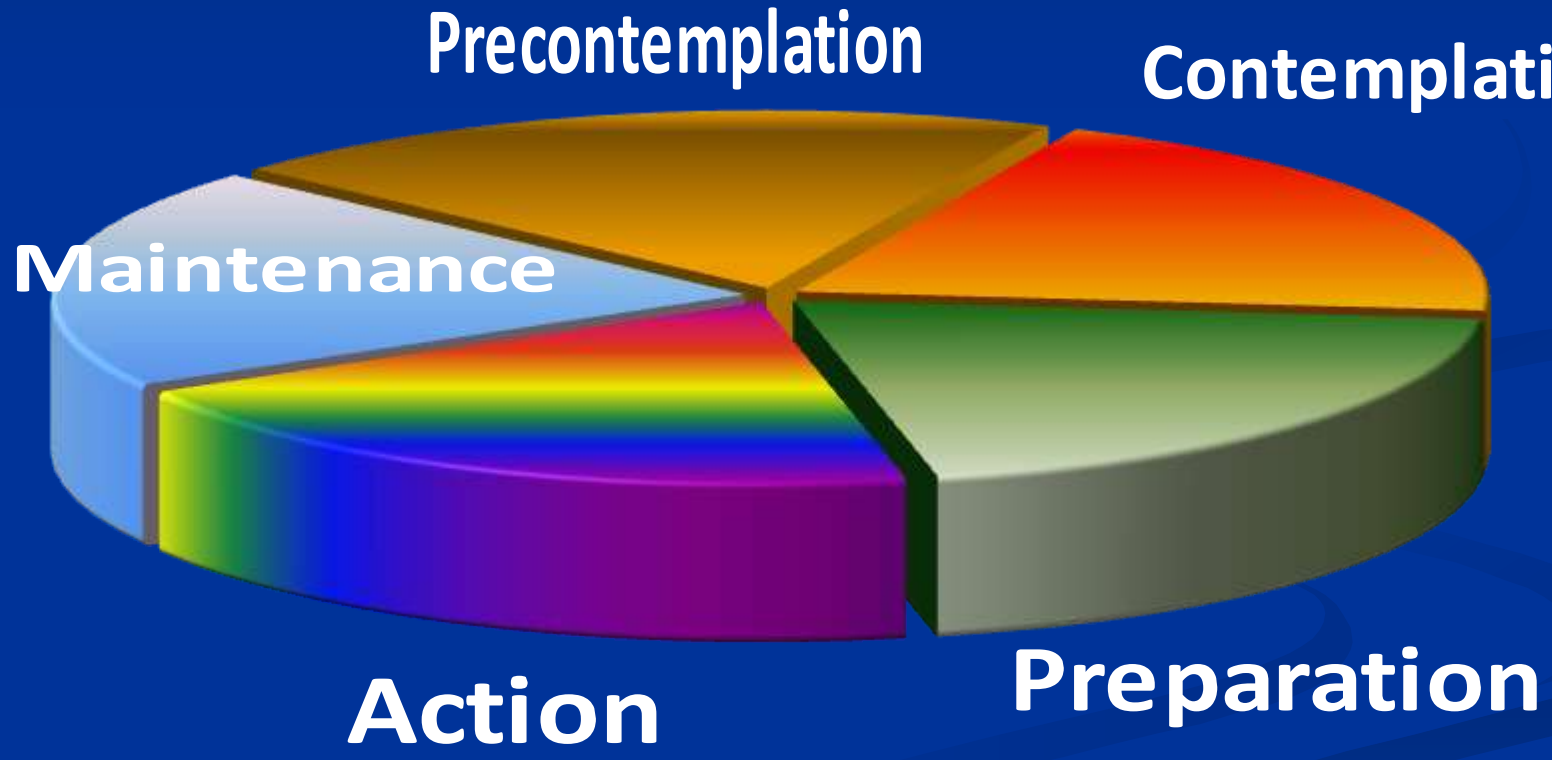
Stages of Change Model



Prochaska & DiClimente 1992
Jf. Barrowclough 2003

Stages of Change Model

Prochaska & DiClemente

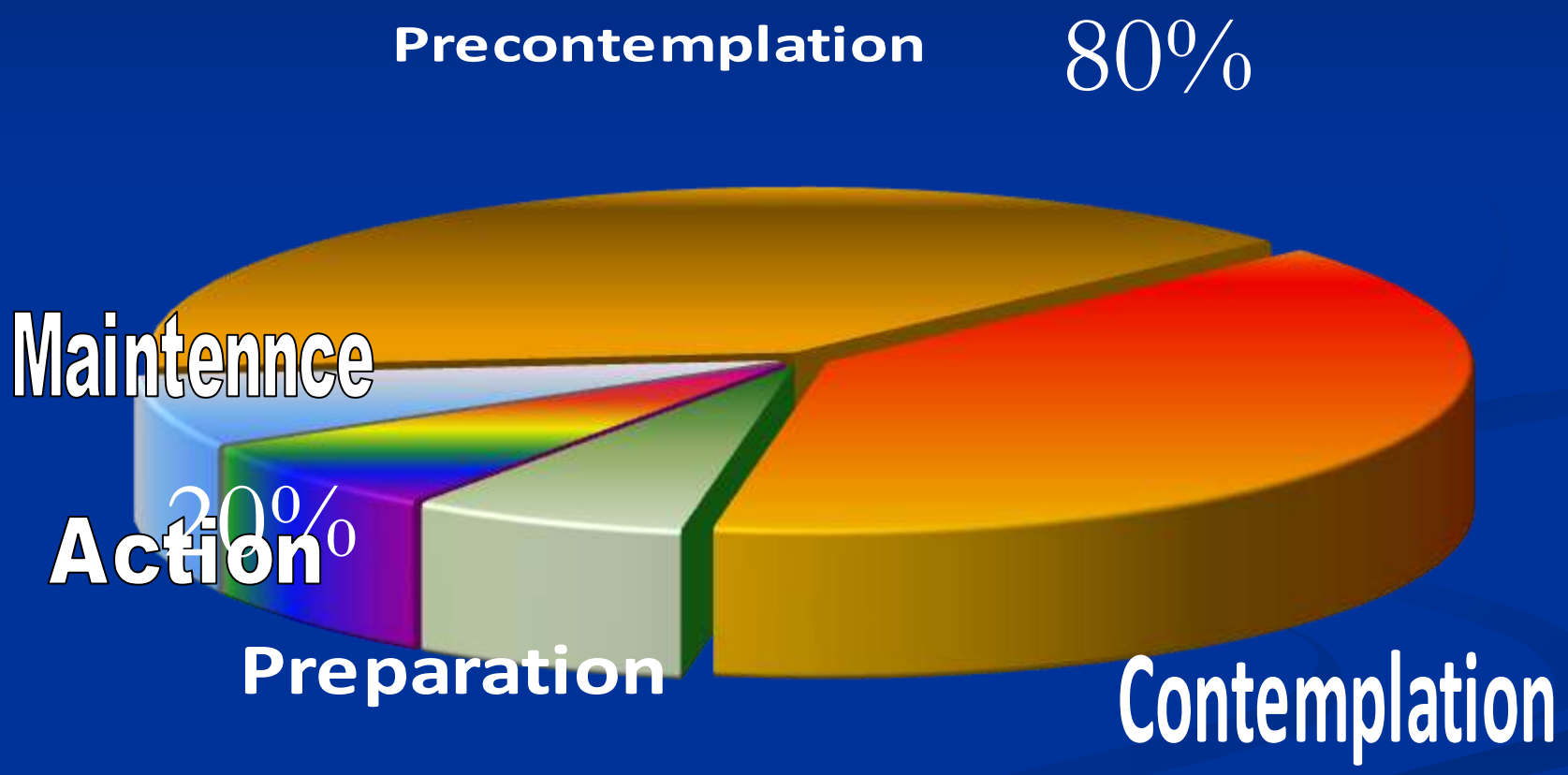


Miller
2007

Stages of Change Model

Prochaska & DiClemente

Our reality



Miller
2007

Change Talk

- DESIRE
- ABILITY
- REASONS
- NEED
- COMMITMENT
- ACTIVATION
- TAKING STEPS

Change Talk

Ingersoll 2007

- Exercise– recognize change- and commitment talk
  - Recognize change talk– Yellow card
  - Recognize commitment talk – Green Card
  - Neither : silence

Change Talk

DESIRE
ABILITY
REASONS
NEED

Commitment talk

COMMITMENT
ACTIVATION
TAKING STEPS

Change- and Commitment Talk

Change talk: Yellow card - Commitment talk: Green Card

- I have this desire to change **Desire**
- The whether is nice
- I have the ability to do better **Ability**
- I have good reasons to change **Reasons**
- I need to do something different **Need**
- I never quite understood soccer
- It will be my commitment to get it right **Commitment**
- I took my medication 10 minutes ago **Activation**
- Today I will exercise 10 minutes, tomorrow 15 **Taking steps**

Change- and Commitment Talk

Change talk: Yellow card - Commitment talk: Green Card

- I'll promise that I will come again. So we can talk about it — **Desire** / **Commitment**
- Its difficult to loose weight. I really hate excises — **Consideration?**
- I wish you could help me get rid of the voices — **Desire**
- Without a girlfriend nobody can change
- Well, I could take my medication more regularly — **Ability**
- If I don't take my medication, I think I might go really crazy — **Need**
- I'll start on it, Monday – but what if I gets side effects? — **Commitment**

Change talk: Yellow card - Commitment talk: Green Card

- I have started taken it in the morning, but not in the evening **Taking steps**
- There's nothing like a good TV show
- I would be better off, if I started again **Reasons**
- I have been getting far too isolated **Need**
- I like the color blue
- I don't like being psychotic – I want reassurance that it wont come back **Need**
- My mother says I need to start on the pills
- I can't find any energy, and its troublesome **Need**

Change talk: Yellow card - Commitment talk: Green Card

- I love my nephew. For his sake. I will give it a chance — Reasons Commitment
- I want kids someday. An that day, I want to be a happy dad without symptoms' — Reasons
- Of course I can stay healthy. It's just sticking to the plan. I've taken the medication for tree weeks now — Commitment
- I don't want to be the black sheep of the family
- I've read that medication might help — Reasons
- I've been so isolated so long — Reasons Reasons
- Ok, But if I don't see any improvement by 5 weeks, I will stop — Commitment

Change talk: Yellow card - Commitment talk: Green Card

- I will do my best to live a better life
- Tomorrow I'll properly look more into it
- Tomorrow I'll properly look more into it, unless I'm very stressed about school or very busy
- If I had a job I'd probably start…
- Taking medication is a big change
- Do you think it might help me?
- If I could believe what you say, I would do so
- I'm only hurting myself" if I don't change

You would think . . .

that when a man
has a heart attack,
it would be enough
to persuade him to quit smoking,
change his diet, exercise more, and
take his medication.

Zarza 2008; Obert, 2006

You would think . . .

that hangovers, damaged relationships, an auto crash, memory blackouts — or even being pregnant — would be enough to convince a woman to stop drinking.

Zarza 2008; Obert, 2006

You would think . . .

that the painful experience of a psychosis would make patients consider taking their medication

Or?

The "Five R's" of How and Why People Stay in Precontemplation

1. Reveling
2. Reluctance
3. Rebellion
4. Resignation
5. Rationalization

Recognizing Resistance
Four categories of resistance behavior:

1. **Negating:** Blaming, disagreeing, excusing, claiming impunity, minimizing, pessimism, reluctance, unwillingness to change
2. **Arguing:** Contests expertise and integrity of the provider.
   Challenging, discounting, hostility
3. **Interrupting:** Breaks in and interrupts the provider in a defensive manner
4. **Ignoring:** Ignoring the counselor, his advice and/or his effort

Miller 2002

Exercise - "you must change NOW."

- Sit in groups
- One is a counselor – One is a client
- The client find a problem (nothing sinister, kinky or totally revealing, that's leave everyone crying or in shock, but a pleasant little problem - for example, 'should exercise more', 'make more green food', 'buy organic products', 'stop smoking', 'finishing a work project' etc (Several of these may be dangerous to???))
- Counselor : listen – find out what the problem is and then….

Exercise - "you must change NOW."

- **Explain why:** (this is not MI)
  Clearly describe why the client should change
- **Tell about benefits:**
  Give at least three specific reasons, where client's life would be much better if they changed
- **Explain how**
  Describe how the client should change. Make a plan
- **Clarify the importance**
  Specify how important it is and how wrong it will go if the client does not change behavior
- **Prescribe change**
  Tell the client when to start – Prescribe it!

In the choice between changing ones mind and proving there's no need to do so, most people get busy on the proof.

John Kenneth Galbrait

What is the problem?

It is NOT that…

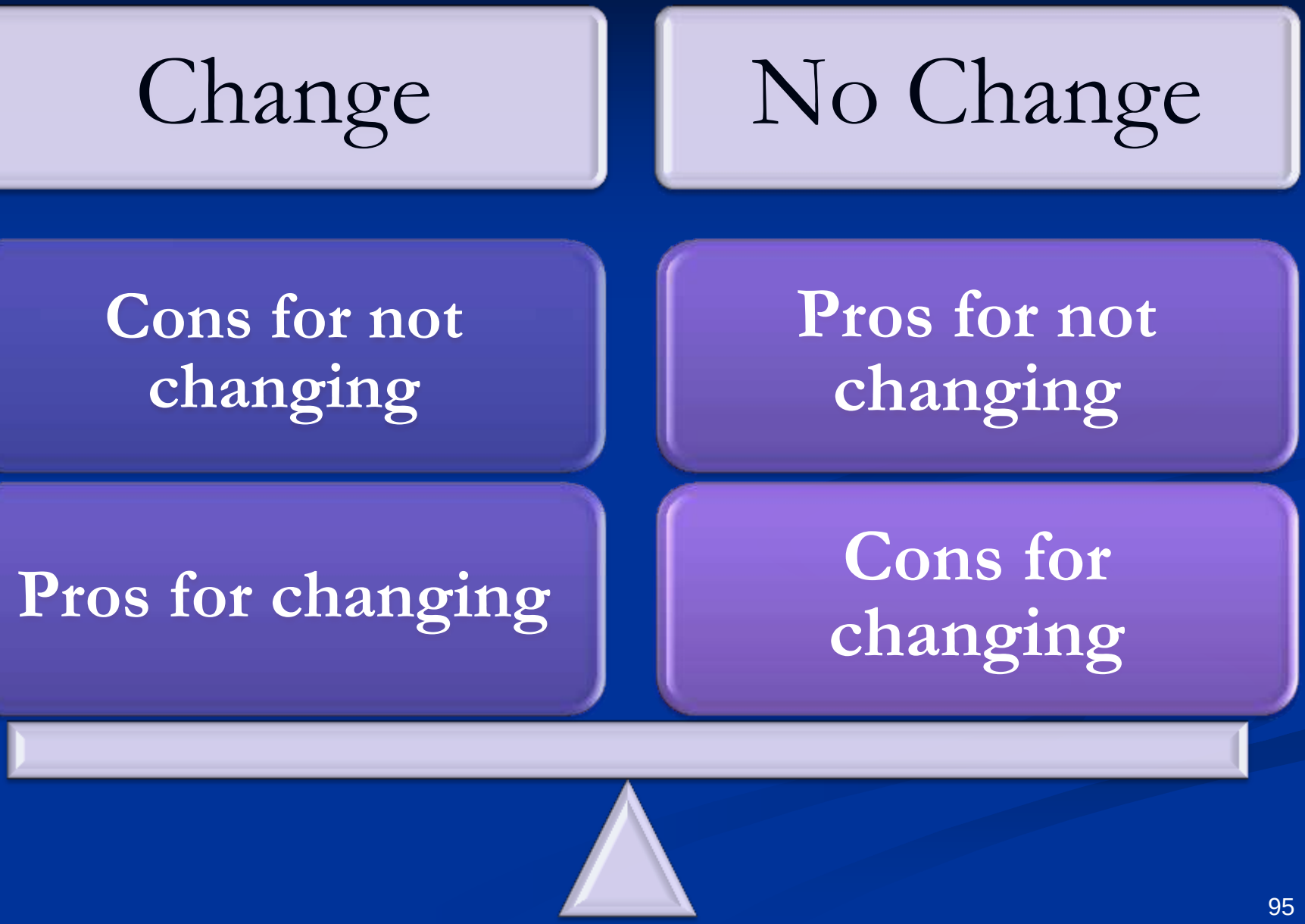
- they don't want to see (denial)
- they don't care (not motivated)

They are just in the early stages of change – or –

They not sure about it!!!

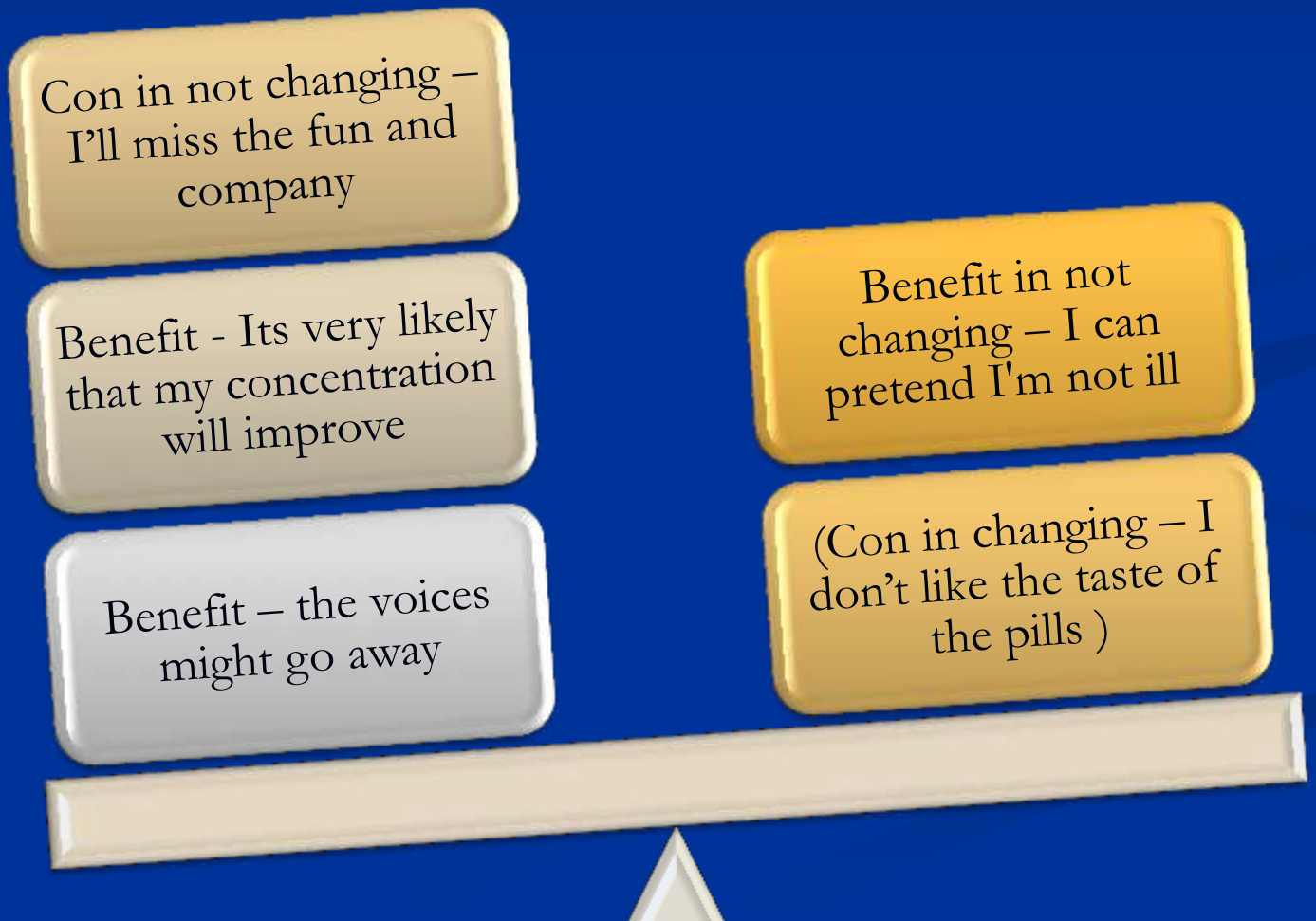
Zarza 2008;

Decision balance

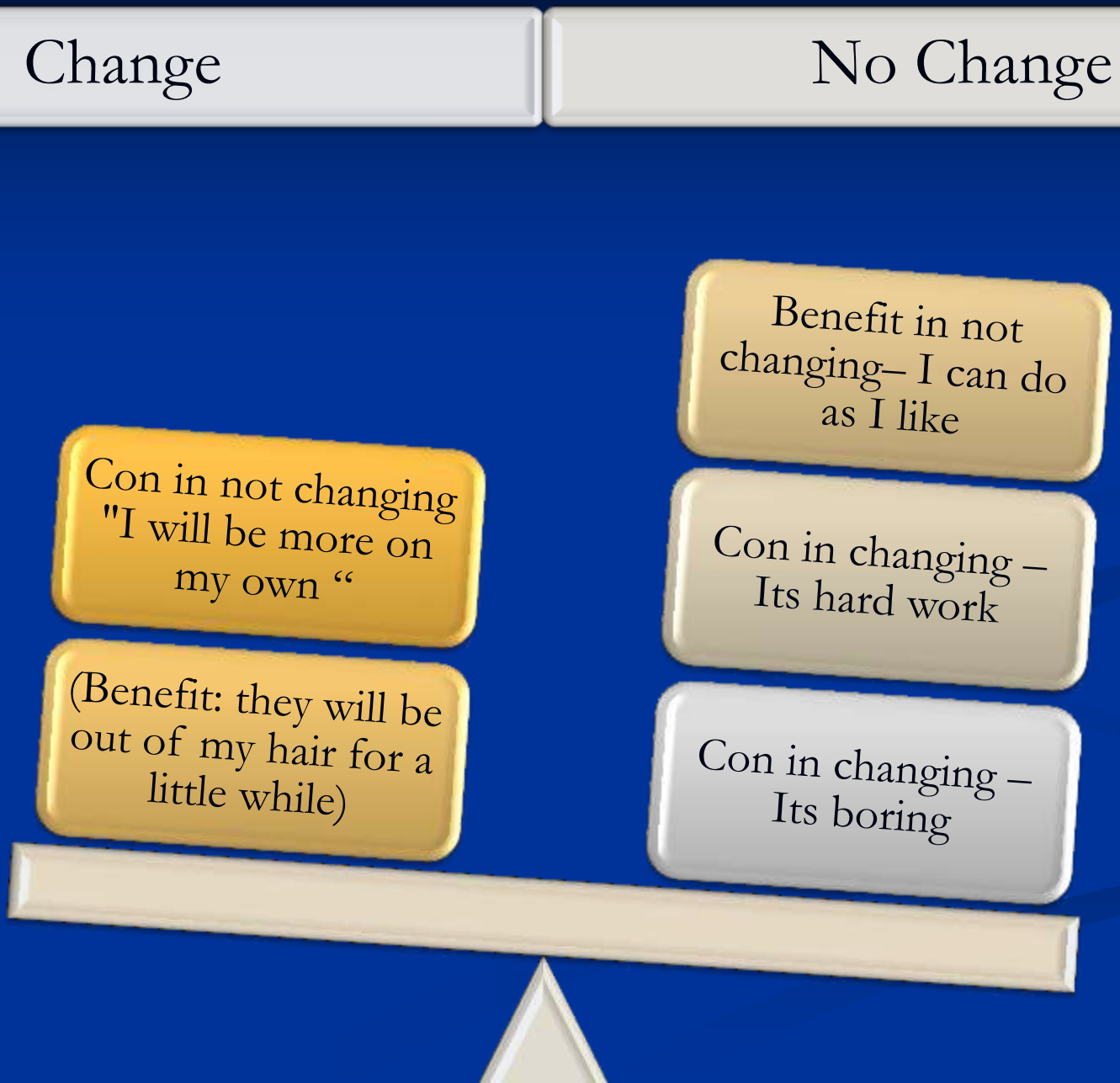


Change talk

Change	No Change



Sustain talk



Sustain talk
Resistance talk?

- “Its best to leave things the way they are“
- "Its just something you say to all patients “
- I don't want to do it
- I do not think the change will help
- I cant believe it

Change Talk vs. Resistance

Change Talk	Resistance Talk
disadvantages of status quo	advantages of status quo
advantages of change	disadvantages of change
intention to change	intention not to change
optimism about change	pessimism about change

"I don't want to die. I want to stop using drugs!"

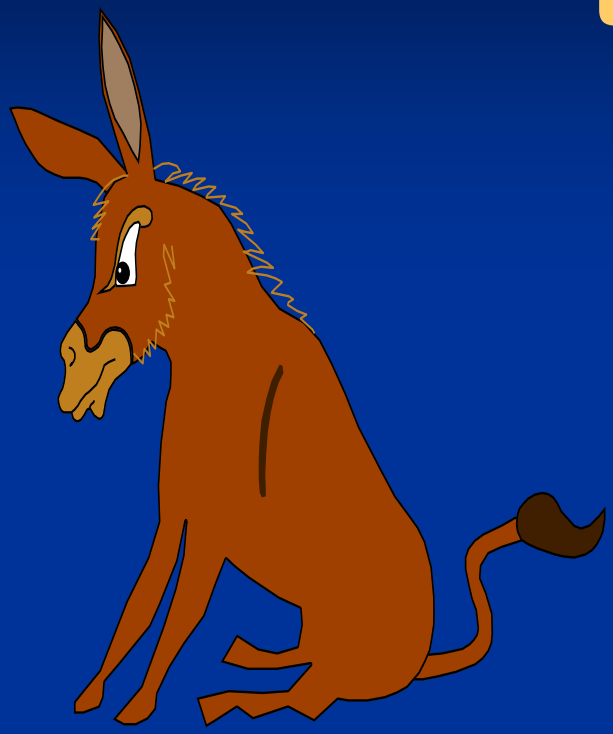
"I believe I can take my meds the right way now."

"Drugs ain't so bad! I don't need to change!"

"The meds won't make me any better. I won't take them!"

Nanín 2003

People don't resist change as such – they resist loss



They resist being changed
And they resist doing what they think is wrong

Vi we see how good it could be, if they just started on medication or stopped smoking cannabis or if they just ……

But they see all the trouble and all that they will miss and what they will be in risk of losing, etc

Some statsment from the website interviews

- “I’ve have the right to make mistakes. A website should tell you, that you yourself, for better and worse, is the one to make the decisions”
- “I like the decision balance. That model should be on the website. I look at the pros and the cons, and then I make the best decision, my decision. You can advice me, but it’s my decision.”
- “If people gets too pushy, I push back or stop listening. It’s the same with a website. if it is trying to push something down my throat, I browse forward”.

- “If it’s gets too preachy: ‘only medication will save you’, then I get the feeling that it’s not respecting my autonomy or my brain”
- **Psychosocial issues**
  Most users highlights the importance of the psychosocial issues. Something meaningful to do, direction in life, education, work, somewhere to live and money for the basic necessities of life, friendship, love, companionship, ect. All this should not be forgotten, as being important in recovery. Again too much emphasis on medication can have the opposite effect. As a patient said: “I want a life and a boyfriend, you offering me a pill?”

Interaction Techniques in MI

OARS

- Openended Questions
- Affirmations
- Reflections
- Summarize

Intervention overview

1. Build engagement
2. Engage in discussion regarding life concerns/key goals and values
3. **Identify how medication fit in to these goals and the client's stage of change in relation to medication adherence**
5. Share mini-formulation/feedback linking concerns/goals/psychosis/medication
6. Work on consolidating motivation for client to progress to action stage if indicated
7. Review, develop and modify formulation and from this identify and develop strategies for change
8. Identify how client can avoid setbacks and maintain change

Gillian Haddock

Open-ended Questions

- Q, where you can't just say "yes“ or "no“, or give out a number, name or place….
- Begin with words and phrases like:
  - ***What?***
  - ***When?***
  - ***Where?***
  - ***Why?***
  - ***Who?***
  - ~~***Whatever!***~~
  - ***How?***
  - ***What brings you here today?***
  - ***Explain to me…***
  - ***Tell me more about…***
  - ***Tell me about what's been going on?***

Avoid interrogation

- Change between open-ended and Closed-ended question, statements and **listening**

Miller:
Max 3 open-ended Q in a row

Good questions?

Leaning by doing and by example

- Since it is possible for you to...What do you do right?
- Seeing that you have overcome.. What did you do?
- What made it possible for you to think…
- What made it possible for you to feel
- What made it possible for you to do…..
- What made it possible for you to accomplish…
- What made it possible for you to switch?
- What made it possible for you to act? etc

Using examples - – others would maybe think.. But you..

Talk about behavior in a neutral way

- Could you tell me more about.. (behavior)?
- What are you feelings toward.. (behavior)?
- What are you thinking about that you.. (behavior)?
- How does your (behavior) fit into your life?
- How does your. (behavior) fit into the way you think about your self? Or into the way you want it to be?
- What you say to me, is that you like to change (behavior) or maybe not right now the way your situation is? What (more than other) is making it difficult now
- I'm not sure I understand. You might like to change (behavior) but there are things that have to be sort out first? Or? When will be the right time? What will it take.. etc

Interaction Techniques in MI

OARS

- Openended Questions
- Affirmations
- Reflections
- Summarize

Affirmation

Admiration

Praising

Respecting

Approval

Endorsement

Encouragement

Recognizing

Veneration

Appreciation

Affirmation

- Notice - and – validate positive steps
- Underline and supports the patient's strength
- Helps in building confidence
- Helps patients to reveal less positive aspects of themselves
- Shows respect
- Shows that you care about the other person and what the other person do
- Strengthens the relationship
- Must be congruent and genuine

Affirmation - how?

- Compliment
  - Your looking great today
  - That a good way to say it
- Give a positive comment on a characteristic trait
  - You are a strong person – you really fight
- Make appreciative statements about behavior
  - I really appreciate your openness and frankness
- When they are doing something good - catch it!
  - OK – you didn't smoke yesterday
- Express hope, care and support
  - I hope you will succeed - I trust your good effort will prevail!

Affirm – Affirm - Affirm

- Underline what you agree with
- Emphasize personal control – It is the patient, that decides what to change – and we show that we appreciate that
- Support – Ask: What have you been doing right - since you manage to succeed …
- Affirm – once again – affirm, e.g.
  - You are very articulate
  - Not many can be so honest about things that are that difficult
  - You are thoughtful and sees many sides of the issue
  - Not many are able to be so in touch with their emotions
  - You have come a long way: When trouble comes, you don't give up. It sounds like you have overcome a lot

Turn around and be affirmative

- Turn to the table next to you
- Talk about experiences with working with psychosis or OPTiMiSE – interview them about there reality, clients and what they like about it, and why they keep on working in this field
- Affirm what you hear
- Don't overdo it
- Don't understate it
- Do it 1%, 5%, 10% or 20% more, than you would normally do
- Only do it, when you actually mean it!!!

Do you know someone who is a bad listener?

- What characterizes them?
- What are they doing wrong?
- What are your feelings toward them?
- What do you like / dislike about them?
- What do you want to do with them?
- What do you think about their future?

How do you react if someone is not listening to you

- Angry - irritable
- In an emergency stage
- In opposition
- Defensive
- Must defend
- Not heard
- Not understood

- Afraid
  Uncomfortable
  Overwhelmed
  Helpless
  Caught
  Humiliated
  Resistance
  Will not want to come back

Do you know someone who is a good listener?

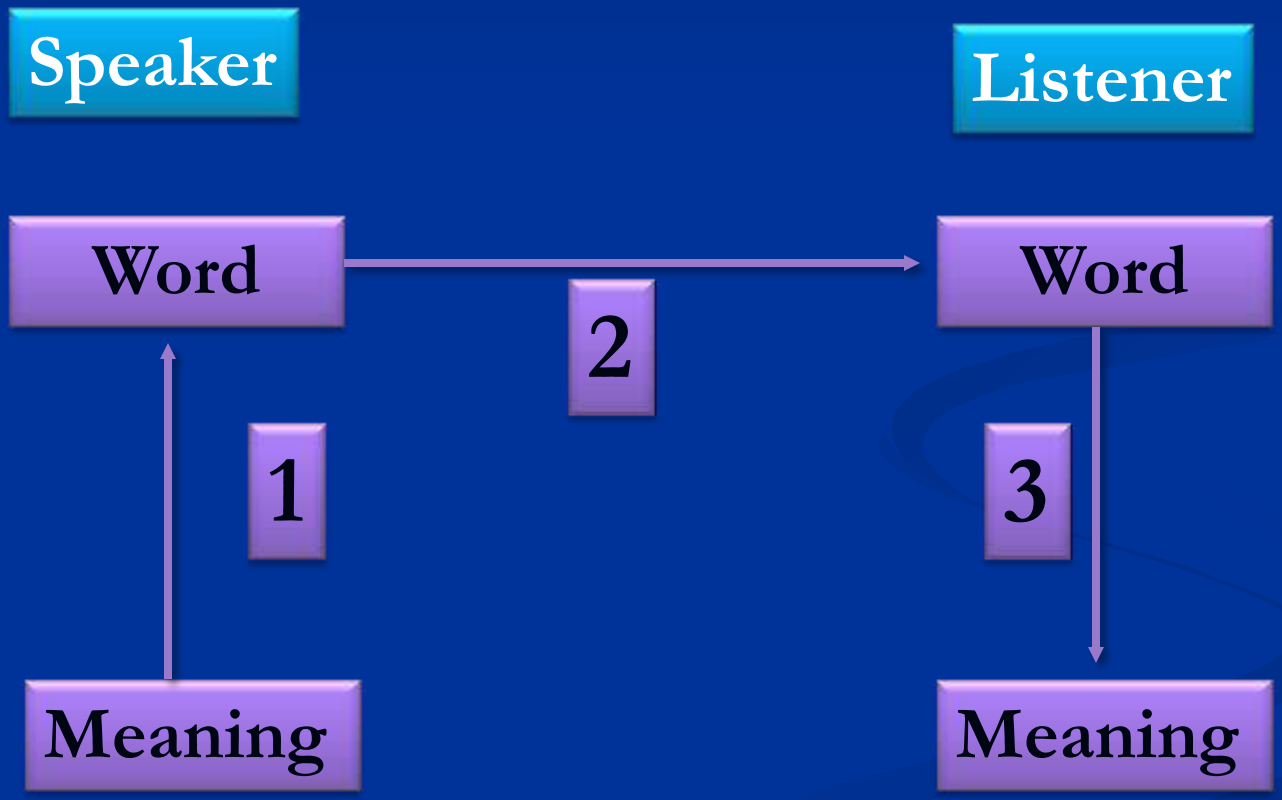
- What characterizes them?
- What are they doing wrong?
- What are your feelings toward them?
- What do you like / dislike about them?
- What do you want to do with them?
- What do you think about their future?

How do you react if someone is listening to you

- Understood
- Want to talk more
- Like the other person
- Open
- Accepted
- Respected
- Dedicated
- Safe
- Strengthened
- Hopeful
- Comfortable
- Interesting
- Cooperating
- Would like to come again
- Prepared to look at change?

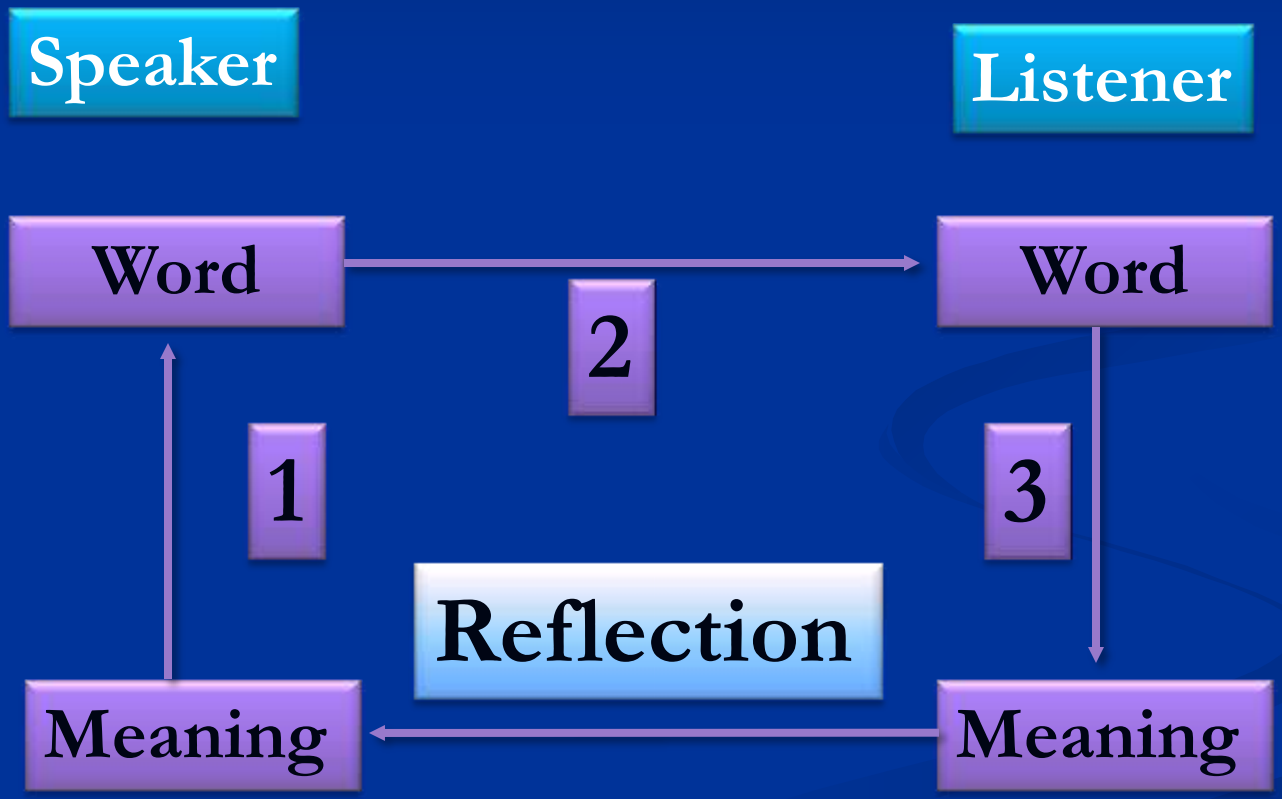
Miller 2007

Three Places a Communication Can Go Wrong



Miller
2007

Reflections



Miller
2007

Exercise – to reflect a thought

- Sit in pairs or groups of three
- Complete the following sentence:

"One thing that I like about myself is that I _____"

e.g"One thing that I like about myself is that I am brave . ."

Think of something that has significance. A meaningful, important and pertinent word

Exercise

- The speaker offer his sentence. "One thing that I like about myself is that I _____"
- The other one or two serve as listeners and respond by **asking questions** of this form:
- "Do you mean that you_____?"
  Closed questions!
- The speaker responds to each such question *only* with "Yes" or "No."
  No additional elaboration is permitted
- Keep it up ☺

When to switch?

- Meaning is captured ☺
- When asked at least 6-8 times "do you mean that you ….." and 6-8 times, not getting near anything meaningful and is running out of ideas... .
  (The speaker can then explain himself shortly)
- Then switch roles ..
- To much time? Take another go at it ..

Thoughs?

- Speaker?
- Llisteners?
- Was it difficult, fun, weird, educational, or?
- Why?

- Lets remember some of the sentences:
- "One thing that I like about myself is that I _____"

This exercise can have several outcomes

Satisfaction. The speaker felt good, understood.

Frustration. That it is frustrating to be able to say only 'Yes' or 'No' because the speaker wants to say more. This is a good example of how even this simple level of reflection pulls for self-disclosure.

Fascination. It's amazing how easy it is to miss, and how many different things can be meant. Speakers may have the experience that it made me think of things I hadn't considered. Again, that is an effect of reflection, even at this simplistic level.

Reflections

- With a foundation in
  - Thinking reflectively
  - Exploring hypotheses about meaning
- Then the next step is to learn to formulate good reflective listening statements

Reflections

- Are statements rather than questions
- Make a guess about the client's meaning (rather than asking)
- Yield more information and better understanding
- Often a question can be turned into a reflection

Miller 2007

Forming Reflections

- A reflection states an hypothesis, makes a guess
- about what the person means
- Try to form a statement, not a question
  - Think of your question: Do you mean that you are a fighter?
  - Cut the question words: Do you mean that you are a fighter
  - Inflect your voice down at the end
- In general, a reflection should not be longer than the client's statement.

Miller 2007

Classical ways to start

- So you feel….
- It sounds like you
- You're wondering if
- You…

Active reflective listening

"Reflective listening is the key to this work. The best motivational advice we can give you is to listen carefully to your clients. They will tell you what has worked and what hasn't. What moved them forward and shifted them backward. Whenever you are in doubt about what to do, listen"

(Miller & Rollnick, 1991)

Different levels of reflective listening

- Content
- Feelings
- Deeper Meaning

Reflective listening is the primary skill on which MI built

Different levels of reflective listening
Simple reflection

1. Repeating
   - Add nothing - simply repeat or restate what you have heard, using some or all of the same words
2. Rephrasing
   - Repeat or restate what you have heard but in a slightly different way

Simple reflection don't go beyond what the patient has said

Different levels of reflective listening

Complex reflection – amplified reflection

3. Paraphrasing
   - Emphasizing statements by adding meaning
   - Overstatements
   - Understatements
   - Continuing the Paragraph

Different levels of reflective listening

Complex reflection – amplified reflection

3. Paraphrasing
   - Important values
   - Self image
   - Metaphor and imagery
   - Double-Sided Reflection
     Highlights the ambivalence in the patients words. “On the one hand you feel… and on the other hand”

Different levels of reflective listening

Complex reflection – amplified reflection

4. Paraphrasing - Reflecting feelings

- Try to understand and identify some of the feelings behind – especially the important ones - the ones with potentials
  - Validates feelings
  - Making the patient conscious of feelings he has experienced
  - Change is often rooted in warm cognitions

Summarizing

- A special condensing form of reflective listening
- Used periodically and as a transition.
- Encompasses what has been said and letting people hear what they had said
- Finding consensus in what has been said so far
- Connecting and reinforcing important issues
- Gives pause and room for reflections
- Prepare the patient to elaborate further
- Gives opportunity to choose direction
  - In choosing what to summarize and what to exclude

Summarizing

- Show that you have been listening carefully
- Draw together the patients desire, ability, reasons, need themes
- Draw together the patients own perspectives on change

Collect the change talk as flowers that are gathered into a bouquet and offered back to the patient

Key method

Evoking and Responding to Change Talk

EARS–Responding to Change Talk

- Elaborate
- Affirm
- Reflect
- Summarize

Resistance? Again - remember:

- Maybe resistance is only one side of ambivalence
- Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction

Thomas Gordon

Roadblocks 1-6

1. Ordering, directing, or commanding
2. Warning or threatening
3. Giving advice, making suggestions, providing solutions
4. Persuading with logic, arguing, lecturing
5. Moralising, preaching, telling them their duty
6. Judging, criticising, disagreeing, blaming

Thomas Gordon

Roadblocks 7-12

7. Agreeing, approving, praising
8. Shaming, ridiculing, labeling, name-calling
9. Interpreting, analysing
10. Reassuring, sympathising, consoling
11. Questioning, probing
12. Withdrawing, distracting, humouring, changing the subject.

If I say:

- **If I was you, I would …**
  - Stop smoking, take my medication, go to the gym, eat heartier, etc.

what we are really saying is:

- **If you were me, you would …**
  - Stop doing what I think is wrong, and do what I believe is necessary

The first start…

- Be prepared. Be able to explain what you do and why you do it
- Start with friendly and open-ended questions that are not too emotionally charged.
  - *Rather : What brings you here today?*

  than
  - *Do you hear voices that say you must kill children*
- But the setting is usually anticipated by the patient. we're not here for the fun of it.
- It's a working relationship

Robertson 2006

Question/Answer Trap

Therapist : You come here to day to lean more about side effects? Is that right?

Patient: Yes. I want to know more

T: Do you take your medication as prescribed?

P: Most of the time.

T: Have you taken it today?

P: Yes

T: How long you have been taking it?

P: tree years

Question/Answer Trap

T: When did you start to take you medication?
P: 1995
T: What kind of problems did you have then?
P: Voices and problems with my girlfriend
T: You still seeing her?
P: Yes
T: Do you live together?
P: Yes
T:How do you sleep at night
P: Fine
T: Do you eat regularly?
P: Mostly

Premature Focus Trap

- "Welcome. Tell me - why don't you take your medication?"
- Being in a hurry, deciding the focus without consensus, without the story told
- Focusing too quickly on a specific problem or aspect of a problem
- Forgetting to give the patient a chance to explore the issues which matter to them.
- "Let's not hear about it – let's fix it!"
- Start where client is…!!!

What does the statement:

"You got a problem"

do for you and your patient?

Taking sides trap

- Arguing for the seriousness of a problem
- Prescribing a course of action consistent with **one side** of the ambivalence, without exploring and resolving ambivalence
- Arguing one side elicits the other
- Becoming argumentative, pushy and too directive

Confrontation/Denial Trap

- The patient counters each argument for change with an argument for remaining the same
- If your patient is not ready for change he will find a way out
- "You would be better off if you … "
- Yes, but I can't …., because……."
- Its not the time, place, circumstances, right now ...
- **C**onfrontation → **D**enial → C → D → C → D….

The best thing you can do is to stop smoking and drinking - and begin to exercise and eat healthier

what is the next best thing

Labeling Trap

- Getting caught up in diagnostic labelling or other kinds of labelling
- Attempting to convince the patient to accept a certain way of perceiving themselves
- Only seeing a part, a small part, of the person
  - **“You are your problems“**
  - **“You are your suffering”**
- Excluding strengths and potentials
- Highlighting sickness and weakness
- Stigmatising and alienating

Labeling Trap

- Don't ; "As a schizophrenic, you must take your medication"
- "Change will not happen, unless they accept what is wrong with them"
- Rather say : "Maybe labels are not helpful here. Your diagnosis is not is not the important matter. You are - and the things that can help you. Could you tell me more about...."
- Shift focus to the important areas

Blaming Trap

- Talking about blame.
- Indicating that the patient is to blame
- or, together, blaming others
- Blaming others = It up to them to change
- Blaming the patient = “Its your fault, Stupid”
- Blaming ≠ changing? – Is it helpful ?
- To give ‘the guilty ones’ a good bashing, is not the purposes in MI

Expert Trap

Providing direction without consensus on where to go

- If you unmistakably know it all
- If you obviously know best
- If you evidently know the way
- If you without a doubt know what the next step should be and how to take it
- If you clearly know how to solve the problems
- If you plainly know how to make it right
- If you have the answers and the expertise
- Why should I do anything – its not my project..

1 'therapist' doing the OARS, one 'participant' telling about yesterday and one observer

- What are your thoughts about MI so fare? The techniques, sprit, principals... etc
- What did you focus on yesterday?
- What did you find interesting, important to remember etc.
- What questions did it raise?

If you think to much?

Resist the righting reflex

Avoid argumentation

Roll with Resistance

- Resistance is a signal shift approach and/or focus
- **Avoid argumentation**
- Reframe and rephrase.
- Acknowledge clumsiness - if it there: "that was my fault", "thank you for correcting me. I really like to understand it from your perspective"
- Agreeing with a Twist ("you're right, maybe you worries about medication is almost a troublesome as the voices" "Maybe its not worth the trouble")

- **Recognize and verbalize**
  - “Maybe your right, you can't change now”
  - “Its too early to talk about change “
  - " just talking about it can be awful“
  - “Maybe you have met a lot of counselors and psychologist telling you what to do. I like to be different and really listen to you”
  - Resistance and ambivalence is normal and understandable – a healthy sign
  - No one likes to talk about change if you feel that your ‘counterpart’ is patronizing, superior and condescending

You emphasize personal control and choice

- You decide
  - If you want to change
  - What you want to change
  - How you want to change
  - When you want to change
- And the rest?
  - You also decide that

- Informational overkill
- To over emphasize weakness and problems
- To be overwhelmed together, with hopelessness
- To go wherever the patients go and get lost
- Wanting to save the patient – taking over
- To be too controlling and rigid
- To be too friendly and intimate
- To be too distant and cold
- To be too guided by an agenda and a manual
- Having a rotten life as a therapist
- ”Transference and countertransference”

“If One Is Truly to Succeed in Leading a Person to a Specific Place, One Must First and Foremost Take Care to Find Him Where He is and Begin There.

This is the secret in the entire art of helping.

Anyone who cannot do this is himself under a delusion if he thinks he is able to help someone else..

In order truly to help someone else, I must understand more than he* – but certainly first and foremost understand what he understands”

“If I do not do that, then my greater understanding does not help him at all. If I nevertheless want to assert my greater understanding, then it is because I am vain or proud, then basically instead of benefiting him I really want to be admired by him.

But all true helping begins with a humbling.

The helper must first humble himself under the person he wants to help and thereby understand that to help is not to dominate but to serve, that to help is a not to be the most dominating but the most patient, that to help is a willingness for the time being to put up with being in the wrong and not understanding what the other understands.”

Søren Kierkegaard, 1859

Remember

An expert is someone who has made all possible mistakes within a narrow field of expertise.

Niels Bohr

I've learned so much from my mistakes. I'm thinking of making a few more

Proposed Behavioral Targets for MI Training

Based on coding of a taped MI session, these levels might be expected as ideal (expert) and threshold (satisfactory for practitioner certification)

	Ideal	Threshold
Global Therapist Ratings	> 6.0	> 5.0
% Therapist Talk Time	< 50%	< 60%
Reflection:Question Ratio	> 2.0	> 1.0
% Complex Reflections	> 50%	> 40%
Percent Open Questions	> 70%	> 50%
% MI Consistent	> 90%	> 80%

http://www.motivationalinterview.org/training/tnt2004.pdf

or said more plainly:

- Talk less than your client does
- On average, reflect twice for each question you ask
- When you reflect, use complex reflections more than half the time
- When you do ask questions, ask mostly open questions
- Avoid getting ahead of your client's level of readiness (warning, confronting, giving unwelcomed advice or direction, taking the "good" side of the argument)

http://www.motivationalinterview.org/training/tnt2004.pdf

12 Strategies for Evoking Change Talk

1. Ask evocative questions
2. Explore decisional balance
3. Ask for elaboration
4. Ask for examples
5. Elicit, provide, elicit
6. Ask, provide, ask
7. Look back
8. Look forward
9. Query extremes
10. Use change rulers
11. Explore goals and values
12. Come alongside

http://www.motivationalinterview.org/TNT_Manual_Nov_08.pdf

http://www.motivationalinterview.org/training/tnt2004.pdf

Evokative Questions??

- Darn Cat
  - What do you wish to do
  - What are you able to do?
  - What are the reasons to change?
  - What do you thinks needs to change?
- What do you think will help?
- Who do you think could help?
- What concerns you about this
- What will happen if you don't do it
- ?

Elicit, provide, elicit

- Elicit - Ask what the patient knows or would like to know
- Provide - Provide information to the patient in a neutral nonjudgmental fashion – keep looking for signs of acceptance
- Elicit - Ask what the patient makes of this, what applies to his situation, what might be useful to explore further – and be open for feedback!

Ask for permission, provide, (elicit, ask, provide, elicit,) ask for feedback

1. Can I tell you something about… ?
2. Tell it
3. What do you think of this?
4. Is it ok if I reply to that?
5. Tell it
6. What do you make of this?
7. Was it ok, the way I informed you?
8. Thanks for participating ☺ !!

Look back

- Ask the patient to remember times before the problem emerged, compare to present situation
- “Tell me about a time when the problem did not exist”
- “What has changed?””

Look Forward

Ask the patient to envisioning a different future

- "How would you like things to be in your future? "
- "If you were 100% successful in making the changes you want, what would be different?""
- How would you like your life to be five years from now?

- "What can make it happen?"
- "Where would be a good place to start?"

Miller 2002

Query extremes

- What are the worst things that might happen if you don't make this change?
- What are the best things that might happen if you do make this change?

Use Change Rulers

- Ask: On a scale from zero to ten, how important is it to you to..”[target change], where zero is not at all important, and ten is extremely important?
- Follow up: ” And why are you at ___ and not zero? ” ” What might happen that could move you from ____ to [higher score]? ”

0	1	2	3	4	5	6	7	8	9	10
Not at all impor -tant										Extre- mely impor- tant

Use Change Rulers

- Instead of “how important” (need), you could also ask ” how much you want ” (desire), or ” how confident you are that you could ” (ability), or ” how committed are you to ____ (commitment) ”.
- Asking ”how ready are you? ” tends to be a bit confusing because it combines competing components of desire, ability, reasons and need.

http://www.motivationalinterview.org/TNT_Manual_Nov_08.pdf

Change Rulers

- Importance
- Readiness
- Support by others
- My ability to help ECT…
- DARN CAT
  - Especially ability is often estimated low
  - I like to, but I can't

Explore Goals and Values

- Ask what the person's guiding values are.
- What do they want in life?
- Using a values card sort can be helpful here. If there is a 'problem' behavior, ask how that behavior fits in with the person's goals or values; Does it help realize a goal or value, interfere with it, or is it irrelevant?

http://www.motivationalinterview.org/TNT_Manual_Nov_08.pdf

Come Alongside

- Explicitly side with the negative (status quo) side of ambivalence.
- Perhaps _____ is so important to you that you won't give it up, no matter what the cost.

Role-Play Exercise

- Get in pairs or groups
- Assign patient/client and practitioner
- Read scenarios
- Review feedback sheet
- Perform role play
- Patient/client gives feedback - what was done well; what could be done differently

Debrief Role-Play Exercise

- Patients/Clients:
  What did practitioners do well?
- Practitioners:
  What did you find challenging?
  What would you work on next time?
- Everyone:
  How did you see the motivational approach working in your role play?

Decision balance Exercise.. Once again

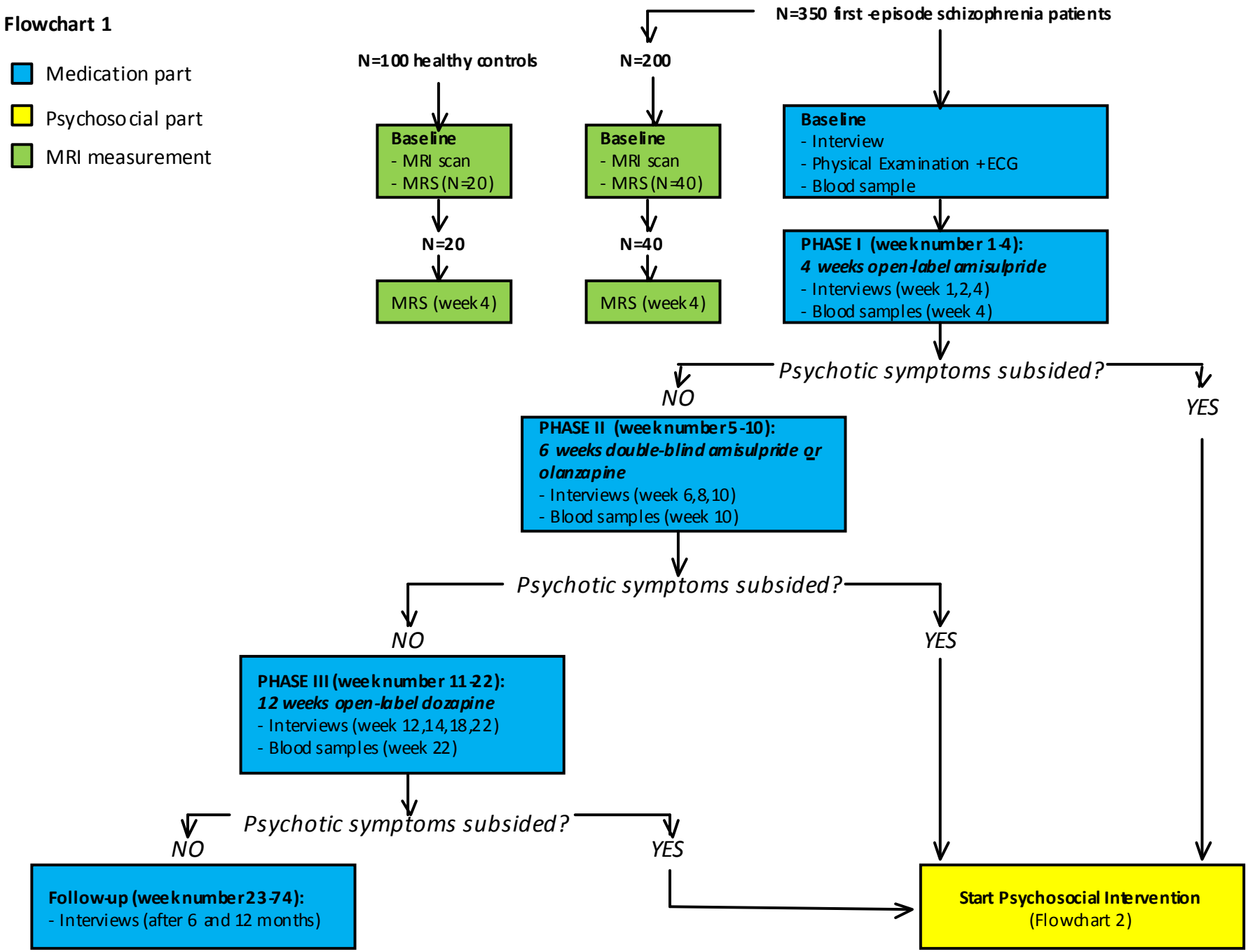
- Sit in groups of two
- One of you is the MI-provider
- One of you is the patient
  (a nice one, ambivalent about medication, but not the patient from Hell….)
- Talk about pros and cons
- Write it down

‘You can do’ attitude?

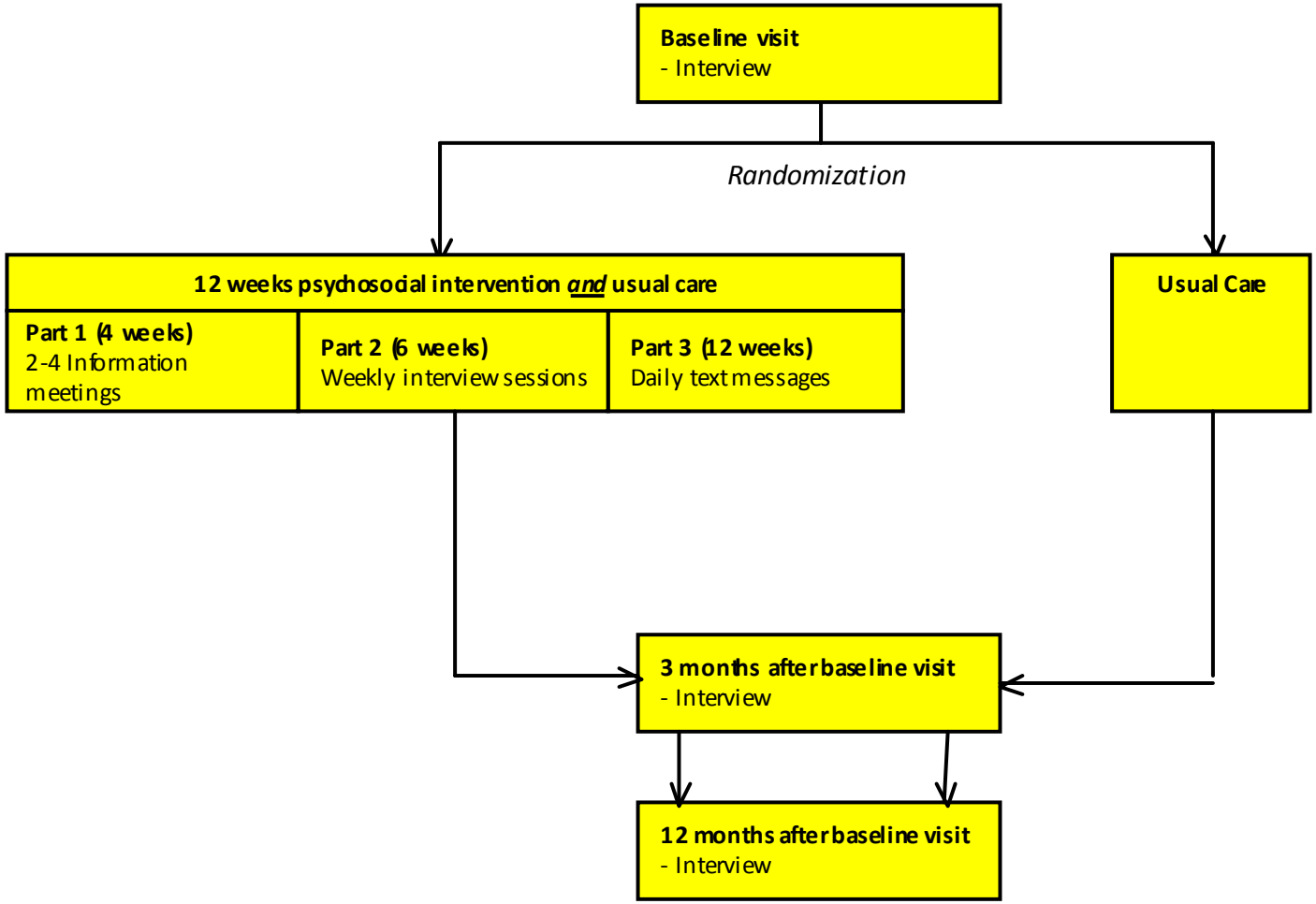
You can:

- Train it at home
- OARS – one at the time
- Make roleplay – make realplay
- Read the books
- Read the compendium
- Read the guidelines
- Talk about it – discus it
- ?

Merete Nordentoft


Flowchart 1
Medication part
Psychosocial part
MRI measurement
N=350 first-episode schizophrenia patients
N=100 healthy controls
N=200
Baseline
- MRI scan
- MRS (N=20)
Baseline
- MRI scan
- MRS (N=40)
Baseline
- Interview
- Physical Examination +ECG
- Blood sample
N=20
N=40
MRS (week 4)
MRS (week 4)
PHASE I (week number 1-4):
4 weeks open-label amisulpride
- Interviews (week 1,2,4)
- Blood samples (week 4)
Psychotic symptoms subsided?
NO
YES
PHASE II (week number 5-10):
6 weeks double-blind amisulpride or olanzapine
- Interviews (week 6,8,10)
- Blood samples (week 10)
Psychotic symptoms subsided?
NO
YES
PHASE III (week number 11-22):
12 weeks open-label clozapine
- Interviews (week 12,14,18,22)
- Blood samples (week 22)
Psychotic symptoms subsided?
NO
YES
Follow-up (week number 23-74):
- Interviews (after 6 and 12 months)
Start Psychosocial Intervention
(Flowchart 2)

Flowchart 2: Psychosocial Intervention



	Week	Randomi-sation	MI*	weight, abd circ	PANSS	Training on sms & website	Adverse event	Con-comitant medication	SOFAS, KPI, DAI, EQ-5D, SCS , Kemp	CALPAS*
Baseline visit	-1 to 0	X				X†			X	
Visit 1	1		X			X†				
Visit 2	2		X		X#					
Visit 3	3		X							
Visit 4	4		X							
Visit 5	5		X							
Visit 6	6		X	X	X		X	X		X
Visit 7	12			X	X		X	X	X	
Visit 7.1‡	18				X					
Visit 8	52			X	X		X	X	X	

Psychoeducation

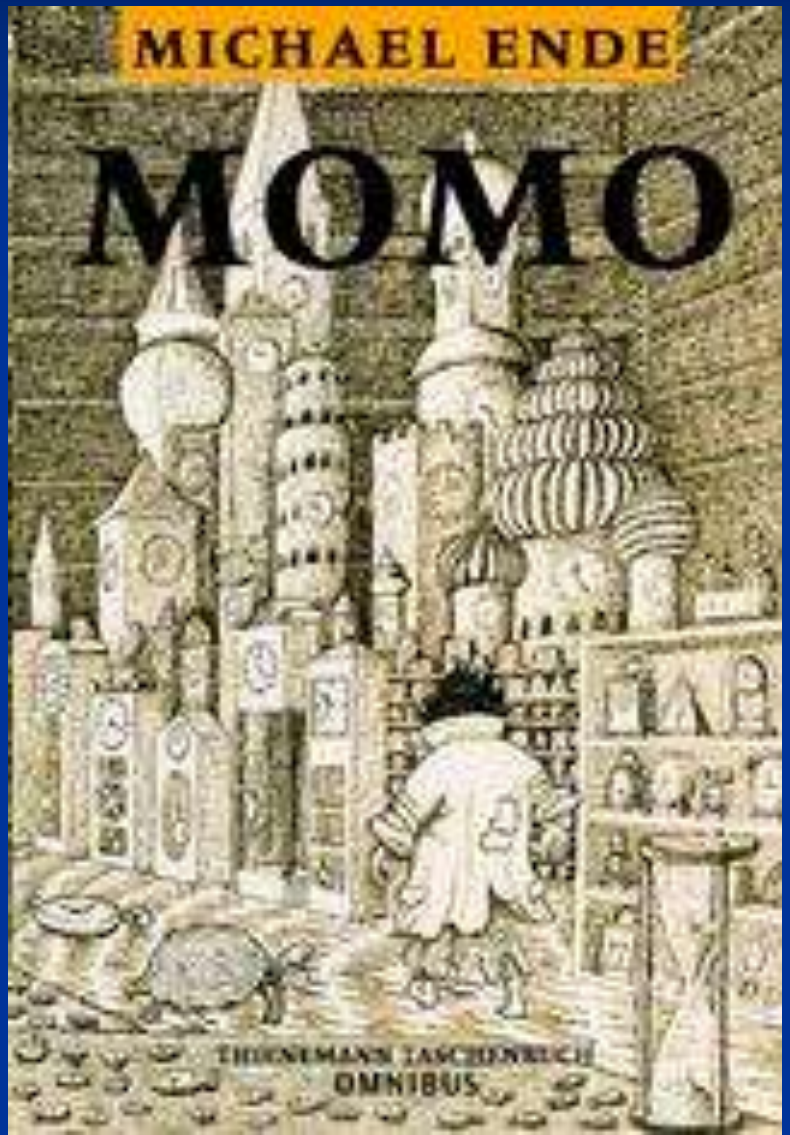
Involving the families

A long awaited guest

- *A long awaited guest who you want to feel welcome and at home during a long visit.*
- *A collaborator, whose insights and attitudes are decisive for the outcome.*
- *An individual with personal preferences that should be taken into account in the treatment to the greatest extent possible.*

Can contact be established?

Be patient and calm



Some times
you will need to
walk backwards
to get anywhere

Evidence for involving families in psychoeducational activities

- Try to consequently involve families
- Single family sessions together with the patient

Attitudes towards relatives:

- The closest collaborating partners
- Who can be of invaluable help
- Who are very involved in relation to the patient and therefore:
- A ressource that cannot be equalled

The approach

The intervention is personal and warm:

- Show you are interested
- Create a bond between you and the family
- Serve as the advocate of the family
- Create a respectful and not too asymmetric alliance
- Do not overwhelm them with too much information

Citations from my supervisor, Anne Fjell:

Thank you for being so engaged

Thank you for that message

And what do you think, Peter?

Guidelines

- **Try to accept things, which cannot be changed**. Let some things pass. Violence must never be accepted.
- **Try to simplify everyday life and conversation**. Make the communication clear, calm and positive.
- **Support the medical treatment.**
- **Avoid alcohol and drugs.**
- **Continue with leisure time activities and everyday life with family and friends.**

Guidelines

- **Be aware of early warning signals for relapse of psychosis**. Talk with the contact person about this.
- **Solve one problem at a time**. Let changes come gradually.
- **Lower your expectations**. Use a personal measure. Compare this month with last month.

Psycho-education for patients

- Biological, psychological and social aspects of schizophrenia and psychosis

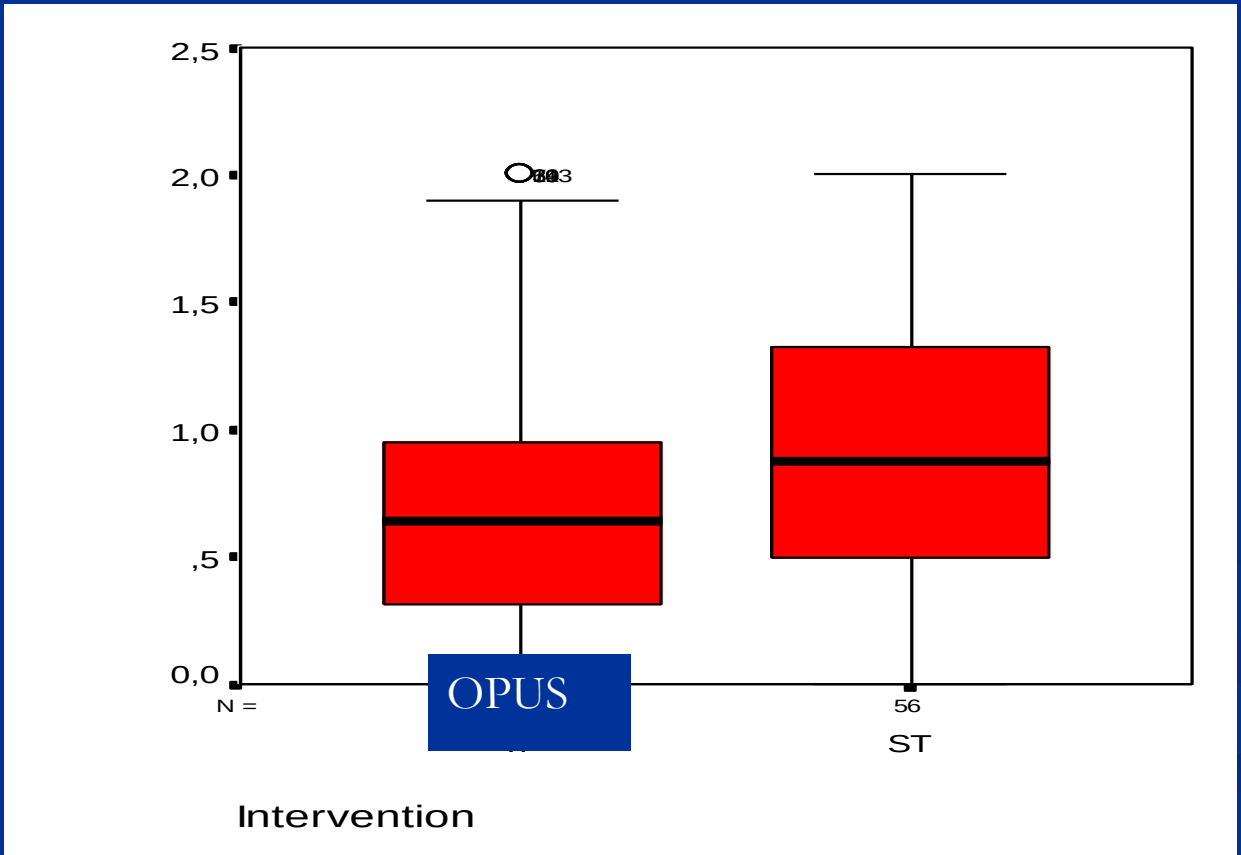
Simple communication

- Don’t try to read thoughts
- Only speak on your own behalf
- Be clear in your communication
- Respect the other person’s opinion
- Avoid abstract speaking; don’t use too many details
- Avoid ”deep” conversations
- Be clear in encouragement and support
- Be aware of difficulties, but focus on progress

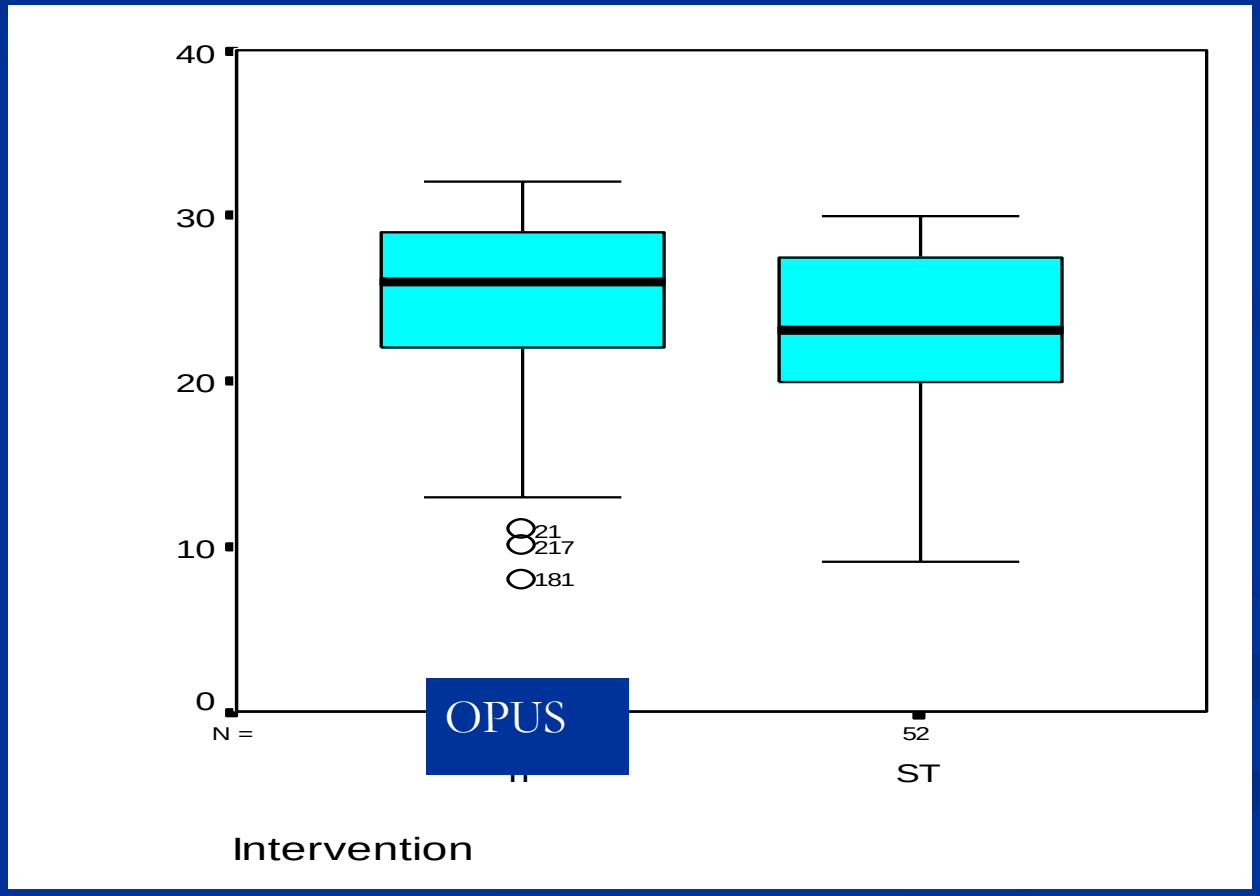
The relatives

- Effect after one year specialised assertive treatment

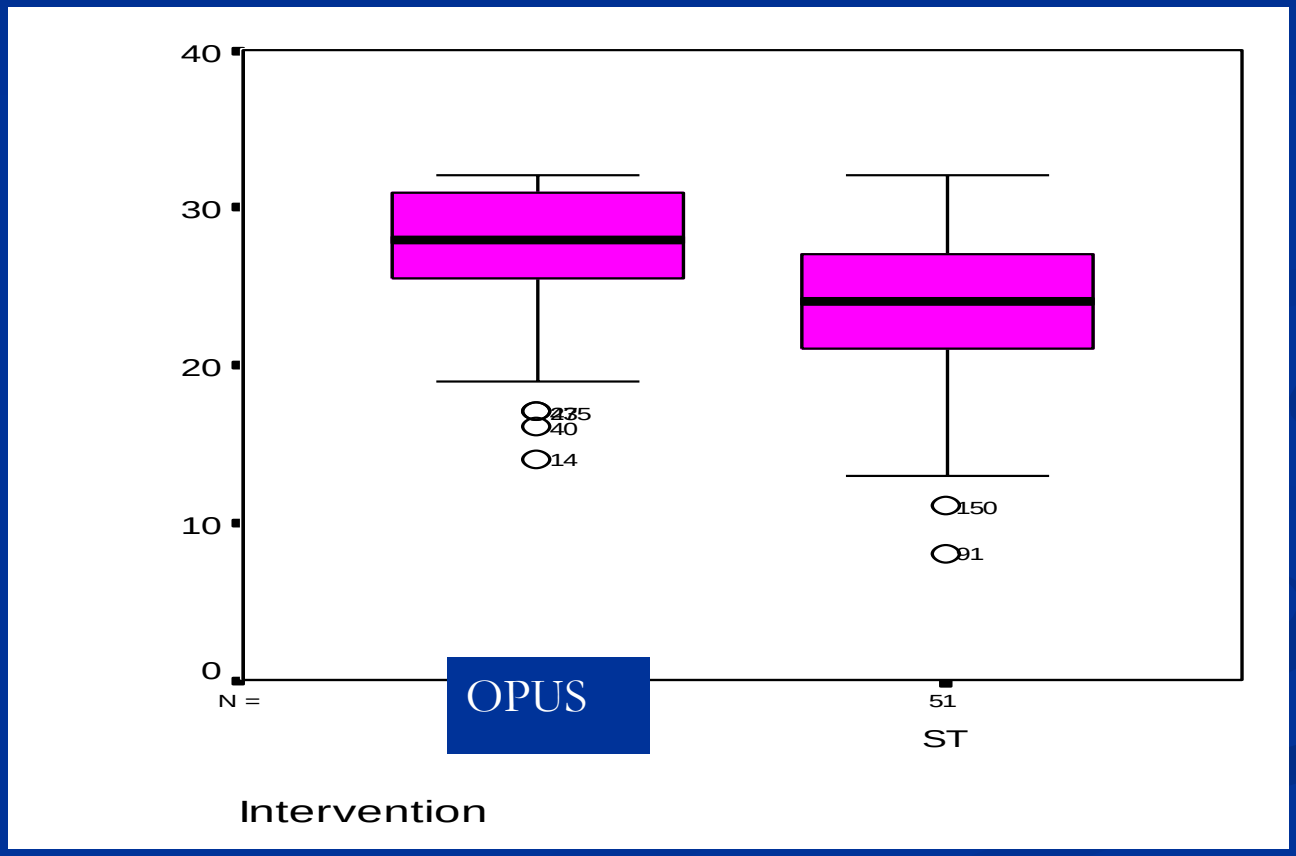
Relatives stress-score, one-year
Social Behaviour Assessment Schedule



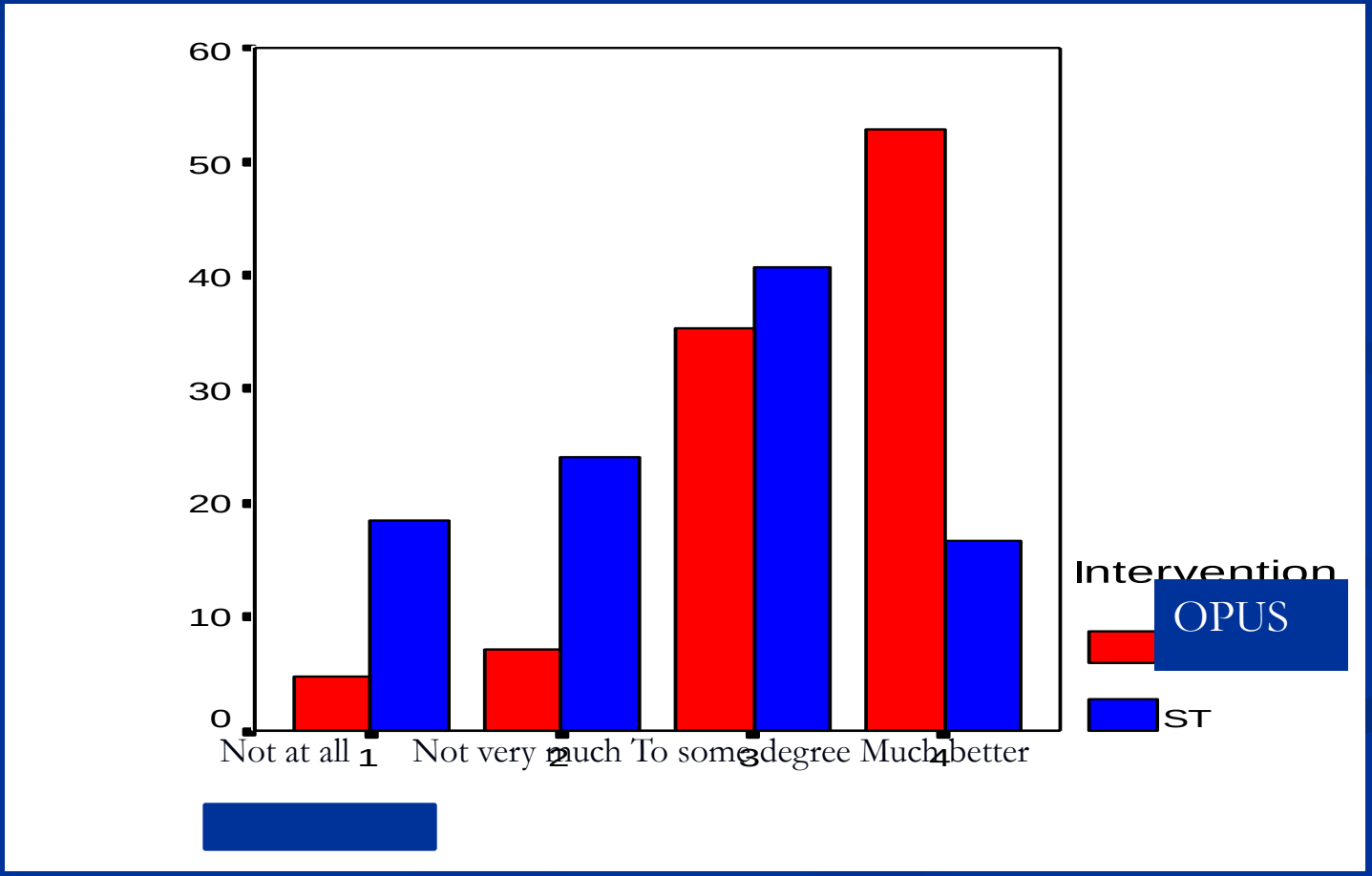
Knowledge about schizophrenia, relatives, one-year follow-up



Satisfaction with treatment, relatives, one-year follow-up



“Did the treatment help you to a better understanding of your mentally ill relative?”



What is psychosis?

Psychosis is the word used to describe a state of mind where a person has a very different view of the world from everyone else.

The person sometimes hears or sees or feels things that other people do not think are there; or they are sure about something other people do not think is true; or behave or speak in ways other people cannot understand.

What is psychosis

- Maybe 2 in 100 people experience psychosis at some point. They may be described as ‘psychotic’ or as experiencing a ‘psychotic episode’. Psychosis is not a disease in itself but is caused by drugs or stress or some illnesses (just like the way fever is caused by flu or different other infections). Schizophreniaand bipolar disorder are both conditions that often cause psychosis. Schizophrenia is the most common cause, affecting up to 1 in 100 people. It most often starts between the ages of 16 and 35, more often in men than women. Schizophrenia’s and bipolar disorder’s causes are not fully understood. Having a relative with a psychosis can mean a person is more vulnerable to developing psychosis themselves.

What is psychosis

- Stressful events can trigger psychosis in people who are prone to it, as can taking drugs like cannabis, amphetamine or cocaine. The length of an episode will depend on the cause - a drug-related psychosis may only last a few days, whereas a psychosis caused by schizophrenia lasts longer than a month. Using drugs like cannabis regularly may lead to schizophrenia, especially in people who use a lot and start young.
  Schizophrenia does *not* mean split personality, though this is a common mistake. Another mistaken belief is that most people with schizophrenia or psychosis are dangerous. 'Psychotic' is *not* the same as 'psychopath'.
  Symptoms of psychosis will vary greatly from person to person and may change over time.

What is psychosis?

- Strange experiences - hearing, seeing, smelling or tasting things that other people think aren't really there - sometimes called hallucinations. Hearing voices is the most common kind of hallucination in schizophrenia. These sound very real but no-one else can hear them.
  Unusual beliefs you are sure about but other people think are not true. These are sometimes called delusions. For example, a person may be sure that other people are watching them.

What is psychosis?

- Confused thinking - thoughts may speed up or slow down and drift from subject to subject, without a logical connection that other people can understand.
  Unusual behaviour. For example, someone might be suspicious of those around them if they think they are being targeted. Or they not seem to respond normally in social situations, laughing at sad news or not reacting to happy events.
  'Negative' symptoms (the *absence* of certain normal feelings and behaviour):
  Losing interest in things that were once enjoyable.
  Lacking the motivation to look after your appearance or personal hygiene.

What is psychosis?

- Avoiding conversation and increasingly keeping to yourself. Communicating emotion may be difficult. Others might notice that your facial expression has become blank or that you lack emotion in your voice
  Early warning signs may be present in the months leading up to the first episode of psychosis and sometimes before later episodes too. Some people get low or anxious or can't sleep. Odd experiences or thoughts may be less severe or happen less often than in a full psychosis. Negative symptoms can come on years before the other symptoms

Medications

- **Antipsychotic** medications are used to improve psychotic symptoms. When people have a psychosis cells in their brains can release too much of a chemical called dopamine.
- All **antipsychotics** block the effect of dopamine in the brain. They are usually taken as tablets, though some people take injections of them every few weeks instead.

- Although these medicines often start working quickly it can take weeks for the effect to build up enough to make a big difference. Some people need a higher dose of medicine than others and they may not get much benefit until the dose of medication is increased to the right level. Sometimes it is necessary to try several different kinds before the right medication is found. However, about 90% of people with psychosis do find treatments that make a difference to their symptoms.

- If people do get a benefit from the medicine, antipsychotics can reduce the chance that they will have another episode. For this reason people almost always carry on taking the medication even when they feel better, to stop them getting ill again in future.

Medications

- **Side Effects**
  Different drugs will have different effects so it is a good idea to read the patient leaflet that comes with your medicine. This will tell you which side effects are more common with this medication. You can also talk to the doctors and nurses about this.
  Some of the more common side effects of antipsychotics include:

- weight gain
- drowsiness
- lack of sex drive
- constipation
- dizziness on standing up
- stiffness
- a tremor
- restless legs
- dry mouth
- blurred vision

Medications

- **Antipsychotic** medications are used to improve psychotic symptoms. When people have a psychosis cells in their Antipsychotics are sometimes divided into two groups. The older sort are also called "**typical**" or "**first generation**" **antipsychotics**. They are more likely to cause side effects like **stiff muscles**, **a tremor** and **restlessness**. This is because the chemical they block in the brain, dopamine, helps control the way you move. Side effect medications like **procyclidine** can help with this, but they have their own side effects.
- The newer sort of antipsychotics are sometimes called "**atypical"** or "**second generation**"**antipsychotics**. They cause fewer movement side effects. Some of them are more likely to cause weight gain or sleepiness. Sleepiness often gets much better after a few weeks. Weight gain is due to the medications making people more hungry. If people taking the drugs avoid eating too much or the wrong sort of food, and take enough exercise, they can avoid gaining too much weight.
- Rare side effects include diabetes or cholesterol problems, so doctors do blood tests to make sure they spot them early and stop them or treat them. The risk of diabetes is only slightly higher for someone taking a second generation antipsychotic than anyone else.

Medications

- If someone gets side effects that are difficult to cope with their doctor may be able to change your medication. Because different medications have different side effects, there may be another antipsychotic that does not give you the same side effects. If you are taking antipsychotics, **don't stop the medication suddenly without talking to your doctor first**, even if you are feeling better overall. Your symptoms could come back. With **some** side effects cutting down dose can help. But again, **don't cut down the dose without talking to your doctor or nurse**. If you cut down to fast or the dose is too low, the medication will not work and the symptoms can come back.

- One antipsychotic, **clozapine**, works even when others have failed; but it can rarely cause severe side effects, that are usually avoided with blood tests. It is a complicated decision to start using it, so before starting it people discuss it in detail with their doctor or nurse.

- **Other medications**
  Often people only need one medication, but sometimes other medicines can help.**Antidepressants** may be prescribed to help depressed mood and reduce the danger of suicide. **Sedatives** can help with sleep for a short time and can help people feel less anxious or agitated in the day. Other medications can help when people get too irritable or aggressive or excited, like **valproate** or **lithium**.

Psychological Therapies

- Although medication is an important part of treatment, it works best in combination with emotional support from friends, family and the mental health team. Some people also have other sorts of psychological therapy, together with medication.

- **Cognitive Behavioural Therapy** helps to identify negative or unhelpful thoughts and behaviours and replace them with more positive ones.

- **Family therapy**. Once the patient is on their way to recovery, this helps the family to understand the problems associated with psychosis and to provide the support needed for the person to continue getting better.

Psychological Therapies

- **Recovery from psychosis**
  The chances of a good recovery are better if treatment is started early during the first episode of psychosis. **About 70% find their symptoms improve a lot** with their first treatment. A small number, maybe 1 in 10, remain unwell despite treatment. About **20% get better from their symptoms and will never have another episode**.

- Unfortunately, **most people** will have another episode at some point, **though the risk of this happening is lower if the person continues taking antipsychotic medication**. It can be hard to tell who will have another episode and who will not. For this reason, even when symptoms have gone away people often carry on with their medication for at least a year or two. Stopping medication too soon increases the risk of having a relapse 5 times. This risk is highest if medication is stopped suddenly, so it is important only to stop gradually and to plan this with your doctor or nurse. They can help you decide when it is the right time to try doing without the medication.

- If you cut down gradually, at the right time, the risk of another episode is about 50%. Even people who have more episodes of psychosis can get better in the long run but the more often someone is ill the harder this is.

Gillian Haddock

Optimise: overview of motivational psychosocial intervention

Sessions

- Psychoeducation, web, SMS (2 sessions)
  - Desirable to include family if patient is happy
  - Commence immediately after randomisation
- Motivational sessions (6 sessions)
  - Approximately 1 per week
  - Some flexibility if sessions missed etc
  - Commence after psychoeducation sessions
  - Delivered in clinic, patient's home…. etc
  - Family only included if patient wishes it
  - Administer CALPAS scale with client

Psychoeducation, SMS

- Web based, available in local language
- Also, available in hard copy
- Aim is to illustrate and demonstrate the psychoeducation for them to use as they wish
- SMS service: a reminder service for individual clients to personalise reminders which they receive by text message
- If patient doesn't want to use these - its up to them!

Intervention overview

1. Build engagement
2. Engage in discussion regarding life concerns/key goals and values
3. Identify how medication fit in to these goals and the client's stage of change in relation to medication adherence
5. Share mini-formulation/feedback linking concerns/goals/psychosis/medication
6. Work on consolidating motivation for client to progress to action stage if indicated
7. Review, develop and modify formulation and from this identify and develop strategies for change
8. Identify how client can avoid setbacks and maintain change

General guidelines

- If client misses a session, reschedule asap even if there are repeated missed sessions
- Deliver as many sessions as possible (up to 6) within 52 weeks
- Sessions aim to be weekly but may not happen this way….
- Be flexible about location, timings etc etc
- If session is short, may count as missed (>10 mins), also consider half sessions, sessions by phone…..

Cont.

- Tape record sessions if possible (for supervision, personal use and fidelity check)
- Record session details (using session checklist), session length (minutes), whether taped, location, fill out fidelity self rating questionnaire (Opti-MI)

Supervision

- PIs will ensure that therapists are adhering to therapy protocol
- Local peer supervision groups (2 weekly) to share recorded sessions, discuss cases
- Up to two supervision sessions per therapist with Allan Fohlmann via Skype/telephone
- Follow-up training seminar with Optimise

SMS and the Web

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