



## **Enhancing Behavior Change in Patients with Diabetes – Part 1**

Daryl Tonemah, PhD

### **Dr. Daryl Tonemah:**

This is Darryl Tonemah. I'm Kiowa/Comanche/Tuscarora. I have a PhD in Counseling Psychology and Cultural Studies and I was the Behavioral Specialist for the Southwest sites of DPP out in Phoenix, and since then I have the wonderful opportunity and blessing to go all over the country to native communities and talk about behavior change and health behavior change in the DPP and I just love doing it. It's my favorite thing to talk about.

It's real difficult for me to put Stage of Change and Motivation Interviewing, to shrink it up because I usually do two full days of Motivational Interviewing and Stages of Change. And to put it into an hour was stressful because I wasn't sure what to keep in and what to leave out. And I wanted to make sure that I always spend the first several minutes selling it to you, because some people, if they don't get that selling part of it they are kind of resistant to it, because they'll say, well, how does this relate to us? So I'm going to sell it to you first and then we'll cut and get into the nuts and bolts of it.

We'll get as far as we can today, or we get as far as we do today. Even if we had enough time, you wouldn't want to do all of Motivational Interviewing and Stage of Change in one day anyway in one sitting, because this is something that you have to stew on. It's something you have to let grow and honestly, it's something that you have to practice when you're away from here. That's how you get better at it. Let me think what else. So I am going to peak your interest in it. Next time we'll probably do -- once you get the language down, next time we'll probably do some case studies and kind of work on our more in-depth understanding.

All right! Let's get started here. Change is hard. Let's just start there. If you are talking about for yourself or for your patients, for your honey, or for your family, change is hard. If changes were easy we would all had done it already. And I'll just assume that whenever I say something really cool like that that you guys are nodding and you are agreeing with me and some of you may be clapping.

But change and how we approach change has evolved over time from a physician-centric where it was more – “here's what you need to do, here's medications you have to take, do you understand it then”. We didn't understand, we just nodded and left. To an RN centric, well, maybe there was a follow-up call, which is, “did you understand what the doc said?” we just nodded and left. To a health coach model which the DPP looking at the studies-- are both health coach model studies. The idea behind a health coach model is that the patient is very engaged in the process of change with their team. And the team may involve the health coach, maybe a doc is involved or a counselor of some type. All those people are part of a team and the patient is engaged as part of that team. And there is new research showing that the more engaged that that patient is in change, the more likely they are to engage in change and maintain that change over a long term. So knowing that, it's kind of our job to engage the patient. Instead of having that hierarchical model, we have to be more on a level playing field and work with the patient.

So I'm going to have two conversations with you real quick. First of all, think about an area in your life that you have to make an important decision. Not I need to go shopping or I need to buy bread, something bigger in your life. I'll give you ten seconds to think about it. I want everyone to have something, otherwise this illustration won't work. You got something? All right! I'm assuming you're nodding.

Now think about how long you've been thinking about making this decision. For some people it's been six months, I know for some people it's been 27 years, was the longest I've had. Brooke's conversation was 27 years, they had been married 26 and-a-half years.

So next slide then. So here are the rules, you have to make the decision right now, this decision right now. By the time we are done today, you have to start moving on your decision. So, something's been hanging over your head for x amount of time, right now you have to make that decision. You're not allowed to have second thoughts, that would mean you're not compliant, I get to call you names, that you're not listening to me, because I'm so smart. All right, is that a deal?

So what is your reaction to this right now? Look at those cool pictures. What is your reaction right now? Do you have to do this change now, if you don't, I can call you non-compliant or it can have consequences for you.

When I asked you to make a decision, you sounded like pre-contemplators. Actually I want to change that, you sounded like contemplators. When you're thinking about doing something, you're in the contemplation phase. You're thinking about it. You hadn't committed to it yet, you're thinking about it. When I asked you, how long have you been thinking about it? For some people it's been six months, for some people it's been 27 years. You've been in this contemplative stage of change for x amount of time.

And usually when I say, okay, you have to make a decision on it today, you have to move on it right now, people become resistant. People defend status quo at that point, and they'll glare at me. [Examples: They'll give me the stink eye. They'll say, you can't make me change. Why do I have to do it now? I'm not ready to do it right now.] And what that is, that's the language of pre-contemplators.

I mean let me paint this for you a little bit better. You're thinking about change. How I was with you, telling you you have to do this. If you don't do it, I'm going to tell -- you have to do it, I told you to do it. If you don't do it, I'm going to call you names, you're non-compliant. I actually made you worse. I pushed you backward, in your readiness for change. Pre-contemplation is before contemplation.

Let's unpack that a little bit more. Let's talk about the stages of change. It's important to understand that distinction I made between contemplation and pre-contemplation, because how we are with patients, we can actually make them worse. Just think about that, we can actually - they can come in thinking about change and how we are with that, we push them back to pre-contemplation.

So let's talk about stages of change. It was developed in the late 70s, early 80s at University of Rhode Island by Prochaska and DiClemente. The initial study that was used was in the area of tobacco cessation, but it's been applied to many other facets of health including weight loss, diabetes prevention, injury prevention. And the idea behind it is that behavior change doesn't happen in one step. It doesn't even happen linearly. They kind of roll back and forth between

different stages and they tend to work through these stages on their way to change and even each of us kind of progresses at our own rate. The things that work for me may not necessarily work for you, in change.

So the stages of change in Prochaska's theory, pre-contemplation, contemplation, action, maintenance, and relapse. I'm going to unpack these individually for you. So the pre-contemplation phase. [Examples: change is not even on my radar, and maybe very resistant to change talk. That person says, no, everything is okay, I'm not diabetic, I don't have trouble with my diabetes, my blood sugar is fine, I'll eat whatever I want. It doesn't affect anybody else.] You guys know people like that - are you that person? This person most likely, you aren't seeing in your clinics. Because if they are in the pre-contemplation phase, they are not even thinking about change. It's not even on their radar. I don't have a problem, why do I need to go to the clinic?

The pre-contemplation continues. So our role with these people, if we see them in the community, if it's our family member- build a relationship, show empathy and caring, affirm strengths, and provide information. And really that provide information may be the best we can do for some of these people, that we just hand them a pamphlet or they pick up a pamphlet in the clinic. Or because if we start saying, you have this problem or this is concerning, they push back. And what do you do when somebody pushes you? You automatically push back. So we have to establish this relationship through the empathy and caring and by giving just fundamental information about it. That person, the idea of it is that through multiple exposures, through information, it clicks with the person eventually.

Now there's four types of pre-contemplators, the four R's of pre-contemplation. One, first is Reluctant, the Waffle, backs off, acts confused. [Example: Where you may say things like what are you talking about? I don't know what you are talking about.] That's the reluctant person. They kind of push you away through acting confused.

The Rebellious, that person gets angry. [Example: You can't tell me what to eat. It's my body. I will eat whatever I want.] That person is more aggressive in their push back.

Rationalizing, they will explain calmly and in great detail why change is not possible right now. [Examples: Well you know, I just can't make change right now because I am taking care of my 14 grandkids, they are living in my house with me and I am just real busy right now. And we've got BINGO every Tuesday night. And pretty soon you are nodding your head, saying what the hay, shoot, you can't change.] And they are very good at rationalizing current behavior.

The Resigned, [Examples: I know I should. I know I should change, this is just how I am. I have tried before and every time I try I pull a hammy or I twist something or I can't walk the next day and I am just no good at change. Some people are good at change and I am not good at change. That's the reason I am one.] And you think about the people in your life or maybe it's you. Are any of these you - or the people that you worked with in their pre-contemplation? And really the techniques are still the same, is that you want to just expose them to some information and express empathy and you're not saying, empathy is different than sympathy, you are not saying, everything you are doing is just fine, you are too busy right now. But you are saying, yeah, it sounds like it's hard right now and you are trying to establish that you are on the same page as they are.

The contemplation phase where you guys were. You've been contemplating making this change for x amount of time and you haven't moved on it yet. That's the contemplation phase.

[Examples: Yeah, I know I should make some changes but I really haven't made them yet, I am thinking about it.] The patient has become aware of the problem but is ambivalent about change. Now ambivalent isn't disinterested. I don't want us to confuse that. Ambivalence is, they are very interested, but they are interested in change and they are interested in status quo. And there hasn't been enough weight given to change, for them to move in that direction, and not until we help them kind of develop some discrepancy and putting some weight in change will they start to move in that direction.

But in the contemplation phase anxiety is rising, they are thinking about it, it's not -- it's on my radar now. Maybe they even tried some things that were unsuccessful. And they can argue for change, then argue against it in the same sentence. [Examples: You know I need to go do this, oh but it's so hot out, I need to go for a walk, oh but it's so hot out. I need to lose weight, oh but, I just love eating.] And there actually you can hear how they talk in their conversations. They will show you that they are contemplating it, but they'll demonstrate their ambivalence. And once we get to like how we communicate with motivational interviewing, we'll see what to do with this and how to unpack that and help them massage it a little bit.

Contemplation, this person in our role, with the person within a contemplative stage. Continue to strengthen efficacy. Efficacy is the belief that we are empowered in our own life that we can do something and how we strengthen efficacy is building on success, small doable doses of change. Evoke reasons to change and risks of not changing.

And this is when you can start using motivational interviewing is in the contemplation phase. If we try to have these kind of conversations with the pre-contemplation person. That person is going to be resistant in four ways, one of the four ways that we saw that they can be resistant in the pre-contemplation phase. But motivational interviewing does work in the contemplation phase, and we will get into that. We will unpack that in a little bit.

Next phase is the preparation phase. And this person is ready to change, look how shining and happy that slide is. This person is ready to change. The window of opportunity for change has been opened, the breeze is gently blowing in (the winds of change), the sun is shining, and ambivalence has been resolved. They are saying I am ready, they are asking you for help, they are asking you for tools, and they've stated the need for change in the preparation phase. And they may be asking you for diet plans, nutrition plans, activity plans, where can I go for a walk, is there a place on the Rez they can walk where there are less dogs. Really, they're going to use you as a tool or resource when they are in the preparation phase.

Our role, facilitate developing a vision of change, provide information like I was just saying. What are some of the benefits and consequences of options walking, we want to see what the good things are, what are some of the not-so-good things are and collaboratively set doable doses of change and should have underlined and bolded and highlighted collaboratively, because if we are making their change for them, if we're making the plan for them, then we are doing it wrong. I really want to emphasize that.

If we are trying to make their plan for them, we are doing it wrong, and because that's the same old medical model where we are creating dependence on us, and that's the opposite of what we want, because what happens when we leave? We have to live kind of in a transient system. So what happens when you leave your job in six months and you're the one that they saw as the head of their change? Then they're done changing. What we want to do is empower them to make change.

Action phase, they're now doing the change behavior. They're starting to execute their plan. They have a reward system kind of set up, maybe they're going to walk x amount of minutes per week and when they get there to that point, they reward their behavior change. Then they may be asking you for support. This is as an aside and I might have this later at a later slide. A behavior that is rewarded is more likely to be maintained. You guys nodding? I can sense that you are nodding. A behavior that is rewarded is more likely to be maintained, which just means that there is value, I place value in change. So there has got to be some light at the end of the tunnel. For me if I meet my exercise goals for the week, I will download a CD or download songs. For the participants, it maybe a movie or time with the kids or time away from the kids, but let them kind of define what the reward is going to be.

Action, our role in that phase, find rewards for behavior change, Continue to teach skills, if it's lifting or maybe it's starting to learn how to take your pulse when you are walking, things like that. Help keep goals small and incremental, with a long term goal in mind. And I want to emphasize that one, because if we want to keep change in small doable doses because that enhances efficacy. If it's broken into small doable doses, it actually increases their belief that they can. If they overshoot what they actually can do at any given time, you can actually decrease the belief that they can do it. We actually make them worse. So we have to collaborate and say what will be a good distance for you to walk today?

[Example: I was working with a woman in Gila River and she came into my office and she said, Darryl, and I said, what, and she said that she wanted to run a marathon. I said, are you a runner? And she said, no. I said, do you like to run? She said, no. I said, do you – and she said, I don't do any of that behavior Darryl. What aren't you getting here? I said, well, let's not start with the marathon today. How far do you think you can go? And that's an important question in motivational interviewing is what are you willing to do? So I asked her, what are you willing to do? She said, I could probably walk about a block. And I said, man there is a lot of single blocks in a marathon, we've got a long way to go. So we went outside and we walked one block and afterward we talked about it and I said, what did you think about that? She said, I can probably do that. So she went out that week and walked a block every day.

Next week she came back, she said she did two blocks and then three blocks and four blocks and weeks went by and then pretty soon she was, we were walking and running, and then more running, and then walking, and then we're doing 5Ks and 10Ks, long story short, too late, is that she now run in many, many marathons and a couple of few years ago, she started doing triathlons.] And I take full credit for all of her behavior change, I'm just kidding.

What she did was she broke up her change into things that she perceived that she could do at that given time. Did that make sense to you? It's like this way, you're nodding. So in starting to promote change, particularly in the preparation and action phases is you're want to find out what are you willing to do and how can we build on that. And that doesn't have to be exercise, that can be calorie intake. [Examples: Are you willing to drink two Diet Pepsis today instead of say you drink four Pepsis every day? Are you willing to drink two Diet Pepsis? If you want to use that example, or do you have to eat four doughnuts a day, can you have two doughnuts a day. What are you willing to do?] That's the question. Put that in your toolbox, that's a good one.

And then the maintenance phase. So the next phase is, this is kind of the person who -- this is kind of who they are now. It's been going on for a while, it's a part of their day, it's a part of their routine, and they're maintaining this behavior. They identify to maintain strategies to

support change and limit slips. Sees change as a lifestyle rather than a diet or quick-fix, it's no longer a fad in their life. What's our job there?

We help them maintain change, we can help them be their support system. We can keep change interesting. With the DPP, we did campaigns. After the initial 16 sessions, we would do campaigns to keep them interested as in survivor. And maybe survivor is still as popular, I don't really know. That show survivor was popular, so we do a survivor campaign, I don't remember what it's about but, it was just a campaign to keep them interested.

We had people walk across, Route 66 across the United States in theory. How many steps they would take on their pedometer wherever Route 66 started. As a team, we would count up their steps every week. And when they got to certain markers along Route 66, we would, let's say it was in St. Louis, I think that was in Route 66, we would call the chamber of commerce there and see if they send us a magnet or a pen from St. Louis kind of, to show that they had been through that town on Route 66. But the point is you're just trying to keep change interesting over time.

And we start to discuss how we can bounce back from slips. And for those of you familiar with the DPP, you know that slips are just, when you fall away from your behavior plan, your behavior change plan maybe you start to eating unhealthy again or you gained weight.

What you want to do is if they are going to fall off that wagon. We don't want them to fall off the wagon and roll into the ditch. We want them to use some of the skills that we worked on together to keep them moving forward, and I think that's part of this relapse. The person has a slip, this is the last stage. And it is not necessarily required to have this stage, but it's important that we talk about it because just in case a person has a slip or consistently returns to previous behaviors, they gain weight, they discontinue their activity plan.

Our role, help patients understand what leads to a slip or what led to the slip? Maybe it's Pow Wow season and they just drive around the country all summer long and every weekend they eat ten Indian tacos. Now we kind of understand that that leads to this behavior and this behavior is contributing to their poor health. So we want to understand we want to help them connect the dots, you kind of understand that from the DPP. Teach problem-solving for future slips, adjust their plans, number one—keep things doable. And where they are right now and what they are doing right now, or perhaps help develop a new plan.

Motivational interviewing, I love talking about this stuff. All right!

So why are we also introducing motivational interviewing? It actually sets up a framework that we can walk through conversations with and through change with our patients. You are all very smart people and they should be taking this, and they have to take this and they should be exercising this, they should, they should, they should -- but they are not.

We know we have the highest rates of diabetes, unwellness, and heart disease and things like this, and so, it's actually just a model that gives us another option for change. So we are having conversations with our patients, clients, family, whoever that are potentially pretty tough conversations because change is hard, it's emotionally driven and we love our habits. We just love our habits. You think about it, think about how you eat, where you eat, when you eat, what you eat or how active you are or inactive you are? Those habits have been kind of cemented over time, and it's kind of part of who we are now. And then we come along as

health professionals and say, well, maybe some of those habits aren't contributing to your health in a good way. Well then, we might just get slapped.

It's tough because often our expectations may be at different places than our patients' are. But it's important to have these conversations because we want better health. Often what happens when we are at a point of change we will talk about stages of change, we are at a point of change, we are at the action phase, and they are at the contemplation phase. We are ready for them to be in the action and they are ready to be in the contemplation. And we're so excited, we're gung ho, it comes from a good place, you all have good hearts. But we are try to yank them into our phase and what we force them to do by doing that is we force them to establish their autonomy again. And they'll say things like, you don't know me, or they'll say, yeah but, yeah but, yeah but. You guys have any yeah butters? And when somebody says, yeah but, that's our bad. That means we got to a point of change before they did, and we have to adjust our method at that moment. Hope you guys are nodding right now. 28:41

But there is a way to have these tough conversations and have them turn into positive and actually turn into change. [Example: My beautiful, wonderful wife, we had been married about a week and her dryer went out. I married, a grown up, she had a house, and she had a washer and she had a dryer, and cable TV, and a TV. And so I was in her living room, I moved into her house after we got married. I was watching her TV in her house, and I thought, man, I am a regular grownup now, and I saw her messing around, or heard her messing around in the laundry room. And she comes out of the laundry room, she says, Darryl, and I said, what? She said, the dryer is broken. And I said, well that's too bad. And she said, can you fix it? And I looked at her and I said, no. She said, why? I said, what during our dating period gave you any inclination that I would know how to fix a dryer? That's not in my skill-set. I am -- if you need somebody to sit around and eat pizza and watch TV I'm your guy, but if you need somebody to fix a dryer, I can't do that. She said, but you are a guy. And I said, yeah, but you know I am not the dryer fixing kind of guy. I'm more of a TV, pizza kind of guy. And what that was, was I thought about that and she had a different expectation of what guy-ness was than I did, and it totally was off her radar that I wouldn't know how to do that. It was totally off my radar that she would think that I know how to do that.] And when you are in relationships either clinical relationship or even in your real life relationships, a lot of the conflict comes from differing expectations at any given moment.

So when you think about your clinical experience with this person what are your expectations when you go into that room versus what are their expectations when you go in that room? Meet them there and kind of move them forward. Just to conclude that story I had to pay a guy to come fix the dryer.

Okay, what is MI? It is a counseling style, series of strategies that is pretty well researched. It's been around for a while like the early 80s was the first edition of it. It was originally developed for folks with alcohol issues by Miller and it has expanded into smoking, health, behavior change etcetera. It was used a lot in the DPP and the Look Ahead studies.

So conceptual beliefs, and this is important. Okay, conceptual beliefs. The client is actually involved -- actively involved in their own care, the client verbalizes reasons for change. We're trying to get the client to tell us why they should change. Instead of us saying well, you should change because, because, because... we're trying to get them to say the reasons that they want to change. It's a very different paradigm.

The clients are co-healers. The professional doesn't carry all the responsibility. That's not your job. If you're working harder than your patient, you're probably doing it wrong. I'm saying that again. If you're working harder than your patient in their change, you're probably doing it wrong because a) you're going to get burned out. Because what if they come back next week and they've gained five pounds, then it's your fault, if you are working harder than they are. And we don't want to lose you. But we want to engage them in change, and again, if you're making all the change plans for them and you leave, then you've made change dependent on you, instead of dependent on them. We don't want that to happen.

It's a collaborative relationship not an adversarial relationship. It's a way of being with someone. You bring your own stuff, you bring your "ness" to it. I bring my Darryl "ness" to these relationships. Behavior change is discussed in a safe way and uses an interpersonal context and it promotes self-efficacy. It promotes the belief that they can make these changes in small doable doses.

The temptation in these clinical relationships is to get them to make a decision or to push them forward and in more cases we get the opposite. We create resistance. Do you guys ever work with those people that say, well, I just have to go in there, I tell them what to do and they just do it. And I think, you must have some sort of magic powers that nobody else possesses. But if you look at it statistically, at the statistics of it. That method works just on a small amount of people, that method works on a very small number of people. But some people say, well, they work for them and must work for everybody and that's not true. Remember, we all go through the stages differently and if you want to look at statistics, the best thing you can do is a client-centered method of change, which is Motivational Interviewing. The client-centered method of change that turns directional at a certain point, we'll talk about that in a second.

In most cases we get the opposite, we create resistance, we get them to say yeah but, yeah but yeah but. Remember, I tried to get you to do something earlier. Do you guys remember this? I hope you are nodding. I tried to get you to do something earlier, when I said you had to make a decision about this today. And I know a lot of you were thinking, you can't make me do that Darryl, you don't even know who I am. But I wanted you to think what was your actual response if somebody made you do something. The temptation is, if they do that, we want to push back then.

Even if they do agree, if they say, okay, well, you've been so forceful and you use your powers of persuasion on me. Decisions made under pressure may lead to buyers' regret and you know what that means. If you go out and buy a new car and it's so shiny and pretty in the parking lot, and the guy was so nice to you. He was so friendly, he is your best friend now and you go home and you think, hey, I can't afford this car. That's buyer's regret. You made the decision under duress or under pressure and that changed how you viewed that decision. Getting people to do it works on a small percentage. Everyone else we ignore. That's intermittent reward. That's where the whole gaming industry is built on. Coercion it tends not to work with most people in the contemplation phase, in which you guys were in and I made you guys worse.

Well, I like this slide, Motivating Change. The more I hear myself, the more I believe myself. I am going to let that stew for a second because it sounds so smart. Wish I had a thought of it. The more I hear myself, the more I believe myself. That is, if you say it, then great, that's great for you. But if I say it, and I own it, that changes my whole perception of change. So as clinicians what we want to do is have a skilled conversation and get them to say, they want to change. And that's coming, we will get there, hold on.

Now we are motivated for whatever we are doing. We are living out our habits as absolute fact, remember that. We are motivated for whatever we're doing. We are living out our habit as absolute fact. So when they come into your office, they weren't born outside your door, remember that. They weren't born five minutes ago, they had this whole life of behaviors that led them to this moment. And what right do we have to say, well if your behaviors are wrong and sick and bad? That's an earned right to have that conversation with them, and we try to do it within the first five minutes. Have you guys ever noticed that? If you're doing it within the first five minutes, if you are trying to problem solve within the first five minutes, it's more about your needs than it is about their needs. You'll say, yeah, I think I believe that, let me say that again. [Examples: If you try to problem solve within the first five minutes, it's more about your needs than it is about their needs. But let me qualify that. If they come in and they are just freaking out, I am not in control, my blood sugar's out of control, I need help, can you do this, can you do this, tell me how to do this? Well more power to you. That's where you can jump in there. Not everybody is like that. But we treat everybody like they are like that though. Well then I'll problem solve for you right-away. What we need to do is earn that right to help them move through the stages of change in a process of change.]

We change a behavior when our current behavior is no longer rewarding, and there's more value in another behavior. That sounds kind of smart. I am going to read it again. We change behavior when our current behavior is no longer rewarding and there is more value in a different behavior, in another behavior. So maybe in the decisional balance, the person with diabetes who is starting to experience some neuropathy or vision problems, at that moment that maybe the tipping point, so maybe I need to do something about this diabetes thing. There is less reward in status quo in that moment, than there would be in change. We want to help them to make that change doable, manageable.

So the flow of motivational interviewing, you listen skillfully, I like to call it having a skilled conversation with somebody. And this is where if we were to have time together for two full days, we would spend about four or five hours just practicing our listening skills. Just how are we actually listening to somebody. And too often, we are not comfortable listening to somebody. We are so used to being experts in exchanging monologues, instead of having a dialogue with someone that we are missing a lot of really, really valuable information.

Okay, second we find the good things versus the not-so-good things. We are trying to look at their decisional balance, kind of resolve some of the ambivalence with them. Next we're going to find the importance. [Examples: how important is it for you to make this change right now? How confident are you, that you can make this change right now? You see, how those are two different questions? Maybe important, but they don't believe they can do it. That actually is a very common conversation. Yeah, so I have a new son and I want to be around for him for a long time, it's really important to me. Well, on a scale of 1 to 10, how confident are you? I am a 1, because every time I've tried I have failed at it or I get sore or go back to where I was with my weight and I have low confidence.]

And the next is, ask, provide, ask. So we want to see what can we do to start creating this change, provide information, and kind of revisit it over-and-over again. Make sure we're on the same page.

And then we collaboratively -- there is that word again -- develop a plan with them, not for them, but with them.

So the flow then is when you start listening skillfully it's very client-centered, that it's – a lot of your basic listening skills, or opening a question, affirming, reflection, summarizing, you kind of do all your wonderful listening skill that you guys have. When you get to the point of summarizing is when it becomes directional. So it's kind of broad, wide open, open-ended questions, and then you can summarize anything that they tell you. But when you summarize is when it kind of gets into the nuts and bolts of motivational interviewing. That summarization takes you to the next steps.

So then it becomes directional. So that's what I enjoy about motivational interviewing. It's several different psychologies. So open-ended, client-centered, moves into directional, and move into the nuts and bolts of change. That's what I wanted to touch on there.

But before we do that we can fall into a lot of these traps and I would like you guys to think about which traps that are most common for you. The Labeling Trap, you have an eating problem, you are obese. Those the Labeling Trap doesn't promote ownership and it may promote resistance actually and in doing that maybe we are trying to establish some sort of power dynamic that we have in the hierarchy of power in this relationship, if I label you, maybe I have more power.

The Blaming Trap, whose fault is the problem? And this is important to look at this one because a lot of times if someone comes in with a new diagnose of diabetes, there is a lot of self-blame or denial. If you're trying to find faults or they're trying to find faults, it doesn't help anything. Really, the best way to look at is, here is where we are. Here is how we start moving forward collaboratively.

Premature Focus Trap, we fall into focusing on what we believe to be the problem. We fall into focusing on what we believe to be the problem. [Example: When I was down in Gila River, there was a knock on the door and I got up and they came in, I said, hey, come on in. They sat down and they said, Darryl, I don't think I can check my blood sugars anymore. And me being a psychology boy, so let's just process this and maybe you have sort of Oedipus complex, and you need to resolve your issues and blah, blah, blah. And then they said, no, I am just out of strips. I said, ouch. I was kind of embarrassed, because I'd immediately fell into the Premature Focus Trap.] And what you want to avoid that, you have your open-ended questions. Tell me how it's been going? How has your diabetes been? How has your health been? And let them go down the rabbit holes that they need to go down.

Taking sides, the most important trap to avoid. The counselor detects a series of problems prescribes a certain part of the action, almost forcing the ambivalent client to resist. And then you see how these kind of all fall, these last three, kind of are very well related. An Expert Trap, impression of having all the answers may come from very sincere place, you guys are good people, but people in their early stages of change aren't ready for this expert person. It can make your patient passive. If you're giving them all the answers you're forcing them into passivity, because why do I have to become creative in my own problem solving if you're doing it all for me.

And then the Q&A Trap creates a power differential, have you done this, did you do this, yes, no, yes, yes, no, yes, yes, no. That's a Q&A Trap and it creates this very distinct power differential, because why are you asking all these close-ended questions that I can just say yes or no to, and then give me all information and then I will give you my wisdom.”