



## **Enhancing Behavior Change in Patients with Diabetes – Part 2**

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### **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.

We have to acknowledge that change is hard and that we are having difficult conversations with our patients. Motivational Interviewing and Stages of Change give us a theoretical framework of how to work with a patient or a participant. And when we get stuck, we kind of fall back on, what is my understanding of change. And Stages of Change and Motivational Interviewing is something for us to kind of fall back on and say, well, where is this person now and what tools do I use for us to keep moving forward.

We talked last time about the Health Coach Model, how the Health Coach Model is becoming more prominent and much more successful. Motivational Interviewing is a key component in the Health Coach Model.

We talked about Stages of Change. Do you guys remember Stages of Change? I hope wherever you are right now you are nodding, that it is, otherwise, it's just me talking to myself in my office. So I will pretend that you are nodding. And if you remember the Pre-Contemplation phase, that person, change isn't really on their radar. They are not even thinking about it. There is really no problem.

The Contemplation phase, that's the ambivalence phase, where they are putting energy toward status quo and they are putting energy towards thinking about changing, but they haven't really moved on that change.

There's Preparation and Action. The Preparation would be the person is getting ready to make change, but hasn't started the behavior. Action is they have done the behavior, they are in the middle of doing the behavior, but they haven't done it for long enough to say this is who I am, this is part of how I roll.

Maintenance phase is stage of change, this is, it's part of my daily life, this is what I do now.

And Relapse, this is a given, but what we want to do is kind of prevent going back into the behaviors that we had previously; if it's eating or inactivity type behaviors.

So that's Stages of Change in a nutshell right there.

So I want to do a quick Case Study. I will read this to you. Now, this came from a conversation I had just recently, might have been just in the last few days.

The patient was in pre-contemplation for years. He didn't do anything for years. I don't have a problem. I don't know why you think I have a problem. I had come over here because I need to pick up some medications, but you guys keep saying I need to do stuff to change. His A1c was over 10. Internally, I don't know if something happened to his family, or he came to the point of wanting to change and he just got after it. He started to exercise, he lost weight, and his A1c is just over 8 now, like 8.3, 8.4. And the staff kind of is saying to him, well, you need to be lower, 8 isn't good enough. 8.5 isn't good enough, we want you to be lower, and we as health professionals know that to be true. But he, in his mind, he says, well, I was at 10, now I am at 8, I have lost weight, I am feeling better. I don't have a problem anymore. If I can just stay right here, it isn't a problem for me anymore. But we know that 6 would be much healthier for him.

And what the staff was saying, their view of the world was that he was in the Pre-contemplation phase. Because he is saying he doesn't have a problem anymore, and we know he has a problem. So they see him in the Pre-contemplation phase. In his mind, he is in the Maintenance phase. This is how -- I am rolling now and I am healthy, that's how he is viewing the world.

So what we need to do as health professionals then is work within his framework. Remember, like I just said, you go back to how you understand change. So in the Stages of Change, if we see somebody in the Pre-contemplation phase, how do we act with that person in the Pre-contemplation phase? And really what you are trying to do is maintain a relationship, develop a relationship, and start getting some information to that person about what is a healthier A1c. What does an 8 run, what does a 6 run?

Because if we are saying to him over and over and over again and it's just hitting his, what we will call resistance, I don't have a problem, I am doing fine, then we are to a stage -- we are to a point of change before they are. And it's that difference, that is creating this resistance. So we have to -- it's on us to change our methodology. So instead of pushing, we use some of our MI skills, which we are going to talk about in a little bit, and start working with the person and find out, okay, here's where you are, how can I work with you in this framework to start inching you a little bit lower.

And I had a conversation with him after this, so maybe it was last week, and they actually had a meeting with him after this, and they started motivationally interviewing him, and they found that he was worried about hypoglycemia. He never said this before until they started plugging in this listening again. And he said, well, if I get below 8, I am worried that I am going to have an episode is what he called it. I will become hypoglycemic. So anything below 8 was scary to him.

Now, there's our negotiation right there. Well, okay, instead of me pushing 6, 6, 6, let me put another 6 on there so it's not 6, 6, 6. 6, 6, 6, 6. What if we talked about 7.5 for a while, and have that be a goal for a while? And what you want to do -- and part of finding out what stage they are in and what methods we use in Motivational Interviewing is, we find out what the negotiable is. And for him the 7.5 is probably negotiable. Right now 6 isn't. But we want to work towards that direction.

I just touched on this, how the client is involved in their care. They tell us why they want to change. They are co-healers, they are involved in the whole process. Behavior change is discussed in a safe way and it promotes efficacy. We touched on that a little bit last time.

Today we get into a little more nuts and bolts of MI. So here is the flow of it, is, we listen well.

We listen skillfully, we have a skilled conversation. Some of us say, well, I am already good at it; I bet you are not. I still have a ways to go, you can always learn something. And I would imagine if I asked your honeys, if you were a skill conversation -- a skilled listener, I wonder what they would say. So we can always become better listeners.

We can find the good things versus the not so good things in behaviors with the person. We find how important change is and how confident they are in making change. And then we ask, provide information, and ask again, is this the direction we can go? Is it okay if we have a conversation about this right now, about change right now, about activity? Yes, then we go through that process with them.

And then we collaboratively develop a plan. But what I really like about Motivational Interviewing is that it's several different psychologies in one. That it starts out very client-centered, very humanistic, Carl Rogers, I am going to listen and listen and I am going to listen well. I am going to ask good open-ended questions. And by the time they leave the office, you have gone from client-centered, to cognitive behavioral, to leading with the behavioral plan. So I think that's one of the really interesting things about Motivational Interviewing.

So some of the Principles of Motivational Interviewing, just for -- would you guys do me a favor right now, can you just nod like you are following me a little bit? Thank you. Principles of Motivational Interviewing, Express Empathy. And this, I can't even express how important being empathetic is. That empathy demonstrates that we are tracking where the patient-client is going. We are demonstrating to them that I want to know what your experience is. If you say I understand, that's not going to get you anywhere. Don't say -- actually don't say that in your setting, don't say, oh yes, I understand. You probably don't understand, particularly when it comes to behavioral change you probably don't understand, because how you understand barriers is unique to you and how they understand barriers is unique to them. So rather than say I understand, expressing empathy demonstrates that you are trying to understand. An empathetic statement would be, it sounds frustrating when you try to make change and your husband makes fun of you. That would be expressing kind of what they said and the feeling that went underneath it; expressing empathy.

Avoid Arguing, because usually arguing and resistance comes when, like I said a few minutes ago, when we are at a Stage of Change different than where they are. And it's that middle ground that we are trying to yank them across this cavern of this middle ground. And they are saying, you know what, you don't know me, and they want to establish their autonomy, and that's where this back and forth comes in. And then we start to feel defensive and then our temptation is to try to make them do it then, which gets us nowhere. Clinically that's just -- it's played out to not be successful for us.

Support Self Efficacy. Self Efficacy being the belief that we can make change. The belief that we can do it. And cognitive psychology-wise, start with your thought, the simple thought that change is possible for me, change is doable for me, and we as a Health Coach, we help them develop these skills that move forward in making change, that's efficacy. One of my favorite quotes, hold on, I am just trying to remember where it is, this is my favorite, I should remember it. Henry Ford, "Whether you believe you can or whether you believe you can't, you're probably right." So if they believe they can't do it, they are probably right; if they believe they can do it, they are probably right, and one of our roles then is to help them believe that they can do it.

Develop Discrepancy, the good things versus the not so good things about making change, and we will talk about that a little bit.

Opening Strategies. Ask open-ended questions. Let me sit on this one for a second. Ask good open-ended questions. That is a skill. It is a skill for life, and it's a skill clinically. If you can ask a good, well-structured, open-ended question, then you can get a long way in understanding your patients. If you can give it to them, ask something, a question -- and a lot of my open-ended questions start with, tell me about? Tell me about? Tell me about?

And sometimes we will think we are asking open-ended questions, but we are actually asking a closed-ended question. [Examples: Do you enjoy exercising? Yes? No, that's actually a closed-ended question. But we think we are asking them -- we think we are asking them to tell us about exercise, but in fact we asked a closed-ended question.

So an open-ended question to try to find out about exercise is, tell me a little bit about your experience with activity? Tell me a little bit about your experience with exercise?] That's wide open, and they can tell you anything they want about that. They could tell you what kind of shoes they wear, they could tell you how they did it when they were a kid, they could tell you how they did it last time they were active. It leaves it wide open. So really practice the skill of asking a good open-ended question.

Then, after you ask your good open-ended question, do one of the next three; listen reflectively, summarize or affirm.

But once you ask your open-ended question, you have to acknowledge that they said something. So don't go question, then let it hang there after they answer it and then ask them another question and then ask another question. When you ask a question, let them know that you heard what they said.

Listen reflectively, the fundamentals of it is a simple reflection, which we are going to talk about again later, is just taking a couple of nuggets of that sentence and just giving it right them back to them. You are holding up a mirror. [Examples: Tell me a little bit about activity in your life. Well, I have tried it a lot and every time I do it, it's frustrating, because I get too hot, and I get sore. You have tried it -- you had a lot of not so successful times with it. Yeah, because blah, blah, blah, blah.] I mean, reflect something out of that sentence, and then they keep going -- we reflect something out. And really we are just taking a few words out of each sentence that are kind of the red flag words and just giving right back to them, and helping them move forward, helping them move forward, helping them move forward.

And you will find actually when you become good at it, right now it kind of sounds like they would know exactly what I am doing, or why are they repeating what I am saying, but when you get good at it, it doesn't sound like that. It actually sounds just like you have become really interested. [Examples: You had trouble with that? Yeah, because blah, blah, blah, blah. It's frustrating to keep going. Yeah, because blah, blah, blah, blah.] Really it becomes part of a flow of conversation when you get practiced at it. You need to practice with your office mates or your honeys when you are driving to Walmart, practice with them and see how they perceive what you are doing. Reflective listening.

Summarize is basically, you have this, they speak for a paragraph, they speak for a few minutes, and then you kind of funnel it down to two or three sentences of what they said. [Examples: So it sounds like -- so what I hear you saying is, fill in the blank. So it sounds like you said, fill in the blank.] And we are going to talk about this a little bit more later, but when you summarize is when it goes from this client-centered, very humanistic, client-centered

focused, to direct and the cognitive behavioral part of it when you summarize, because you step right into resolving ambivalence once you can summarize it. Because you could summarize anything when they are talking to you. [Examples: tell me about activity? Well, the weather is good, but every time I try, my honey makes fun of me, and my dog goes with me sometimes and we walk by my neighbor's house, and my neighbor, he likes to wave at me when I. Okay, am I going to summarize the neighbor thing? No. What I am going to do is I am going to summarize the, well, it sounds like you have tried a lot in the past and there's parts of it that you enjoy, the social part of it, but some of it sounds kind of hard. You sound like you have not so much support at home, and it's really limiting your desire, your want, your need for activity. Yeah. Okay.] I just summarized their whole thing into a direction, and that's going to form my next conversation of the resolving ambivalence conversation, which we will get to in a second.

Affirm, find what they are doing right, find what they are doing right. If we were all in a room together and I were to ask you, who here is a naturally affirming person? And if there's a room of, I don't know how many people are on right now, let's say there's 100 people on, probably five people would raise their hands and say I am naturally affirming person, which is great, that's probably about right. And if I ask how many people were naturally sarcastic? Me and the rest of us would have to raise our hands. But what we need to do is find what they are doing right at this given time. If they show up, sometimes they are five pounds heavier, but they showed up. Remember, they didn't have to show up, so them showing up takes effort. So we have got to find something within this dynamic, between you and them, or in their own lives that they are doing right, because it's a lot more powerful and easier to make change out of positive than to try to drag it out of the wreckage of negativity, we want to find this positive and move forward on that. So be sure to be affirming.

Then, elicit self-motivating statements; elicit self-motivating statements, and I do believe my next slides are related to that. Let me check.

4 types of Self-Motivational Statements: Problem Recognition, Expression of Concern, Intention to Change, and Optimism for Change. Problem Recognition, Expression of Concern, Intention to Change, and Optimism for Change. All right! Let's talk about these just a little bit. Kind of unpack these. Using Self-Motivation, how types and how to.

Problem Recognition Questions. We want them to realize, okay, there is an issue going on here. And we can put this in the framework of – well remember, the Pre-Contemplation person, that person is going to naturally -- well, first of all, we may not see the Pre-Contemplation person that much, because they don't believe they have a problem. If they are coming into your office, they are most likely at least in the Contemplation phase. So give yourself a break there. They are at least motivated enough to see you. So they are already thinking about change, but maybe they are just dipping their big toe into change and not ready to commit to something at a bigger scale. That's where this conversation comes in.

Some of the questions, we have some sample questions here for you guys for Problem Recognition. [Examples: What makes you think that this is a problem for you? Inactivity, we'll use inactivity. What difficulties have you had in relation to exercise? In what ways do you think you or other people have been harmed by your weight gain, your inactivity, your diabetes? That one is probably related more previously to the previous manifestations of MI or with alcohol or smoking. In what ways has this been a problem for you? How has not exercising stopped you from doing what you want to do?] And these are just sample questions. But really we want them to say, this is why this is a problem for me. So if you ask me this question, so I

am coming in Pre-Contemplation, in what ways has -- for me, being so cool, been a problem for you? Just kidding.

[Examples: So in what ways has diabetes been a problem for you, or your raising blood sugars, or gaining weight been a problem for you? Well, I am not able to exercise like I used to. I am really worried about diabetes. I am really worried about high cholesterol, heart disease, things like that.]

And they are telling you then, kind of the issues related to weight gain, whatever that activity or inactivity is. And that's very powerful, because Motivational Interviewing, the more I hear myself, the more I believe myself, cognitive psychology actually. The more I hear myself, the more I believe myself.

So if they come into a clinical setting and we say, your weight gain is going to affect your blood sugars and it's going to affect this with you, then I am saying it. It's much more powerful if we can form a good question and get them to say it to us. That's basically what Motivational Interviewing is. We want them to tell us reasons to change. Because we want them to tell us why there is a problem. And you can use those questions there, or if you have better ones, you probably do, so you whip out some of your better ones.

Concern. Once the person talks about the problem, okay. The helper then shifts and elicits statements from the person about how he or she is concerned about that problem. [Examples: So what is there about your drinking that you or other people may see as a reason for concern, weight gain, drinking? What worries you about excessive eating, about inactivity?] And these were examples from like the original behavioral MI. [Examples: In what ways does this concern you? How much does it concern you?] I like this one a lot. This ties into the Motivational Interviewing idea of looking forward or looking back. [Examples: So if you made all the changes and they work out just right, how do you think things would look? If you didn't make any changes, what do you think would happen if you didn't make any changes at all, let's look five years down the road?] And we want them to express concern at that moment. And again, we could say it all. We want them to say it all. We want them to say it all. We don't want to work harder than our patients do.

Intention to Change. So we have -- expression of that there is a problem, that there is a concern, and now, okay, let's talk about change then. Once concern statements are out, then the helper again shifts to elicit statements from the person about the intention to change. Here is where it's important for the helper to make sure the person knows that certain behaviors must change and ask what else the person could do. Let's see, what do those look like? [Examples: The fact that you are here indicates that at least part of you thinks it's time to do something. I like that one too, because remember, they are already motivated to make change, so let's call it out then. The fact that you are here kind of -- you are demonstrating that you are interested in making change.] And I always talk -- when I talk to patients I always say that we are demonstrating our motivation at any given moment. We are demonstrating whatever we are motivated for at that time. So they are coming in, demonstrating that they are interested in making change. [Examples: What reasons are there you see for making change? What makes you think you need to change? What makes you think it's time for a change? What would be some of the advantages of making change?] We have got to pull from them the intention to change. We want them to say this to us, and you can use these questions, but like I said, you probably have better ones than this, so you whip out some of your better ones.

Let's see here. Optimism. Ooh, I love optimism! I am Mr. Brightside. Once the person talks

about making changes, the helper then reinforces self-efficacy by eliciting statements from the person regarding their optimism about the change to be made. Remember, we always, always, always want to give hope. Remember that. We need to be a place of hope and we need to have optimism and affirming as just part of how we roll. [Examples: What encourages you that you can make a change if you want to? What do you think would work for you if you decided to change?] And I like that one, because that leads us into this how we make change into doable doses. How do we make small doable change over time? [Examples: What would work for you if you decide to change? You know what me giving up bread the size of a hubcap ain't going to work for me today, but maybe sharing it with my honey, that can work for me today. Or instead of cutting out the Big Slam or Grand Slam over at Denny's, instead of cutting that out, what if sharing it, or not eating all of it, that probably would work for me today.] So they have to have hope that something can work for them.

Responding to Resistance. Oh man! You know what, we can talk about this all day long, but we have ten minutes, so let's do that instead, I am sure you guys have better things to do. So what is resistance, let's describe resistance. Resistance in the moment. Unwillingness to change. [Examples: No, I don't have a problem. You know, that's your idea, that's not my idea. I don't want to do that.]

Sidetracking. They start talking about their neighbor's cousin's dog's hair. They try to go down different roads to get you off the topic of change. Well, remember, they are there for a reason, so always remember that. When you are feeling this resistance in the moment. Remember they don't have to be there. So it's our job to use our skills, conversation skills to bring them back and move them toward change. Because it's there, but sometimes it's hiding, and it shows up in resistance. Also, remember that resistance is energy. Resistance isn't necessarily a bad thing. But it's a clue for us to, let me change my approach at this very moment. [Examples: Somebody's saying, yeah, but, yeah, but, yeah, but, yeah, but, or they start sidetracking, or they start answering a different question. You guys see that a lot of NFL coaches will do that, you will ask a question and they will answer a totally different question, or they will just say, yeah, acquiesce, okay, yeah, you are right, you are right, uh-huh, you are right. Oh, bless your heart! Bless your heart! In Oklahoma bless your heart means shut up. So they are really saying shut up. Bless your heart! You are trying to help, bless your heart!]

Being overly cooperative. All that is, is resistance in the moment, because if they are overly cooperative, we know that nothing is going to change when they leave, so we want to be aware of what the dynamic is in that moment.

Resistance between appointment resistance. Not completing certain tasks that they said they were going to do. Late for session. Sometimes we will say, well, that's running on Indian time, which is a possibility. But sometimes it's, well, I am going to demonstrate my autonomy. You're not the boss of me. I will get there when I want to get there.

No-shows, I am sure that doesn't happen to you guys, because everyone would love to see you guys.

Or not picking up the phone. And remember, they don't have to pick up the phone. They don't have to show up. They don't have to do anything. So if they do these things, it's because there is a nugget of motivation there that we can work with.

Resistance is a cue to change strategies. It is a case manager problem, not a client problem. Isn't that just mean of me to say? [Examples: If somebody is saying, yeah but, or if I am getting push back it's because, I have gotten to a point of change before they have and they have to

yank back. They have to say, you know what, Darryl, you don't know me, yeah but, yeah but, yeah but.] And they are demonstrating that I haven't earned the right to be at that point yet. Does that make sense to you? And often it happens when we start to problem solve. Unfortunately, one of our defaults when we start to feel this resistance is that we want to problem solve. We want to tell them, well, you need to do this and you need to do this and you need to do this, and I don't know if you are like me, I don't like when people say that to me. I don't like when people try to force their will upon me, so I will become passive-aggressive, burn their car or something like that, or unfriend them on Facebook. But what I am doing though is saying, you don't me well enough to have the right to solve my problems for me. Plus, we shouldn't do that anyway, because if we are the one working harder than them and trying to solve all their problems, then what happens to their health when we leave? Because you are not going to go home with them. So we want to empower, teach the skills to our participants, patients that they can be controlled or helped, and we shouldn't have to be involved in it.

So if you are creating a resistance, if there's resistance going on, it's my bad, it's your bad. It's not their bad, it's my bad, and what can we do to make these -- what can I do to adjust? Actually, we are going to talk about what we can do to adjust. I think it's my next slide. If it is, then I will look so smart.

Resistance exists between people; there has to be someone/thing to resist. If I stop pushing back, then there is nothing to resist. If I all of a sudden align myself with them, then there's no resistance. As long as I am pushing back and they are pushing back, we can do resistance. Well, what if I stop pushing? So right now I have my hands against each other, if you can imagine I am pushing it right in front of me, we are pushing back against each other. If I take my hand away, what is my other hand going to do if it's aligned? So what we want to do then in this resisted moment is change our method and realign ourselves. Hopefully, that's my next slide.

Kind of-ish. Rolling with resistance. Remember, resistance is energy. So how can we use this energy to keep moving forward? If we align with them, we can use that energy. The important thing is to not take it personally. They are not mad at you, but there's a dynamic, we as human beings, we get in the same room together, you talk about change, this dynamic is going to shift, and sometimes it feels like resistance and sometimes it feels like they are mad at me. But I don't need to take it personally, but I need to think, well, how can I help in this situation? How can I use this resistance? And how can we keep moving forward?

The simplest way, I don't know if it's my next slide. It is. See, I look like a genius now. The simplest way of addressing resistance is the simple reflection. What? Yes. Remember I talked about reflection is just holding the mirror up and saying, here's what they said, here's what they said, here's what they said. So simple reflection, meeting resistance with non-resistance. Examples: So we are talking and saying, well, how did it go this week, and you seem like you are moving forward. This is so hard. I mean, I am just tired of doing it. Probably our response is, well, you know it's good for you, and if you keep doing it, you are going to get healthier, just listen to me, we are the ones with all the letters behind our names.] But that creates more resistance, and pretty soon you are escalating.

[Examples: But if this person says, this is so hard, I am tired of it, I am tired of doing it, instead of having that, well, it happens to be the right moment, let's align with them. Yeah, change is hard, because it takes a lot of time and effort.] Do you see how disarming that is? It totally takes the fuse off of -- it disarms that lit fuse. [Examples: And if they say, yeah, I don't like,

yeah, it's hard to make changes, and it's frustrating when people ask you to do it a lot. You come here and it seems like we are on the other side. Yeah, it does seem like that. Yeah, I can see how that can be frustrating.] You demonstrate with empathetic responses and just simple reflections. If we had more time and we want to get down different rabbit holes, there's amplified reflections and there are strategic responses and things like that. But you know what, the most simple way is you take the foot off the gas, tap the brakes a little bit, and align yourself with them with just a simple reflection.

You are not going to do them any harm by listening better to them. You are not going to do them any harm by listening better to them. So if you feel like there is this dynamic in the room and you feel like there's resistance, the temperature of the room changes, not literally, figuratively, the temperature of the room changes and you can feel this heat of resistance building up. Rather than being a thermometer and just going with the temperature in the room, you become a thermostat and you control the temperature of the room. Does that make sense to you, that little metaphor? Rather than being a thermometer and just reacting to the temperature of the room, you become a thermostat and you control the temperature of the room. And you do that by going back to your basic fundamental listening skills of empathetic responses, simple reflection, and realigning yourself with the patient that you are both on the same team and you both want to move forward.

[Example: Here is another conversation I had just the other day with some people from Behavioral Health in the community. Behavioral health is required to see court ordered patients with alcohol problems. After they do required tests, depression test, things like that, they engage in counseling with them. And the counselor said to me, when we were talking the other day, the counselor said, the patient is being resistant because I ask them, so what is your plan now? And the patient says, what? I don't have a plan. What are you talking about? And then the counselor says, they are just being resistant. What do you do with that resistant patient?]

Now, let's fall back to our understanding of change. If they are being resistant, what happened in the room? There was some sort of dynamic change in the room. So what happened was, they were having two different conversations, right? The counselor was in the Action stage of change, was in the Action stage. Well, okay, what's your plan? And that's the kind of question you ask in the Action stage.

[Example: But if a person is court ordered to be there, that person is probably in the Pre-Contemplation stage, well, I don't have a problem, but I was forced to come. In other words, I am weighing my options here and I guess I would rather come here than go to jail, so here I am.] So they are in the Pre-Contemplation phase and the counselor is asking an Action question.

And then she says, but he is just being resistant. Well, yeah, of course he is being resistant, because his -- you are way at a different conversation than where he is. And we know, because we are all so smart. What do we do when -- during that gap, to bridge that gap? We change our method. He is not a bad patient at that moment, we need to change our method. So we need to tap the brakes and go back to, it's frustrating to have to be here and need to be court ordered and then having me ask you a plan.

Yeah. I don't know what we are doing here. And you know what, with a pre-contemplative patient that may be as far as we get is having just a conversation, because that plan thing is way down the road. The Pre-Contemplation person, we just present them with information, establish relationship, and then when the spark goes off, then we can move forward, but if we

start to try to yank them forward is when we create resistance. We make them -- we can actually push them backward in change.

If somebody comes in at the Contemplation level and we say what's your plan? I don't know, I haven't been thinking about this forever, what do you mean have a plan? We actually pushed them backwards then, because that language is Pre-Contemplation language. If they come in at Contemplation and we are moving too fast, we can actually push them backwards.

Fall back into your fundamental, foundational Stages of Change and Motivational Interviewing skills. Stages of Change being kind of our framework, where are they and what kind of conversation can I have with wherever they are?

Resolving Ambivalence. The good things versus the not so good things. So if I were to draw a - - they call it teeter-totter, seesaw, a balance, you know what I am talking about. Anyway, and on the left hand side you put the left hand up and on that side there is a plus and a minus, and on the right side there is a minus and a plus. In resolving ambivalence, we want to find out what are some of the good things about current behavior.

Remember, we all know that we are motivated for whatever we are doing. We are motivated for whatever we are doing. So if you understand that, what are we getting out of it? What are some of the good things about our current behavior? You can ask that question. Then underneath that, what are some of the not so good things about our current behavior? And always remember, when you ask a question, you demonstrate that you heard what their answer was. So you listen reflectively or you summarize or you do something to show that you heard what their answer was. So over on this side is status quo of current behavior, what are some of the good things, what are some of the not so good things?

Let's go over to the other side, way over to your right hand side now. On top is a minus sign. What are some of the not so good things about change? What has been hard about change in the past? What hasn't gone so well for you and how has it been for you? That's change. Underneath that is a plus sign, So what are some of the good things about change? What would some of the good things about change be? Now, this is a big -- that last plus is a big conversation, because they are telling us why they want to change.

Imagine that guy who came in with alcohol problems and he got to the point of me saying, can you tell me what I would like to change? And he actually says, the reasons why he wants to change. It's a very different conversation than me saying, you need to change, because of your family, because of this, because of jail, because, because. It's a very different conversation. Because the more I hear myself, the more I believe myself.

[Examples: So we get to the point of the positive, what are some good things about change. Okay. Well, how important is it for you to make this change right now, on the scale of 1-10 (1 being not so much at all and 10 being really important)? On a scale of 1-10, how important is it to you? I would say an 8. And we want to find out why they choose 8. Why did you choose 8 instead of 7 or 9, because my 8 is probably different than your 8, why did you choose 8? And then we reflect on what they said. How confident are you that you can make this change? Probably about a 3.] And usually that's how it rolls, because people are seeing us, so there's some sort of importance for change, but maybe they have struggled with in the past and they can't do it very well.

[Examples: So how confident are you that you can make this change? Probably a 3. Why did

you choose 3 and not a 4? Because I want to understand that a little bit better.] Then we reflect what we heard and that informs our next conversation. Because if it's already important, we want to help them with confidence. So it's okay if we talked about kind of how to increase that confidence a little bit, ask for permission.

[Examples: What do you think we can do collaboratively to make that 3 a 4 over the next couple of weeks? I am not trying to make that 3 an 8, efficacy-wise that's too much, we want to build smaller incremental change over time. So what can we do to make that 3 a 4 over the next couple of weeks? So if it's somebody who is starting to exercise, well, I really just need to know how to stretch, let's start there. Would it be okay maybe you came next time and I brought a physical therapy or an exercise person in to show some stretches, would that kind of boost that 3 up?]

And here's your plan. Here is a Plan Sheet that I worked up for our coaches with the DDPP. And you start with today's Date; what the Goal is; next Timeline, next two weeks; History, how you have dealt with change in the past; Strengths, what do you have going into change right now?

[Example: Well, the weather is still good, it hadn't snowed yet. The Rez has just established a new dog ordinance. So I can walk down the road.] What are some of the Barriers? This is important, because efficacy-wise if you come up to a barrier and you have low self-efficacy, you are going to spend a lot less time trying to get around that barrier, or you will be a lot less creative. You'll hit that barrier and you will say, oh, okay, well, I guess I tried.

What you want to do, is with them collaboratively identify the barriers and what can we do about it if they pop up. My Role, which would be your role as the Health Coach, what can I do to help you be successful here? And what is the Reward? A behavior that is rewarded is more likely to be maintained. A behavior that is rewarded is more likely to be maintained. So what small thing can we reward ourself with? Ideally you want it to be internal. It feels good to feel good, I am just happy. But if we are first starting out and we haven't had a lot of success in the past, then a lot of people may not have that intrinsic, so maybe they need a headband, water bottle, or something like that.

Here's some -- this next slide is our book sheet. I can't remember, citations for a couple of books on Motivational Interviewing. And I think that second one is really interesting, *'Motivation Interviewing in Health Care: Helping Patients Change Behavior'*.

Thomas Edison's teachers said he was "too stupid to learn anything." He was fired from his first two jobs for being "non-productive." As an inventor, Edison made 1,000 unsuccessful attempts at inventing the light bulb. When a reporter asked, "How did it feel to fail 1,000 times?" Edison replied, "I didn't fail 1,000 times. The light bulb was an invention with 1,000 steps."

I want you to consider us learning this skill as a process, as well as understanding change for our patients as a process too."