Motivational Interviewing for Loved Ones

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MAPNET, New England MHTTC
April 28th, 2023

SAMHSA
Substance Abuse and Mental Health Services Administration

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Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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Acknowledgment

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At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D, served as Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration.

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This work is supported by grants #1H79SM081775 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Presented 2022

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Motivational Interviewing for Loved Ones

Emily Kline, PhD

About Me

- Psychologist (Boston Medical Center) & faculty (Boston University)
- Director of Psychological Services at Wellness and Recovery After Psychosis (WRAP) Program
- MI has been the best tool in my toolbox
- Funding from MA Dept of Mental Health and National Institute of Mental Health to develop and pilot this content
- No commercial interest

What is “Motivational Interviewing”?

- “MI” is a communication style widely used by health professionals to talk about making healthy changes – research shows it works!
- Developed with the goal of increasing motivation for treatment among people with substance use disorders
- MI is based on the idea that the best way to influence another person’s behavior is by respecting their independence and creating space for them to explore their own motivation for change.

Why would caregivers want to learn MI?

"Putting your foot down" isn't getting the result you want

Though we can't control others, we can control ourselves – we can try new behaviors to "clean up our side of the street"

Great way to work on connection, even if we don't get the behavior change we want right away

Motivational Interviewing for Loves Ones ("MILO") is an **adapted** MI curriculum for family caregivers

MILO 101

- When we see someone we care about struggling, we want to help them…

- But for some reason, they don’t appreciate it!!!

The Righting Reflex

- The impulse to help others by
  - FIXING their problem
  - GIVING them advice
  - MINIMIZING their issue

You might sound like this…

In order to consider a healthy choice or a change, people need to feel:

Understood

“My therapist never judges… he tries to see my point of view”

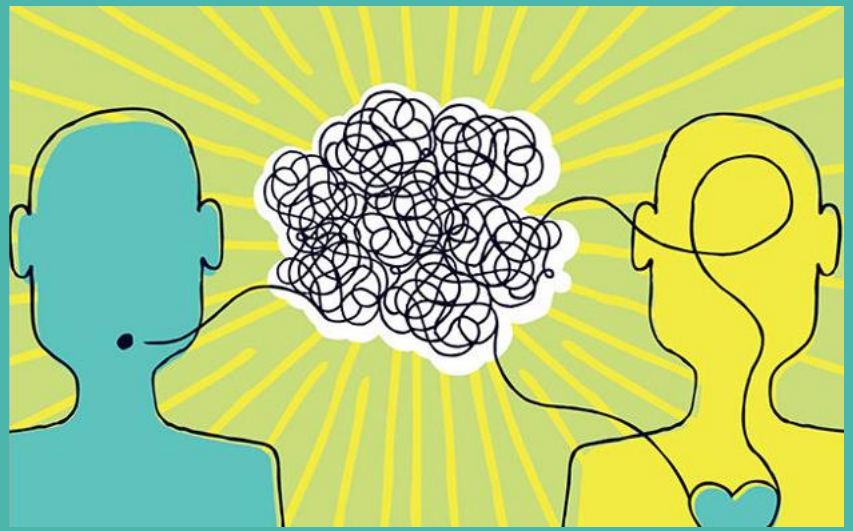
Confident

“I know I can quit smoking this time”

In Control

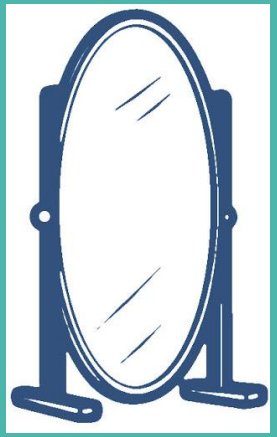
“No one can make me take medicine – I’ll decide for myself”

Building Understanding Confidence & Autonomy



Tool #1: Reflections

Convey empathy and careful listening



WHAT IS A REFLECTION?

- A Statement, Not a question
- Specific – not generic
- Repeat back what you heard the person say, or guess at the feelings beneath
- Helps the person:
  - Feel understood and accepted,
  - Hear their words think a little deeper about what they meant.

TYPES OF REFLECTIONS

- Simple: **repeat** back what you heard
- Complex: reflect the “gist” or overall **meaning**
- Feeling: name the **emotion** you’re hearing
- 2-sided: On the one hand... but on the other...

Reflections Don’t Judge

- Reflections are different from praise – they don’t evaluate whether someone met expectations
- Reflections don’t indicate whether you agree/disagree
- As we get older, we like appreciation (“thank you”) more than evaluation (“good job”)

REFLECTION EXAMPLES

All my friends do it. So, it’s not a big deal. Just get off my back, okay?

- Simple: You feel like it’s not a big deal.
- Complex: Smoking seems normal to you.
- Feeling: My concerns are annoying to you.

I hate school.

- Simple: You hate school.
- Complex: School has been tough lately.
- Feeling: You’re feeling down.

Reflections Practice

Type a reflection into the chat:

Therapy is dumb.

Marijuana is an organic remedy.

Tool #2: Asking Curious Questions

Get curious about another's perspective and values

Question Examples

OPEN ENDED QUESTIONS
get people talking

I'm not going to see that doctor again.

- What happened last time you met with her?
- Help me understand where you're coming from.
- What do you see as the pros and cons?

Open vs. Closed Questions

Instead of this (Closed)

- Are you feeling better today?
- Did you take your medications?
- Are you going to go to your therapy appointment today?

Try THIS (Open)

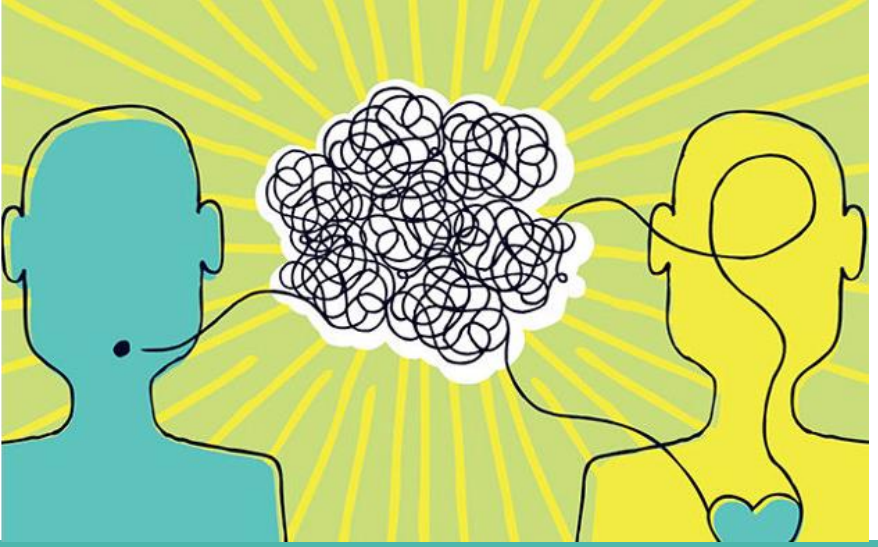
- What did you do today?
- What's going on with your medications?
- How has therapy been lately?
- What do you see as the pro's and con's of meeting with your therapist today?

Questions Practice

Type an open-ended question into the chat:

Therapy is dumb.

Marijuana is an organic remedy.



Time to Practice!

Tell me more about why you quit dancing.

Listen as this Parent:

- Reflects key points and values
- Asks an open-ended question
- Listens as Simone finds some unexpected motivation!
- Encourages her to pursue her own idea

Research Results

Research Questions

- Will caregivers want to learn these skills?
- Is this kind of training feasible using remote technology?
- Can this program help parents to feel less stressed and better about themselves as parents?
- Can this program help families have less conflict and more fun?
- Can a brief program make a lasting difference?

Participants (n = 131)

- 82% women (moms, grandmas, a few sisters), 18% dads
- 78% White, 6% Asian, 8% Black, 8% other or more than one race
- 7% Hispanic/Latino
- Average age of 53 (kids ranged from 14-30)

- 54% reported that their child had experienced psychosis
- 60% reported their child had at least one previous psychiatric hospitalization
- 49% reported that child was abusing drugs or alcohol

MILO for Early Psychosis: 2-Phase Trial

Phase 1: Feasibility

- 30 participants “open label” MILO
- May - Dec 2020

Phase 2: Efficacy

- 40 participants “mini RCT”
- 20→ immediate intervention
- 20→ 6-week waitlist (crossover design)
- Jan 2021-April 2022

Study 1: Feasibility

- Aims: learn whether caregivers would sign up for MILO, attend multiple sessions, find the content relevant and useful, and get their suggestions for improvement

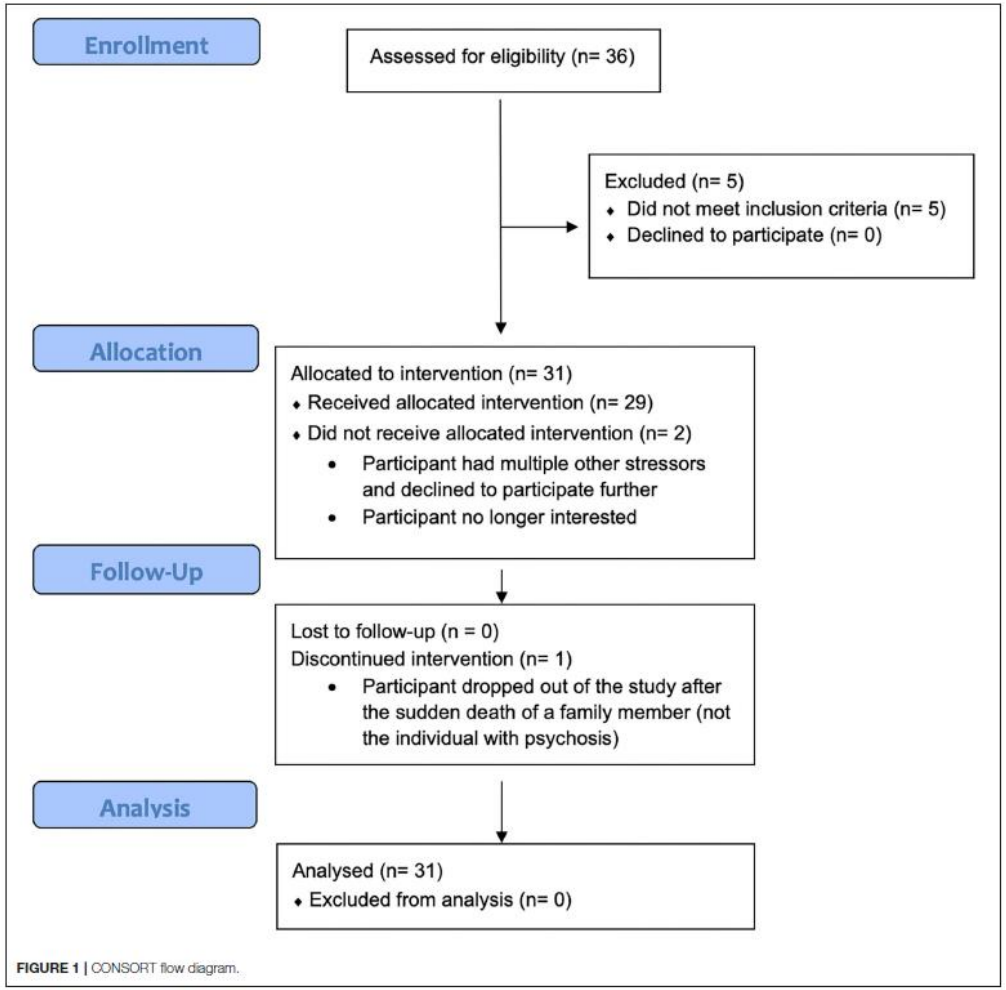


FIGURE 1 | CONSORT flow diagram.

Feasibility

- High interest from parents
- Telehealth expanded accessibility for many
- No one dropped out after 1 session, and almost everyone attended the full course
- Of the 29 participants who did 3+ sessions, 28 did post-MILO assessments

Satisfaction

- Twenty-five of the 28 participants who completed post-intervention assessments reported that they had used the skills they learned
- Twenty-six out of 28 participants who completed post-intervention assessments reported that they would “definitely” recommend the service to a friend in need of similar help
    - And a lot of them did!

What did participants think about MILO?

Prompt	Identified theme (number of responses within this theme)
What have you found most helpful about this program?	MILO skills (22) Motivational interviewing "spirit" (7) Expertise and/or empathy of facilitator (6) Individualized advice about a specific family situation (6) Role plays (6) Convenience of telehealth (1)
What changes would improve this program in the future?	Offer more sessions and practice opportunities (11) Change wording/response options in one or more questionnaire (4) No changes (3) Provide scripts or memory aids to help with skill implementation (3) Improve telehealth platform (2) Offer training in a group format (2) Expand to diagnoses beyond FEP (2) Provide more rationale for motivational interviewing (1)
What barriers to implementing the MILO skills did you experience?	No barriers (9) Limited contact with the individual with psychosis (7) Not enough training/practice (5) IP not responsive to attempts to use skills (4) Difficulty managing own emotions during conversations (3) Not enough time for longer conversations (1)

Study 2: Efficacy

- Aim: compare MILO to waitlist control

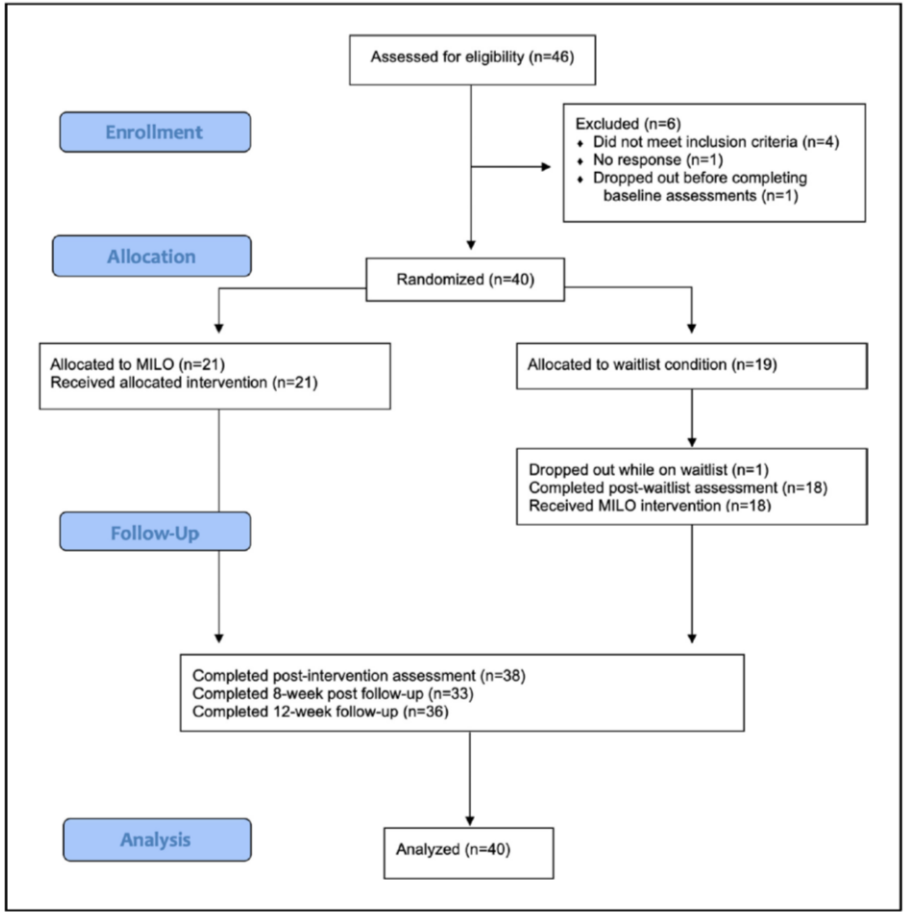


Fig. 1. CONSORT flow diagram.

MILO vs. Waitlist

Linear regressions: effect of MILO vs. waitlist on caregiver outcomes.

	Model R^{2}[c]	Change R^{2}[d]	β	t	p
Stress (PSS)	0.45	0.05	0.22	1.75	0.088
Parent self-efficacy (PSAM)[a]	0.68	<0.01	−0.07	−0.67	0.508
Family conflict (CBQ)	0.47	0.11	0.33	2.76	0.009
Expressed emotion (FQ)[b]	0.57	0.08	0.28	2.53	0.016

Caregivers who did MILO reported significantly less conflict and expressed emotion than those who did waitlist.

Trend effect for stress.

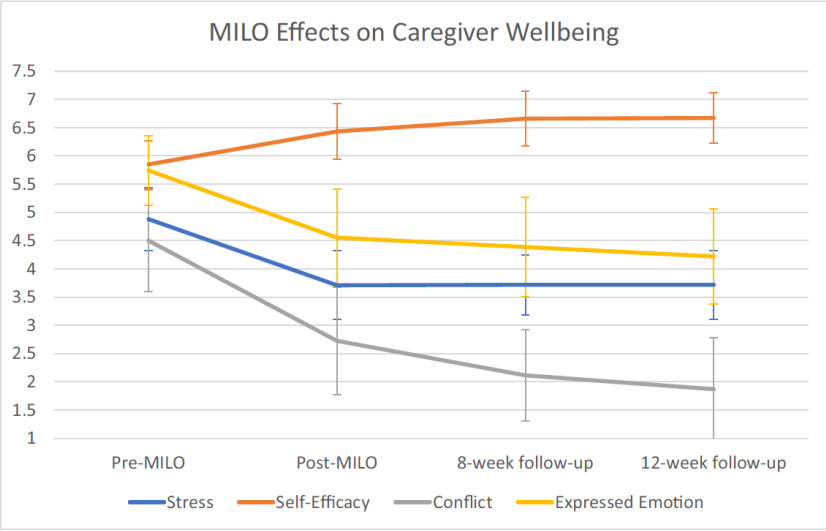
Repeated measures ANOVA: caregiver outcomes.

Domain (measure)	Pre-MILO	Post-MILO	8-week follow-up	12-week follow-up	F	p	d
Stress (PSS)	19.52	14.84[a]	14.87[a]	14.87[a]	12.41	<0.001	1.29
Self-Efficacy (PSAM)[b]	58.50	64.32[a]	66.59[a]	66.71[a]	7.89	<0.001	1.08
Family Conflict (CBQ)[b]	9.00	5.45[a]	4.23[a]	3.74[a]	15.35	<0.001	1.43
Expressed Emotion (FQ)	54.45	47.32[a]	46.39[a]	45.32[a]	13.50	<0.001	1.34

PSS = Perceived Stress Scale; PSAM = Parenting Self-Agency Measure; CBQ = Conflict Behavior Questionnaire; FQ = Family Questionnaire.

[a] Post hoc analysis with Bonferroni correction indicates significant change from Pre-MILO baseline; no other post-hoc comparisons were significant.

[b] Greenhouse-Geisser correction used due to violation of sphericity assumption.



IMPACT OVER TIME

- Large effects in all caregiver domains
- Effects stable or continuing to improve after 8,12 weeks

Study #3

- Group format (6-10 participants x 8 hours)
- Transdiagnostic population
- Hybrid feasibility-effectiveness design

Participants (N = 62)

- Caregivers of youth ages 14-24 with a wide range of psychiatric diagnoses were invited to participate in this pilot trial
- The top behavioral concerns were defying rules (64%), substance use (41%), and difficulty with schoolwork (38%).
- Regarding psychiatric diagnosis, 20% reported that their child had no diagnosis and 80% reported one or more diagnoses (including anxiety disorders, uni- and bi-polar mood disorders, ADHD, and PTSD)
- Nearly half (43%) reported that their child had at least one prior overnight admission to a psychiatric unit for treatment, and nearly all (97%) reported that their child had received some form of therapy for mental health concerns

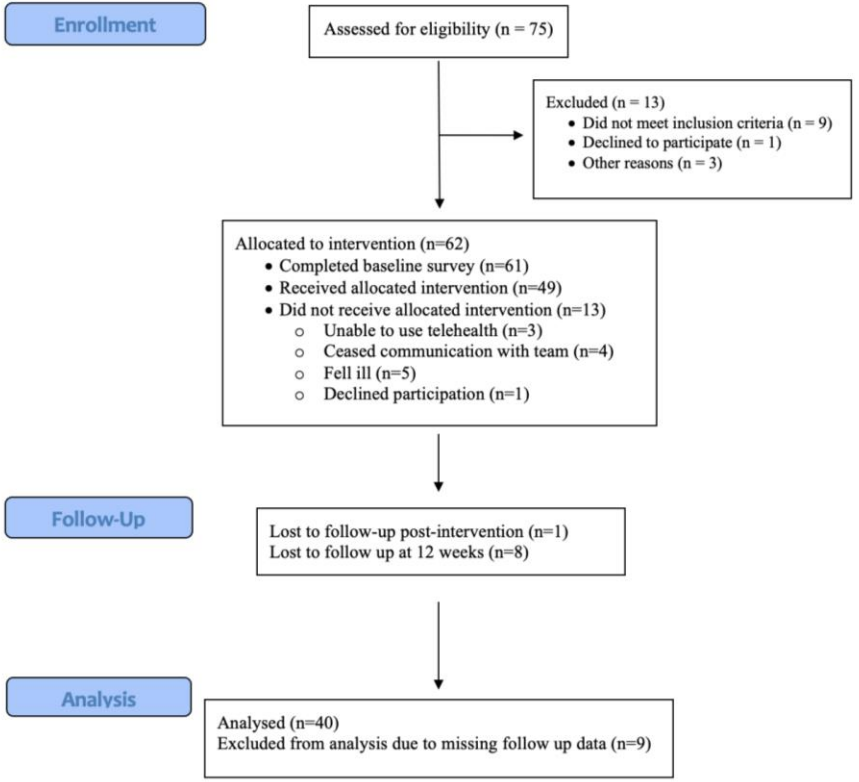
Participants

- 93% Mom/Stepmom/Grandma, 7% Dad
- 56% Married/Cohabiting, 44% Single
- 79% White, 2% Asian, 11% Black, 8% other or more than one race
- 10% Hispanic/Latino
- Average age of 53 (range 34-77)

- 92% lived with child at the time of the training
- 43% reported their child had at least one previous psychiatric hospitalization
- 31% received DMH services for their child

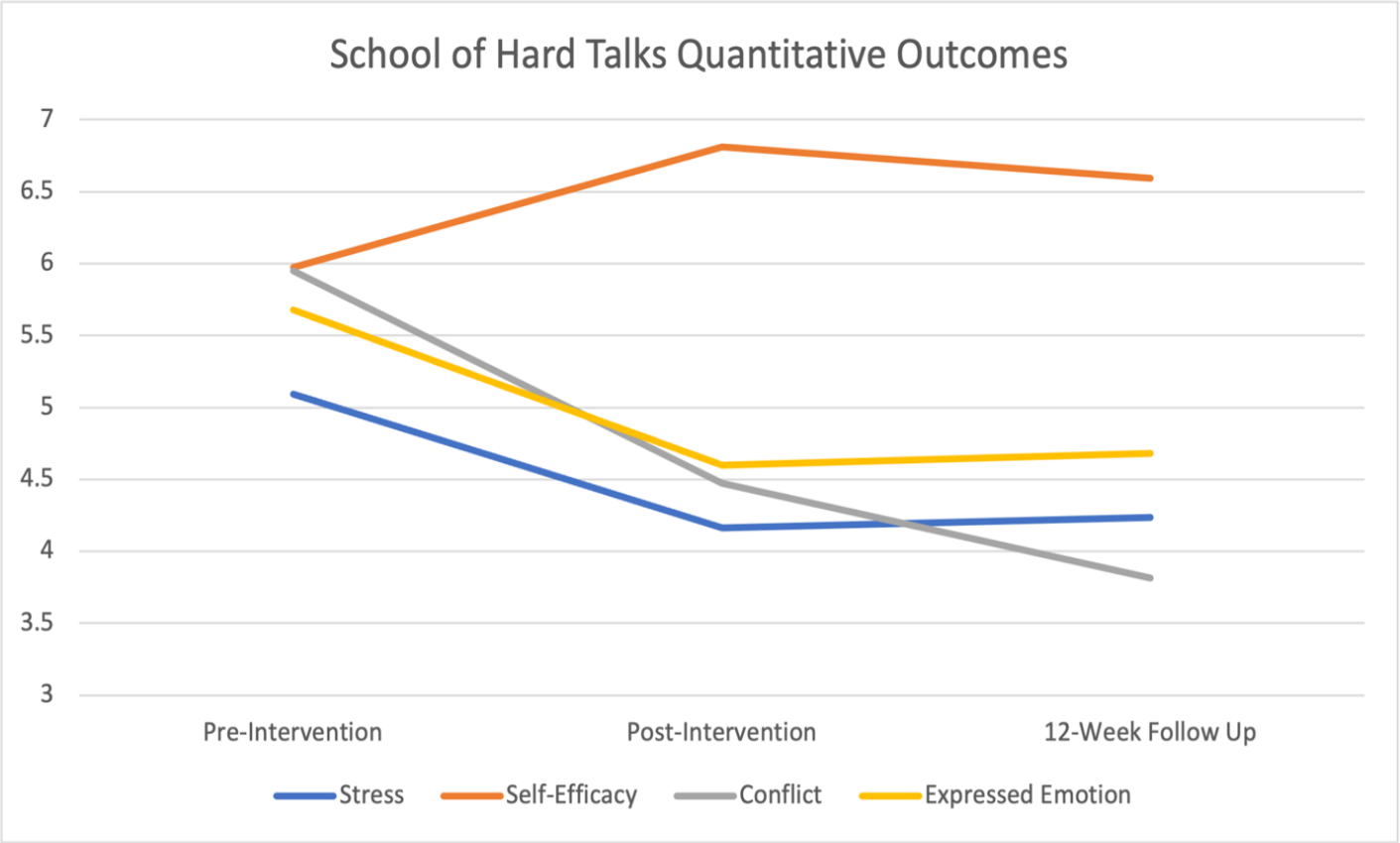
Retention/Feasibility

- 80% of participants who enrolled attended at least five hours of group training and 59% attended all eight hours.



Quantitative Outcomes

- Participants' motivational interviewing skills (assessed via direct observation) improved significantly
- A repeated measures ANOVA indicated significant and large effects on all four outcomes of interest (stress: $F [2,78] = 13.15$, $p<.001$; confidence: $F [2,62] = 10.70$, $p<.001$; expressed emotion: $F [2,64] = 20.09$; $p<.001$; and conflict: $F [2,78] = 13.20$, $p<.001$).


School of Hard Talks Quantitative Outcomes
7
6.5
6
5.5
5
4.5
4
3.5
3
Pre-Intervention
Post-Intervention
12-Week Follow Up
Stress
Self-Efficacy
Conflict
Expressed Emotion

“What’s the most important change you’ve noticed since [learning MILO skills]?”

The children are willing to listen to me, not just dismiss what I am saying.

Conversations are not as intense or volatile. I have skills that help me cope and thus, help my children.

I find that I hold back on criticizing my child for her decisions and instead I try to find out from her what her motivations are by asking "curious questions" rather than "judging".

I think I have more productive discussions with my children and that makes me feel better about myself and as a parent.

Did participants master the skills?

- For the most part, yes! (75% attained “proficiency”)

Sample Items

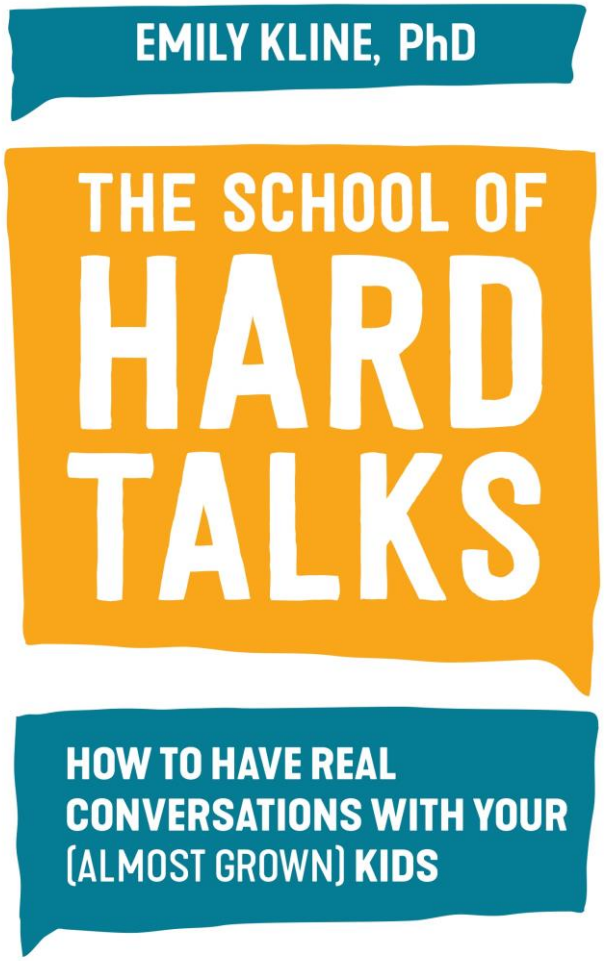
- **Expressed Emotion:** My child does not appreciate everything I do for them.
- **Stress:** In the last month, how often have you felt that you were unable to control the important things in your life?
- **Confidence:** I know I am doing a good job as a parent.
- **Conflict:** For the most part, my child likes to talk to me.

RESEARCH CONCLUSIONS (SO FAR)

- After a brief training, family caregivers **can** master some basic MI skills that will give them more confidence in handling challenging conversations
- MI helps parents manage their role as caregivers to teens and young adults struggling with mental health
- Often the young person is ambivalent about involvement with mental health services – but we can be more creative in finding ways to support those who **are** motivated (parents, caregivers, partners)

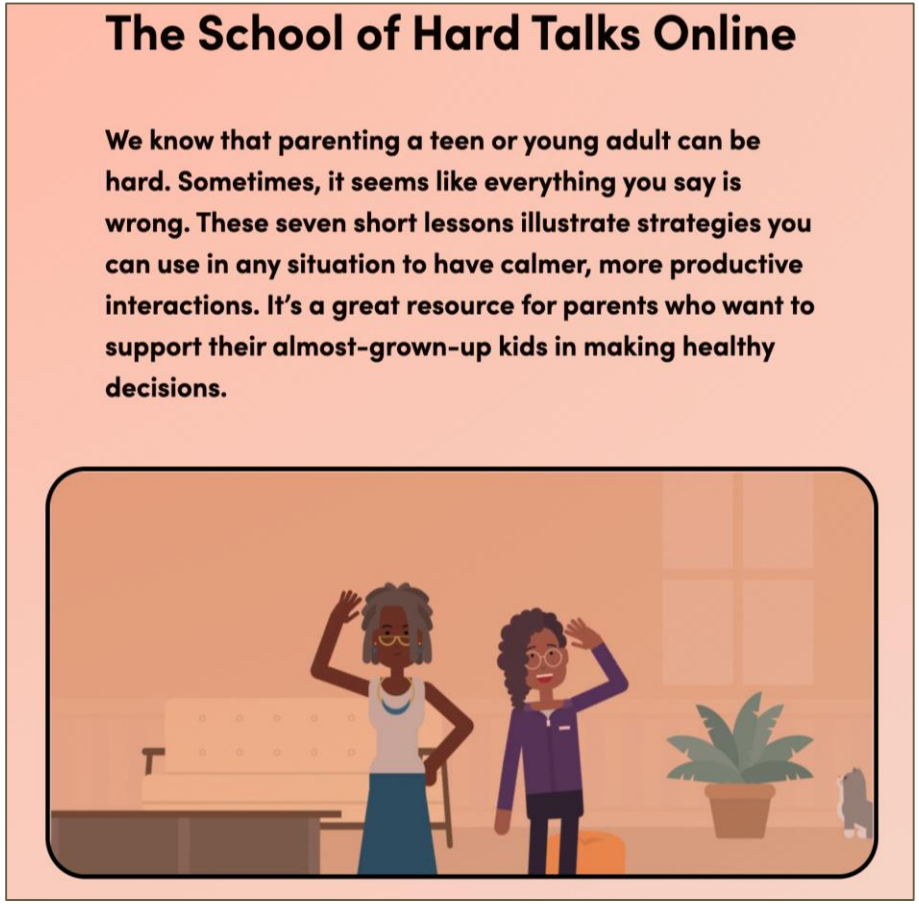
Want to learn more?

Resource #1: Book



Resource #2: E-Course

- FREE E-Course at: https://handholdma.org/what-can-i-do/the-school-of-hard-talks-online-lessons-from-motivational-interviewing-for-everyday-families
- (Or just google “School of Hard Talks Online”)
- Seven interactive 10-minute e-lessons + take home points



Resource #3: Instagram

- Follow **@learnaboutMILO** to see my students and I demonstrate MI skills, see MI skill flashcards, and learn the results of our research studies

Resource #4: MILO Clinic

Piloting at Boston Medical Center

learnaboutmilo@bmc.org

Thank you!

- MAPNET
- MILO team: Heather Thibeau, A. Simone Sanders, Beshaun Davis, Alicia Fenley, Emily Barnard, Bediha Ipekci, Jada Gibbs, Vicky Zheng
- BIDMC Mentors: Matcheri Keshavan, Shirley Yen
- DMH partners: Kelly English, Theresa McIntyre, Margarita O'Neill-Arana
- UMass Donohue Institute: Dana Remian
- DMH parent partners & Home for Little Wanderers
- And most of all… the amazing caregivers who participated in this research!

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MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

The purpose of the MHTTC Network is technology transfer - disseminating and implementing evidence-based practices for mental disorders into the field.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office.

Our collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. We work with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals.
Our services cover the full continuum spanning mental illness prevention, treatment, and recovery support.

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