Motivational Interviewing in Palliative Care

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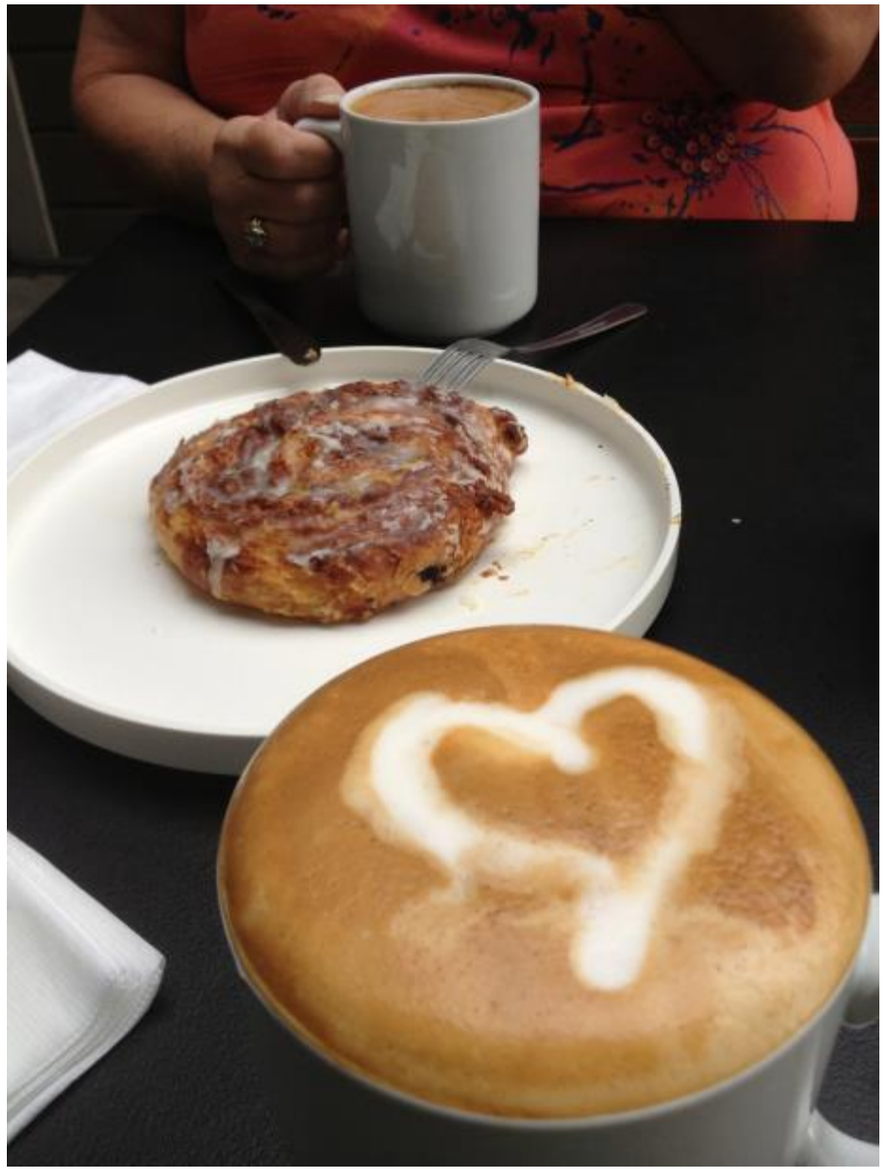
“The single biggest problem in communication is the illusion that it has taken place.”

–George Bernard Shaw

Introductions

- By show of hands
- Where you work and area of specialization



Objectives

- Contrast salient palliative care issues at the time of diagnosis, mid disease, and end stage.
- Evaluate cultural and linguistic aspects that affect communication.
- Identify four methods of verbal reflection.

Today's Session

- Review studies
- Skills & Practice
- Notice our own triggers & reactions

Exercise

Studies

- Many clinicians say communication with families is the most stressful part of their job
- Clinicians speak over 70% of the time
  - McDonagh, et al. 2004

Pitfalls

1. Giving Pathophysiology Lectures
2. Forcing your agenda
3. Offering reassurance prematurely
4. Pushing the family to make a decision
5. Talking too much

Arnold, R.,2010

Empathy

Brene Brown on The Power of Empathy

http://youtube.be/1Evwgu369Jw

Empathy

How do you display empathy?

How do you recognize empathy?

“People don’t care about how much you know till they know how much you care.”

–Theodore Roosevelt

Disease Trajectory

- Needs early after diagnosis
- Transition in the mid stages of disease
- Late stages

Demo #1

- It happens everyday
  - What did you see?
- How’s that working for you?
  - What went right?
  - What was the affect on communication?

Demo #2

- What was different?
- How did that feel as a family member?
- What was the result of the shift in method?

Tips

1.Recognize your own agenda

2. Sit down

3. Be curious- find out what they’re about

4. Listen

5. Ask permission

Body Language

- Between 55 and 70% communication is non-verbal
- In emotional situations body language usually prevails over words
- Patients feel vulnerable and search for non-verbal cues

Hall, Edward 1959
Weitz. W. (Ed). 1974
Stepanikova, Irena. 2004

Body Language

- Greet patient/family in a friendly manner
- Shake hands if culturally acceptable
- Sit down, eye on same level as patient
- Sit closest to patient
- Try and look relaxed even if you don’t feel it

Body Language

- Feet flat on ground
- Heels and knees together
- Shoulders dropped
- Hands flat in lap
- Smile
- Make eye contact (while family talking)
- Break eye contact (if angry or crying)

Buckman, Robert. MD. 2009

Listening Posture

- Keep your lips pressed together
- Nodding, smiling
- “Uh-hmm”
- Avoid interrupting
- Slight lean forward

Buckman, Robert. MD. 2009

Universal Emotions

- Happiness
- Sadness
- Anger
- Disgust
- Contempt
- Surprise

http://www.ekmaninternational.com/paul-ekman-interanatonal-pic-home.aspx

Cues to Avoid

- Tapping fingers, pens, pencils
- Clenching fists
- Yawning
- Looking out the window
- Tapping your feet
- Crossing arms or legs
- Shifting weight from one foot to another

Rogers, C. 2002

“Do not condemn the judgement of another because it differs from your own. You may both be wrong”

—Henry Wadsworth Longfellow

Motivational Interviewing

- **Motivational Interviewing** is a method that works on facilitating and engaging intrinsic **motivation** within the client in order to change behavior. MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Hidden Dynamics

- Resistance
  - Patient/family resist discussing the future
  - Disagree with clinician’s point of view
  - Argue against the treatment plan

Hidden Dynamics

- Ambivalence
  - Sometimes patients and families are ambivalent and unable to make a decision
  - They may be forced to choose between two undesirable options

- “A practitioner who is listening, even if it is for just a minute, has no other immediate agenda than to understand the other person’s perspective and experience.” (Rollnick, Miller, and Butler, 2008, pg. 66.)

Motivational Interviewing

R- Resist the Righting Reflex

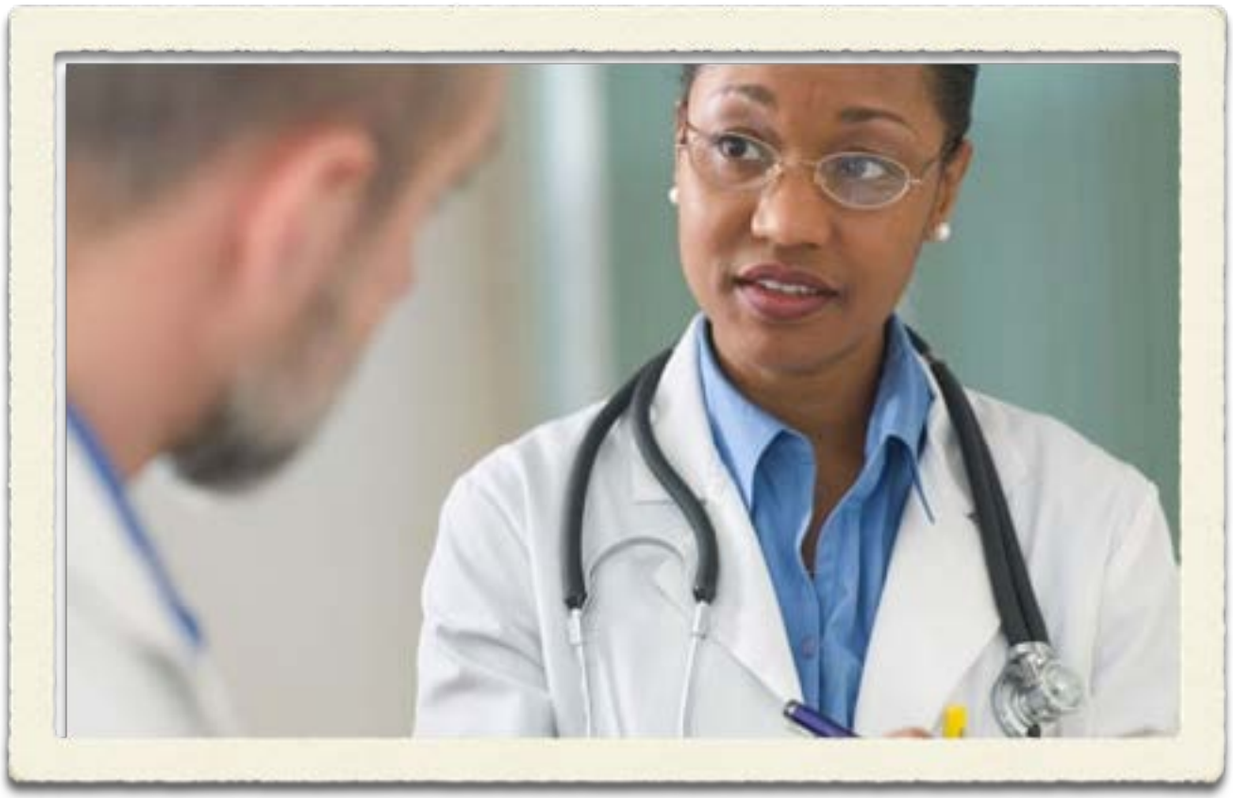
U-Understand the patient’s motivation

L-Listen

E- Empower the patient

Reflective Listening Skills

- Open-ended questions
- Repeating
- Rephrasing
- Paraphrasing
- Reflecting



Open-Ended Questions

What do you understand about your condition?

How do you think you loved one is doing?

What complications are you aware of that may occur?

What do you understand about CPR?

What would your loved one say if they could talk?

Reflective Listening
Simple Reflections

- **Repeating**-
  - repeat an element of what was said
- **Rephrasing**-
  - re-word *without* interpretation

Reflective Listening
Deeper Reflections

- **Paraphrasing** - infers meaning
  - Statement: I don't like thinking about the possibility of being in an nursing home.
  - Reflection: Being in a nursing home would be unacceptable to you.

Reflective Listening
Deeper Reflections

•**Reflection of Feeling**- emphasizes emotional content

- Statement: I don’t want to suffer. My mother did and it was awful.

- Reflection: The thought of suffering really upsets you.

Skills Practice

- Approach /Avoid Exercise
  - Open-ended questions and reflections
  - 60 year old diabetic “non-compliant” female w/foot ulcer

Other techniques

- Acknowledge
  - This must be difficult
  - I can’t imagine how hard this must be
- Validate
  - You are doing exactly what an agent should do
- Normalize
  - Often families of people with
  - Feel a bit awkward about making a loved one DNR. Do you have any of those feelings?
- Silence

Explore for Meaning

Helpless	Just pull the plug	Tough it out
Dignity	Useless Existence	I can still beat it
Control	Nothing else can be done	I’m not dead yet
Hopeless	Dependent on others	I’m a fighter
Suffering	No way to live	I believe in miracles
Lingering	I have faith in God	Not going to give up
Vegetable	Don’t want to be a burden	I can’t do anything

Burden
Vegetable
Suffer
Do things right

Common Concerns

Patient

- Silent due to denial, fear or painfulness of conversation
- Suspicious about provider’s motive for discussion
- Other priorities, symptoms/finances/family stress

Agent

Common Concerns

Agent

- Dominates conversation
- Wishes are in conflict with patient
- Stronger personality than patient
- ANGRY family

Working with Interpreters

- **Prepare the interpreter before the meeting and debrief afterwards**
- **Use first person and talk directly to the patient/family**
- **Maintain eye contact**
- **Minimize jargon; avoid humor, metaphor, proverb**
- **Give information in short bits and pause for interpretation (1-2 sentences)**
- **To test understanding ask the patient/family to repeat If you need to talk directly to the interpreter, use his/her name or “interpreter**
- **For more information: https://www.aamc.org/students/download/70338/data/interpreter-guidelines.pdf**

Working with Hearing Loss

- Ask if patient has hearing aids or uses an assistive device
- Ask family or caregiver for tips on how best to communicate
- Minimize background noise
- Use a deep voice
- Look directly at the patient

Working with Hearing Loss

- Slow down and speak clearly
- Use written communication to supplement important points
- Paraphrase rather than repeat
- Consider using a amplifier, pocket talker
- If person skilled in ASL, use an interpreter

http://ucsfhealth.org/education/communicating with people with hearing loss/

Resources

Arnold R. et al. (2010). Educational modules for the critical care communication (C3) course-A communication skills training program for intensive care fellows

Back A, Arnold R, Tulsky J. (2009) Mastering Communication with Seriously Ill Patients. Cambridge University Press: New York.

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Matulich, Bill (2013) How to do Motivational Interviewing: A Guidebook, Second Edition.

Miller, WR & Rollnick, S. (2012) Motivational Interviewing: Helping People Change, Third Edition. The Guilford Press: New York.

Resources

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Weitz, W. (Ed.) (1974). *Nonverbal Communication.* London:Oxford University Press

www.motivationalinterviewing.org

www.motivationalintervieingonline.com