

Utilizing Motivational Interviewing and Goal Attainment Scaling Across Disciplines in PCS Treatment

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Disclosures

Alina Carter and Mary Ann Williams-Butler are full-time employees of Emerson Hospital

Learning Objectives

- Describe rationale for the use of MI and GAS as part of concussion treatment
- Define and discuss key elements of MI including definition, three levels of listening, use of PACE and use of OARS components
- Describe GAS including definition and process of setting long-term and incremental goals based on functional patient needs
- Demonstrate ability to use key elements of SMART goals to develop appropriate GAS goals
- Practice MI and GAS approaches in the context of PCS treatment to optimize outcome

“Things do not change
We change”

Henry David Thoreau David

Thoreau

Post-Concussive Syndrome

Four Main Symptom Domains

Somatic, Cognitive, Affect, Sleep Dysfunction

Protracted symptoms

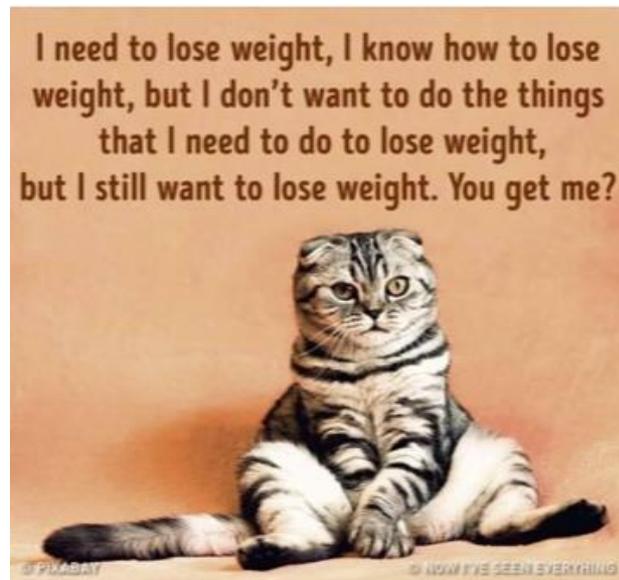
Neurogenic vs Psychogenic vs Behavioral Factors

Persistent concussion symptoms = Long-term dysfunction

Rabinowitz & Levin, 2014

Motivational Interviewing

Arranging conversations so that people talk themselves into change based on their own values and interests



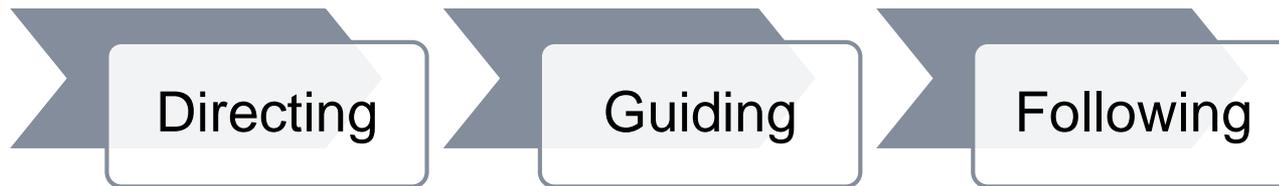
Defining Motivational Interviewing

Motivational Interviewing is

- a collaborative, goal-oriented style of communication with particular attention to the language of change
- designed to strengthen personal motivation and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion

Miller & Rollnick, 2013

Helping Conversations on a Continuum

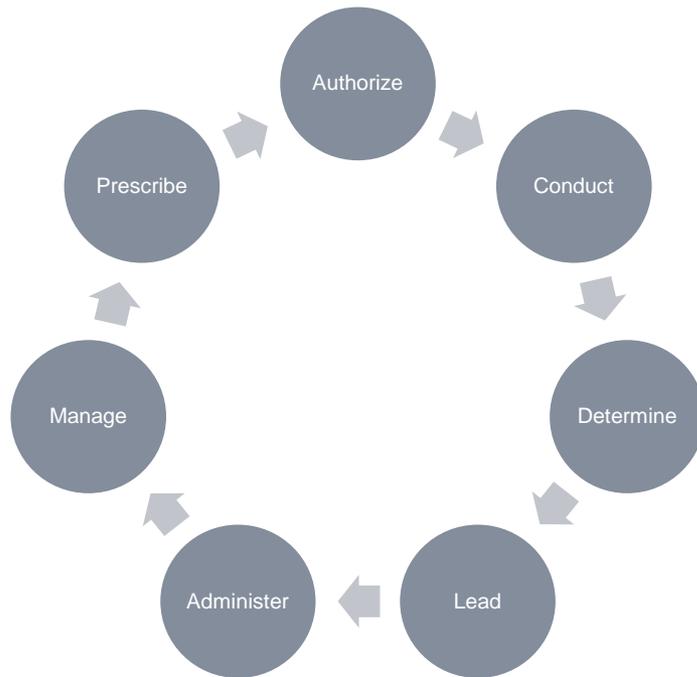


Helping Conversations - Directing



Provide information, instruction, and advice

Tell what to do and how to proceed

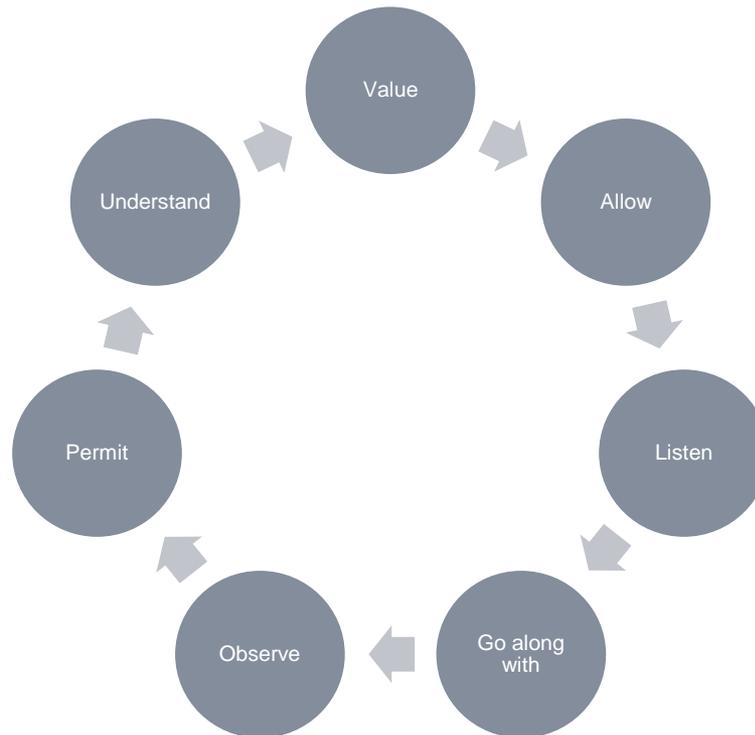


Helping Conversations - Following



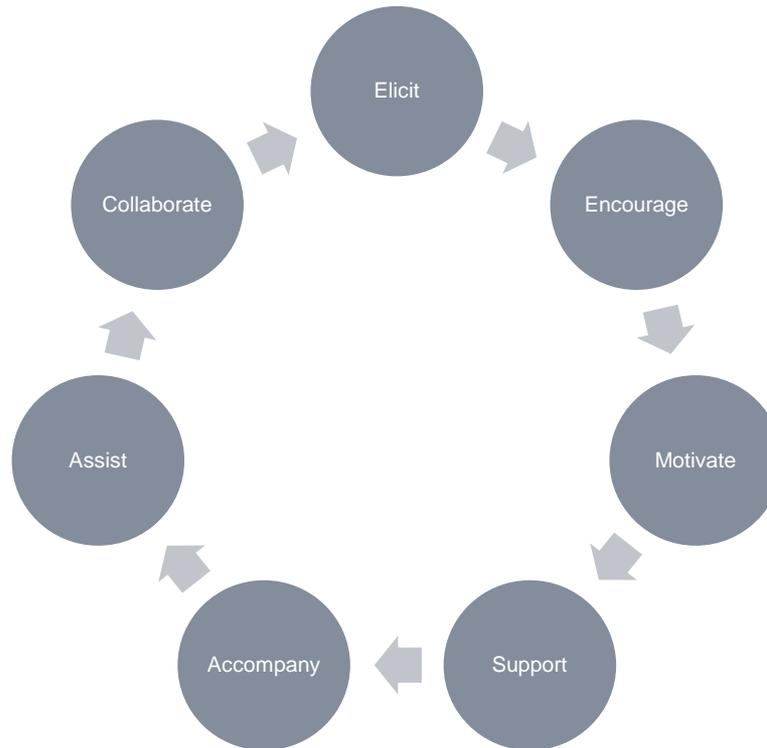
Good listener who takes interest in what other person says

Seeks to understand and respectfully refrain from inserting their own material



Helping Conversations - Guiding

Good listener who also offers expertise where needed
MI lives here incorporating aspects of directing and following



Ambivalence

Most people who need to make a change
are ambivalent about doing so

Ambivalence -> simultaneously wanting and not wanting
something or wanting two incompatible things

“Yes, but...”



Ambivalence

- Normal part of the change process – if ambivalent, one step closer to changing
- Most common place for people to get stuck on way to change
- Path out of ambivalence -> choose a direction and follow it
- The ***patient*** should be voicing the reasons for change

EXERCISE #1

Person 1: Choose something you have been thinking about changing, should change, want or need to change, but haven't done yet. A change you are ambivalent about.

Person 2: Tells you how much you need to make this change, gives you a list of reasons for doing so, emphasizes the importance of changing, tells you how to do it, assures you that you can do it, and exhorts you to get on with it.

How did you respond?

EXERCISE #1

Follow Up Discussion

BEWARE – The Righting Reflex

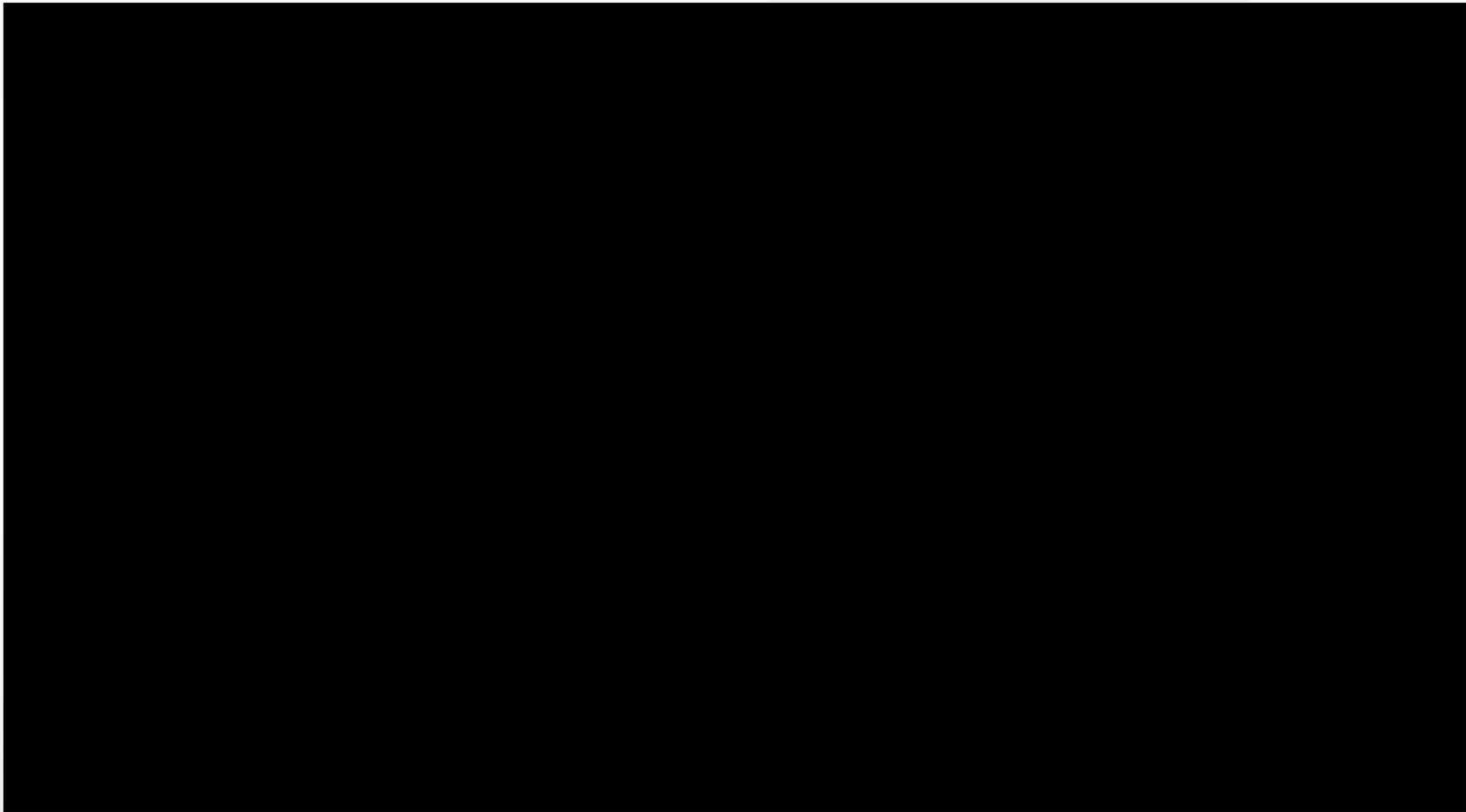
Involves belief that you must **convince** or **persuade** the person to do the right thing

With the Righting Reflex, you believe the patient will change if only I...

- ask the right questions
- find the proper arguments
- give critical information
- provoke the decisive emotions
- pursue the correct logic



People often will feel bad in response to the righting reflex which doesn't help them to change



People are more likely to be persuaded
by what they hear *themselves* say

Key Elements of MI - PACE

Partnership
Acceptance
Compassion
Evocation

Partnership

Like a dance rather than wrestling match

NOT a way of tricking people into changing

IS a way of tapping their own motivation and resources for change



Acceptance

Includes providing:

- absolute worth
- accurate empathy
- autonomy support
- affirmation

Clinician's approval or disapproval is irrelevant.

Compassion



To give priority to the other's needs



Evocation

Deficit Model => the person is lacking something that needs to be provided

Implicit message is, “I have what you need, and I’m going to give it to you.”

I have...

- knowledge
- insight
- diagnosis
- wisdom
- reality
- rationality
- coping skills

Evocation (cont)

Strengths-Focused Model => people already possess much of what is needed

People who are ambivalent about change already have both arguments within them – those favoring change and those supporting status quo

They already have their own positive motivations for change

Their internal voices more persuasive than any arguments *you* might provide

Clinician's role => evoke and strengthen already existing internal motivation for change

EXERCISE #2

Person 1: Talk about something you want to change, should change, need to change, have been thinking about changing, but haven't changed yet.

Person 2: Gives no advice at all instead asks you questions and listens respectfully to what you say.

- Why would you want to make this change?
- How might you go about it in order to succeed?
- What are the three best reasons for you to do it?
- How important is it for you to make this change, and why?

Listener then gives back a short summary of what speaker has said.

Then listener asks one more question: "So what do you think you'll do?"

EXERCISE #2

Follow Up Discussion

How to get there? OARS

Based on Miller & Rolnick (2013)



OPEN questions asked => invites person to think before responding, promotes dialogue and means to solicit additional information in a neutral way

AFFIRMING => comment on something positive about the person

REFLECTING => allows person to hear again the thoughts and feelings they are expressing, perhaps in different words

SUMMARIZING => reflections that pull together several things a person has told you

Informing and Advising



Informing and Advising





Person-Centered Care
vs.
Therapist-Centered Care

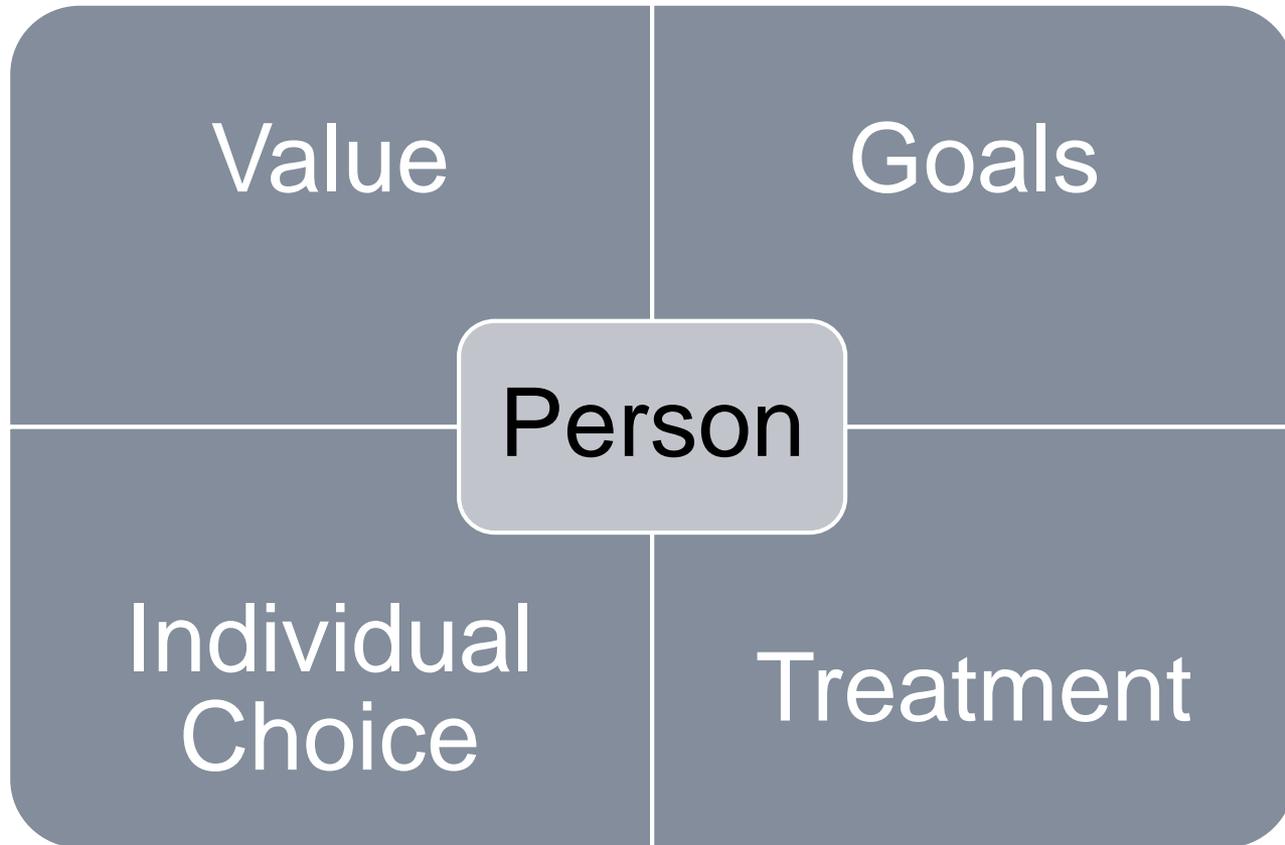
Person-Centered Care

Same injury same problems?



Treat the symptoms not the concussion. Treat the person not the patient.

Person-Centered Care



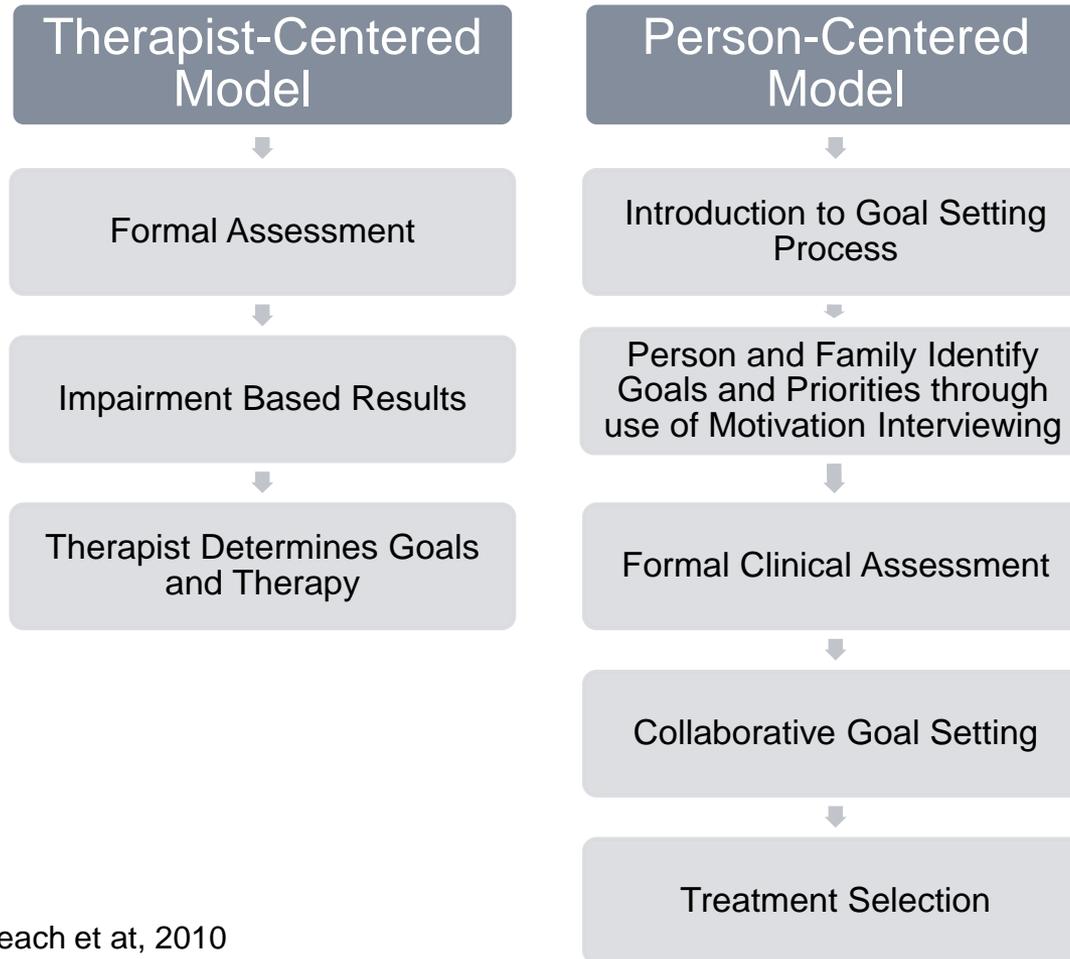
Brummell-Smith et al, 2016

Person Centered Care

WHO-ICF

- Maximize functional improvement that are important to the individual.
- Optimize participation in meaningful tasks

Models of Care



Adapted from Leach et al, 2010

Models of Care

Therapist-Centered Goals Examples

1. Patient will recall 4/5 objects in a delayed recall task.
2. Patient will respond to auditory comprehension questions with 90% accuracy.
3. Patient will cross off 90% of targets in symbol cancellation task.

Models of Care

Person-Centered Goal Examples

1. Patient is walking 10 minutes everyday.
2. Patient is cooking with the support of her spouse 2x/week.
3. Patient contributes to book club conversation 2x/meeting.

Person-Centered Care

Let's Try!

1. Read Case History
2. Each Group Identify One Person-Centered Goal.

Person-Centered Care

After conducting a motivational interview, the clinician may discover...

- JP would like to improve tolerance for studying.
- JP would like to return to socializing with his friends.
- JP would like to return to soccer.
- JP would like to improve tolerance to reading textbooks.

Triple Aim

1. Best Outcomes
2. Best Patient Satisfaction
3. Best Value (Lowest Cost)

But how do we measure change?



Goal Attainment Scaling

GAS

- 5 Point Scale
- Individualized Criterion-Referenced Measure
- Accountable for specific time frame
- Patient rates Current Level of Importance
- Patient Involved Throughout

Goal Attainment Scaling

Development of GAS goals

- Developed in 1968 (Kiresuk and Sherman) to evaluate mental health problems
- 1969 The National Institute of Mental Health provided funding to develop, implement, and disseminate.
- Currently used to evaluate service delivery in rehabilitation, education, and medical fields.

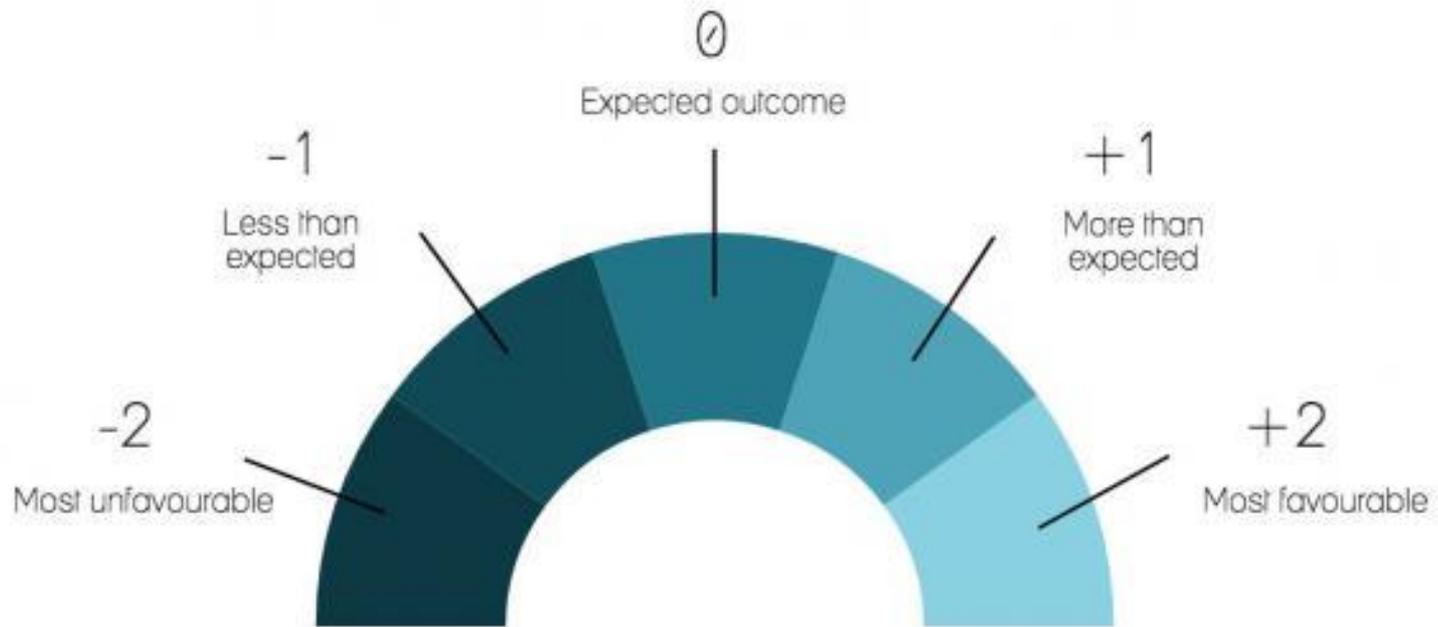
Goal Attainment Scaling

How to Write a GAS Goal

- Step 1: Person/Family Interview to determine goals and values that determine what needs you can help meet.
- Step 2: Help patient prioritize
- Step 3: Break down the goal to relate to your practice (Cognitive Rehabilitation Therapy, Physical Therapy, Occupational Therapy, Education etc.)
- Step 4: Use motivational interviewing with the person/family to determine what “success” looks like.
- Step 5: Determine specified period to work on each goal (e.g. 3 months)

Goal Attainment Scaling

GAS



Dept. of Veterans' Affairs

Goal Attainment Scaling

How to Write a GAS Goal

Recommend identifying 2-3 GAS
Goals at a time

Goal Attainment Scaling

How to Write a GAS Goal

Write in the present tense.

“I read my newspaper for 20 minutes”

vs.

“I want to read my newspaper for 20 minutes.”

Goal Attainment Scaling

How to Write a GAS Goal



J6 Design

Goal Attainment Scaling

How to Write a GAS Goal

SPECIFIC

Is my goal specific?

Improve cognition

Vs.

Remember medications

Goal Attainment Scaling

How to Write a GAS Goal

Measurable

How does this goal reflect success?

- Yes or No?
- Specific days/months/times

Goal Attainment Scaling

How to Write a GAS Goal

Attainable

Do I have the resources to attain success?

- Is the person equipped with appropriate strategies?
- Does the person have an action plan?

Goal Attainment Scaling

How to Write a GAS Goal

Relevant

Is this relevant to my life right now?

- What is the person's priorities?

For example - Medication management means increased independence. Increased independence is my priority.

Goal Attainment Scaling

How to Write a GAS Goal

Time Based

Can I include a specific time frame for this goal?

Remember medications

VS.

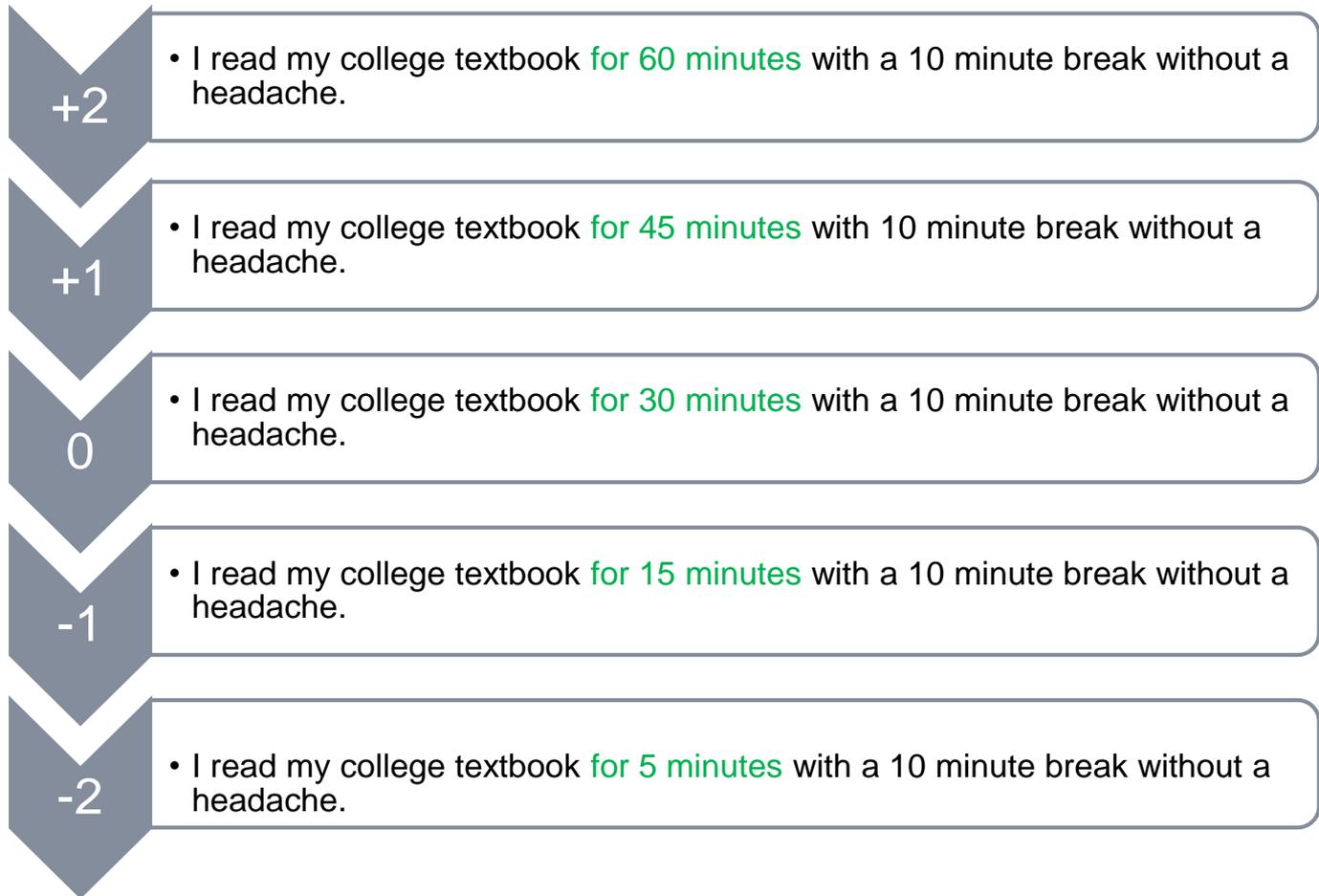
Remember medications independently in 2 months.

Goal Attainment Scaling

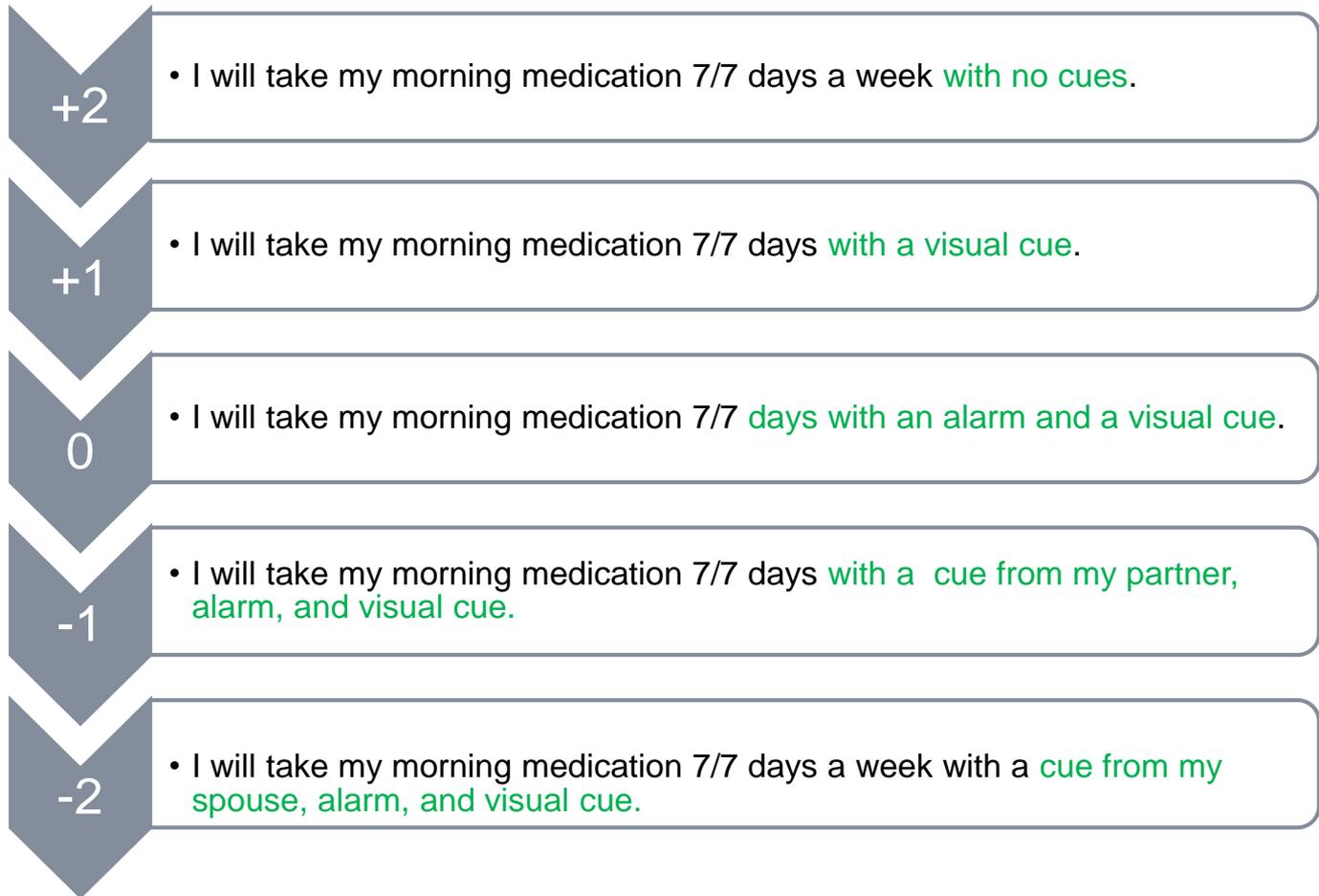
How to Write a GAS Goal

Improvement should be measuring one variable of change, keeping others constant.

Goal Attainment Scaling



Goal Attainment Scaling



Goal Attainment Scaling

GAS Documentation – SOAP NOTE

Objective:

Memory: Patient is currently at a -1 (Taking daily medication with a visual cue.) Set up alarm in patient's iphone for medication reminder in the am/pm. Patient is working towards GAS goal score of 0 (Taking daily medication with reminder from phone alarm.) Provided step-by-step written instructions to set alarm on phone.

Assessment:

Patient has progressed from a GAS score of -2 to -1 in the two weeks. He has independently shifted from using a visual cue as well as a reminder from his wife to just using a visual cue to take his medication. Patient is motivated to work towards his goal of relying solely on the auditory cue of his phone alarm for medication management. Discussed functional applications of using an external auditory memory cue for other short-term memory daily needs. Patient was independent with inputting a phone alarm into his phone by the end of the therapy session.

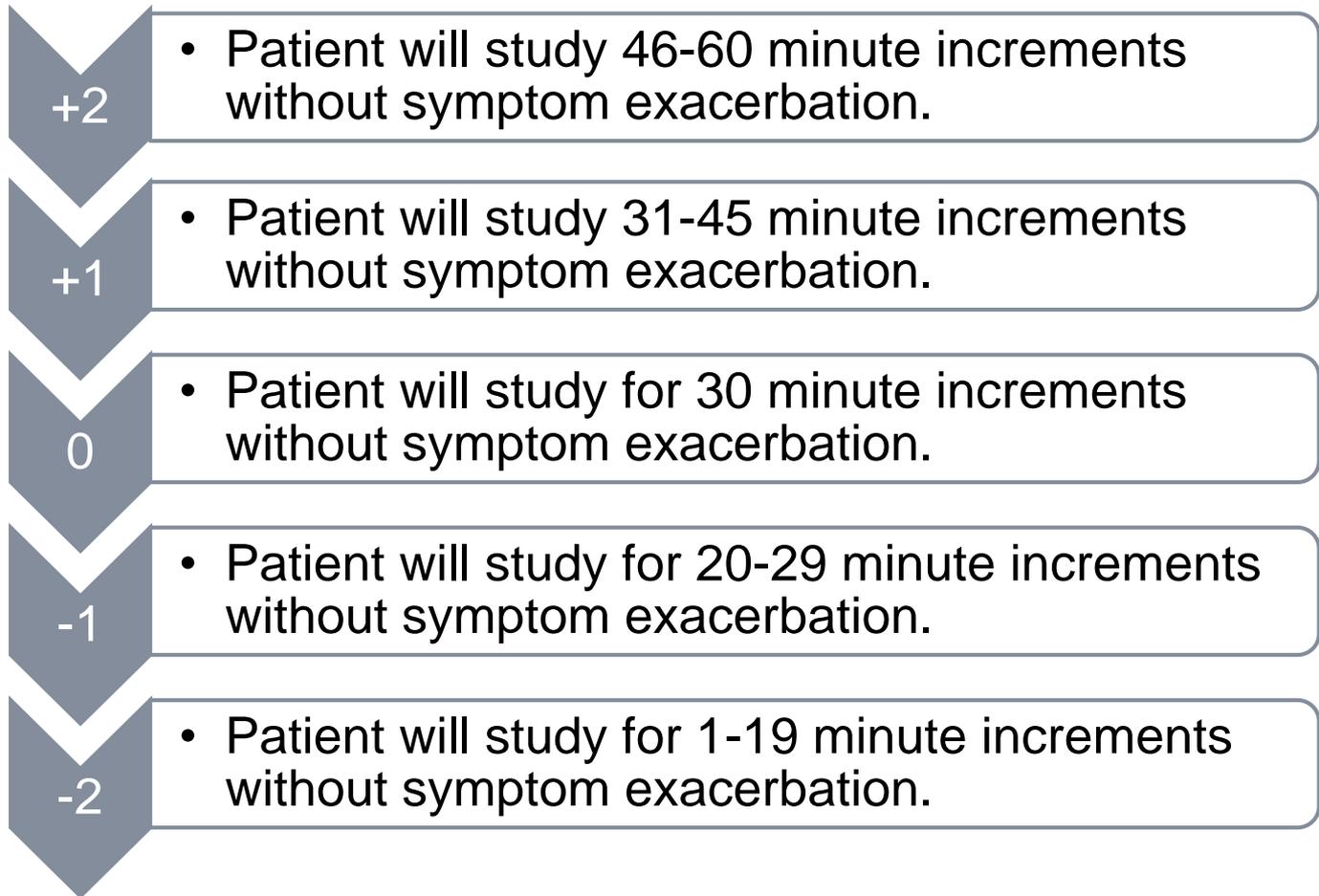
Goal Attainment Scaling

Let's Try

Get into groups and scale the goal you previously identified up and down. Remember, try to change only one variable.

+2	
+1	
0	
-1	
-2	

Goal Attainment Scaling for JP Example



Goal Attainment Scaling

What can we measure?

- Skill Level
- Efficiency
- Strategy use
- Family Support
- Education
- Environmental Modification

Goal Attainment Scaling

What can we measure?

$$T = 50 + \frac{(10 \sum W_i X_i)}{\sqrt{(1 - r) E W_i^2 + r (\sum W_i^2)}}$$

Goal Attainment Scaling

Merits

- Criterion referenced vs. norm referenced
- Measures individual goals
- Measures functional goals
- Promotes cooperative goal setting
- Reflects person-centered model
- Can yield a numeric score for analyzing group performance

Goal Attainment Scaling

Potential Benefits

- Improved delivery of intervention
- Improved clarity of treatment objectives
- Realistic expectations
- Improved patient satisfaction
- Improved motivation

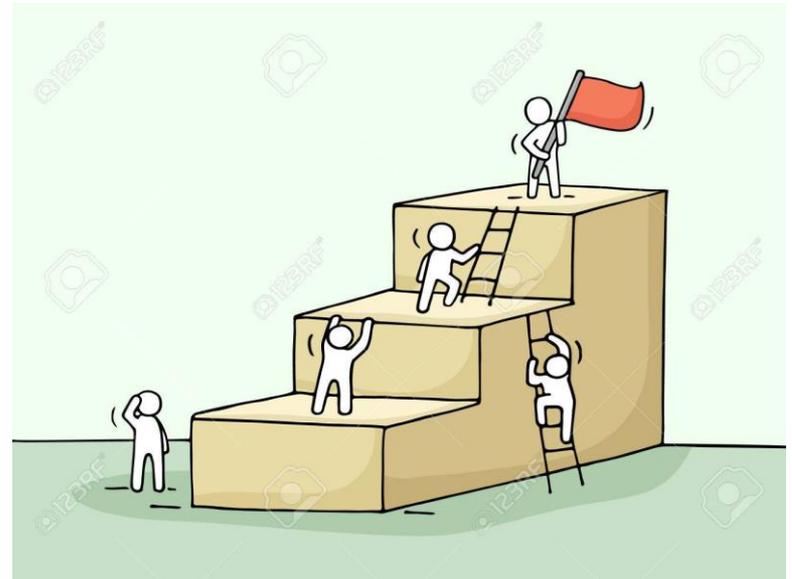
Putting MI & GAS Goals Into Practice

- Anticipated challenges?
- Individual practice applications?
- Barriers to success for the clinician?
- Barriers to success for the patient?

In Conclusion

Faith is taking the first step
even when you don't see the
whole staircase.

-Martin Luther King, Jr.



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