Talking to Change: An MI Podcast
Glenn Hinds and Sebastian Kaplan

Episode 13: MI with CBT and Health Behaviour Change with Adolescents, with Dr. Sylvie Naar

Sebastian Kaplan:

Hello, everyone, and welcome to the latest episode of Talking to Change: A Motivational Interviewing Podcast. I am Sebastian Kaplan based out of Winston-Salem, North Carolina in the US and joined, as always, by my good friend, Glenn Hinds, from Derry, Northern Ireland. Hey, Glenn.

Glenn Hinds:

Hey, Seb.

Sebastian Kaplan:

So, as we often say, that we're excited about today's episode. We have a wonderful guest. We're sure to have a really interesting conversation. But before we get started with that, Glenn, why don't we do some orienting to where the audience can find us?

Glenn Hinds:

Sure, Sure. So, our Facebook page is Talking to Change. Our Twitter handle ChangeTalking. We've been receiving some great feedback and conversations on that, and we encourage people to continue to do that. We've got a question for Sylvie today from Rory, that has come through the Twitter, so thanks for that, Rory. And then our email address is podcast@glennhinds.com.

Sebastian Kaplan:

Great. Yeah, I'm glad you did that, Glenn. Posing the question ahead of time. This podcast thing is relatively new for both of us, so I like that as something that we've learned along the way to start doing. Because we always wanted feedback and questions about particular episodes or future episodes, so I thought that was a nice touch. So, yes. Rory, thanks so much for contributing to today. Okay, and I apologize if I'm coughing a bit. I'm a bit under the weather. I might have to clear my throat on occasion.

Sebastian Kaplan:

Alright. So, now to introduce our wonderful guest. Our guest today is Sylvie Naar. Sylvie is the Distinguished Endowed Professor in the College of Medicine's Department of Behavioral Sciences and Social Medicine at Florida State University, where she is the Founding Director of the Center for Translational Behavioral Science. She is trained as a pediatric health psychologist and has conducted health disparities research with minority youth for the past 20 years. She has had several federally funded projects developing and evaluating interventions to improve health behaviors in adolescents. She has both clinical and research expertise in behavioral interventions for youth living with HIV,

focusing on adherence to medications, adherence to appointments, substance use, and sexual risk. She has had several federally funded projects utilizing Motivational Interviewing to improve health behaviors in adolescents, both in randomized clinical trials and in implementation evaluation contexts.

Sebastian Kaplan:

She has had experience in multi-site evaluation studies of complex, multi-level interventions for Health Resource and Service Administration's Special Projects of National Significance and the National Institutes of Health clinical trials. She has worked with the Adolescent Trials Network for many years. She has been the principal investigator on two multi-site trials within the Adolescent Trials Network for HIV/AIDS, and she is on the Behavioral Leadership Group for this network.

Sebastian Kaplan:

Finally, she is a national and international expert on Motivational Interviewing with particular emphasis on adolescents and young adults. She is a member of MINT, and she has worked closely with the developers of MI, Bill Miller and Steve Rollnick, to author the first textbook focusing on adolescents and young adults for Guilford Press' Motivational Interviewing series. She has provided numerous MI trainings to agencies and treatment organizations locally, nationally, and internationally. Both her training and her research have utilized practitioners from multiple disciplines, including community health workers, to deliver Motivational Interviewing.

Sebastian Kaplan:

One additional piece to her bio is she's also the co-author of a recently released book entitled Motivational Interviewing and Cognitive Behavioral Therapy: Combining Strategies for Maximum Effectiveness, also put out by Guilford Press.

Sebastian Kaplan:

Sylvie, it is a great pleasure to have you on. Thanks for joining us.

Sylvie Naar:

Thank you for having me.

Sebastian Kaplan:

Like we said, there's lots of places where we could go with such a rich career that you've had up to this point, but we thought it would be nice to just hear your MI story from the start. So, maybe we could start with that. Where did you first hear about MI, and then we'll take it from there.

Sylvie Naar:

Sure. So, back in... and I'm going to age myself... '94, '95, I started off as a psychology intern at the Children's Hospital of Michigan, and I was working with kids with chronic

medical conditions, mostly from inner-city Detroit, and then we were supposed to refer them for psychotherapy and they were supposed to come into our offices and do traditional psychotherapy and then we would see them in the clinic for these sort of brief interactions. We were struggling with the fact that they weren't coming and weren't engaging in the traditional work that we did. And I was like, "There has got to be another approach." Also, when we were seeing them in clinic for the 10 or 15 minutes, it didn't feel like we were maximizing the potential. We were just doing assess and refer, assess and refer.

Sylvie Naar:

So, there was a colleague at Wayne State who was a really early MINTie, Steve Ondersma, and I was talking to him about these struggles. In fact, his future wife was my intern partner at the time. He was telling me about Motivational Interviewing. I said, "This could be really effective." He was in the substance abuse world, where MI had started, and I said, "This could be really effective in this setting."

Sylvie Naar:

So, I did a pilot study using MI with youth living with HIV. I wasn't yet trained in MI at the time. I was the PI and Jeff Parsons and colleagues trained my folks. I remember vividly watching a video of one of the sessions with this kid, who I had seen in my psychotherapy and didn't really get anywhere. He was responding, and he finally comes back and says, "Hey, I do think I want to use condoms," and he pulls out this condom and said, "Yeah, Dr. Naar gave me this condom months and months ago, and I never even thought to use it." It was just this eye-opening thing for me that the traditional things we were doing were just not effective, which was a lot of CBT-like stuff, but it was a lot of psychoeducation. Using the MI approach with this kid who I had struggled with was really eye-opening.

Sylvie Naar:

So, it wasn't until my next trial. I was busy having babies and all that, and then when I had my next trial, I said, "I want to be one of the therapists in the trial," even though I was PI. Then, actually ended up training before I actually even did MI. I kind of was following Jeff Parsons around as we trained people in five cities for my next trial, which was a multi-site trial of MI adapted for youth with HIV. That's when I became trained myself. I was sort of PI, but I was also a newbie in terms of delivering the intervention.

Glenn Hinds:

So, you learned by following a practitioner before you actually went away and trained specifically in Motivational Interviewing, and you were watching people practice it and looking...

Sylvie Naar:

Yeah.

Glenn Hinds:

It sounds like one of the things that drew you to it was that desire within you to... You saw things that weren't working in traditional settings and you said, "It would be great if there was something else."

Sylvie Naar:

Yeah.

Glenn Hinds:

MI seemed to offer you that.

Sylvie Naar:

Yeah. I was a researcher, so I was like, what in the literature has been shown to be effective with populations that don't really respond, and that was... Yeah.

Glenn Hinds:

So again, I imagine that there are lots of people listening to this today who will be recognizing that our patients, our clients, aren't engaging with our treatments. What can we be doing differently? And, I think, perhaps, there's an opportunity for us to learn from your experience today. What it is they can be thinking about differently, about how to engage, not just young people, but patients in general and treatments that they don't seem to want to be involved in at the moment.

Sylvie Naar:

Yeah. Absolutely.

Sebastian Kaplan:

I'm actually curious, because you were probably a well-intentioned, well-meaning intern and professional. Right? And just wanting the best for the clients that you were serving. What were you trying to do that wasn't working, and then what in particular struck a chord for you?

Sylvie Naar:

Yeah. I think I had some natural engaging strategies. The kids liked me, and I liked them. I also ran a camp program, and I connected with them. So, the humanistic kind of approach was working from that standpoint, but we weren't getting behavior change. We were doing a lot of, like I said, psychoeducation, a lot of skills teaching. "Here's how you put on a condom." "Here's a condom demonstration. Now you try it." That kind of stuff, and maybe also some psychotherapy of trying to get into the kid's thoughts and feelings around having HIV. All that kind of stuff.

Sylvie Naar:

The MI approach of really trying to figure out intrinsic motivation. "Why might this be important to you?" I remember vividly, for this kid, he actually had some issues with

potentially transmitting HIV to another sex partner. He just didn't see the risk of other people as being the motivator, and we always assume that's the risk. "You don't want to pass on HIV." His thing was, "Well, how do I know she doesn't have it? She didn't ask to use a condom." But, when we started getting into that he could catch other things that would make his health worse, that was his motivation. So, it was, again, eye opening of when we don't illicit what is going on with the individual, we have a lot of assumptions about why people might want to change, and our own biases obviously influence that process. So... Yeah.

Glenn Hinds:

Yeah. So, the harm that this individual was going to do to someone else in itself, would suggest that's a good reason for you not to do it, but it's not a good reason for this individual. What you are pointing out is that what we think will make people change itself is really interesting, but itself is not necessarily true for the person we are working with. And what MI offered is that opportunity to say, "Well, under what circumstances would you be willing to do it differently, or what would change your mind?" And that what is different.

Sylvie Naar:

Right. In the case I mentioned, he did have the skills. He was carrying the condom. That is what he is supposed to do. He had just never opened it. It was probably expired by the time he got into this MI session. That was another example, all the skills in the world are not going to make a difference if you don't have the motivation to use them.

Sebastian Kaplan:

So, a key early lesson there, I suppose, is connection, that therapeutic rapport, if you will, that's important, but it isn't necessarily enough to produce behavior change. And education. Relying a lot on advice giving, education. That's not always enough.

Sylvie Naar:

Yeah.

Sebastian Kaplan:

Yeah. The shift to searching for what was in it for them. What was the key reason that they could identify for themselves, or this kid in particular, to make that change?

Sylvie Naar:

Mm-hmm (affirmative). Yeah. Another early lesson. Another little story that I like was how MI allowed, through just these basic communication skills, allows you to cross cultural boundaries.

Sylvie Naar:

So, again, the kids that I was working with were almost exclusively African American, inner city kids. One of our therapists in this really early trial was Caucasian, Jewish-

American, lived in the suburbs, wealthy. And she's talking, using the MI skills, and it's working with this really difficult case. I remember he's talking about smoking blunts and drinking stuff that I don't even know what it was, and she goes, "I'm the whitest girl in America. Can you tell me in your own words what this means to you, and what you're doing?" And he cracked up and immediately just started talking about all kinds of behaviors. That was another learning lesson. Yeah.

Glenn Hinds:

So, her authenticity seemed to shift something for him?

Sylvie Naar:

Yeah. Her authenticity and also sort of like, "You're the expert. You teach me what your life is like." You know? And that is very much in the spirit of MI.

Sebastian Kaplan:

Right. The client as expert or seeing the work as a collaboration or partnership. To use the specific MI spirit terminology. The partnership between two experts, as opposed to just one expert in the room.

Sylvie Naar:

Mm-hmm (affirmative). Absolutely.

Glenn Hinds:

So, it sounds like that was all very exciting. It sounds like it really energized you in what you were witnessing, and it drove you forward. So, where did that take you? What lead you from that place to where you are now? Where else did you find yourself going?

Sylvie Naar:

I'm trying to think. So, from there I went into pretty much more traditional research trials. So, we had a multi-site study of Motivational Enhancement Therapy as applied to HIV, like I said, in five cities, which showed effects in viral load, substance use, and sexual risk behaviors. We also simultaneously were doing some computer-delivered MI with Steve Ondersma's group, and that was also very powerful to see. It's basically like an avatar that does reflective listening and affirmations and eliciting questions. To see that having effects in such a brief computer-delivered intervention was, again, eye opening to me about the power of what MI could do.

Sylvie Naar:

I was pretty much early on integrating MI with CBT-like interventions. I guess I could talk about that. So, at the same time that I was tearing my hair out with these adolescents/young adults with HIV, I was also working in diabetes and asthma clinics with kids that were more 12 to 16 younger kids that were engaged with their families. So, the HIV kids were 16 and up, and most of them, either their parents had died from HIV themselves, so they were on their own or in foster care or relative care, or they were over

18 and not connected with their families. So, we were doing a lot of individual work. But, with these younger 12 to 16 year olds, we were looking at family-based treatments, and we started working with a group that does multi-systemic therapy, which is an approach that has been used more with, juvenile delinquency originally, and then drug use. It basically allows for a menu of evidence-based treatments, but it's still a research methodology that you can test. So, it's home based, once or twice a week for six months doing mostly CBT-like and behavioral parent training interventions.

Sylvie Naar:

We were doing that, and publishing on that approach to improve diabetes and asthma adherence and health outcomes. So, we started integrating the two. The MST folks didn't do MI. They did their research, and MI was a different kind of research. They didn't really blend them. They talked a lot about therapeutic alliance and engagement, but they did it a little bit more in the abstract, like I think a lot of traditional CBT therapists do. It wasn't like, "Well, how do you use language to make that happen?"

Sylvie Naar:

After we were doing the studies, we started training the therapists in MI as another piece, and that's when I started thinking more and more about integration. That was happening kind of at the same time.

Glenn Hinds:

Again, what's interesting is that what you're saying is that you were doing lots and lots of research, and it sounds like you were doing lots of research with what probably could be described as quite isolated individuals whose lives were quite complex. But, what's also really interesting is that it seemed to be that the research was showing something positive, about what it was that you were doing and that the motivational interventions was having a beneficial impact. I imagine simply because that's something you're so used to it could be easily lost to the listeners to recognize that you were working with quite isolated people.

Sylvie Naar:

Yeah.

Glenn Hinds:

The research consistently was showing that doing it this way was really helpful for them.

Sylvie Naar:

Yeah. I think that's really true, and we never tested MI separate. You know, "Here's multi-systemic therapy with MI, and here's multi-systemic therapy without MI." It was more like in a real-world kind of setting. We're having therapists go out to the home and doing treatment, and we're going to train them the best we can. Yeah.

Sylvie Naar:

Later on, we moved into an obesity treatment study, where we did a more formalized kind of integration and started doing some of the communication studies like Moyers and colleagues do. Looking at what are the provider utterances that are sequentially linked to patient statements and all that kind of stuff. And I can talk for a long time about what that research showed.

Sylvie Naar:

Yeah. So, that was a big move in my career, integrating with MST and CBT. I was probably trained in CBT first. People always talk like, "Did you learn MI first, or CBT first, or both simultaneously?" I was trained more in the CBT first and behavioral treatments.

Sylvie Naar:

So, that's one shift, and then the other big shift in my thinking was just doing a lot of training. I was doing a lot of HIV research, but then on the side a couple of the clinics would say, "Hey, would you come and train our whole clinic? We didn't get to do X-Y-Z." So, I started learning a lot. I would still do what I do in research in my training, in terms of measuring outcomes and looking at fidelity and learning a lot about the struggles of what it's like to teach MI and get folks to practice MI to fidelity like a research trial, and differences between doing it in a research setting where you hire therapists who are hired for research purposes versus in the real world. That lead me to where I'm at right now, which is my research in using implementation science to really understand how do you get evidence-based treatments in the real world settings.

Sebastian Kaplan:

Some of those early years spent combing MI and CBT for several challenging health conditions, as well as MI and multi-systemic therapy, I wonder if you could think back and remember what was a particularly interesting or exciting finding in some of those early studies that you did?

Sylvie Naar:

When you say, "interesting finding", do you mean from an MI standpoint or from the health outcome standpoint? Or...

Sebastian Kaplan:

Well, I suppose either directly a finding about MI, or something that you learned about MI, or something that you've found that MI lead to as far as a health outcome.

Sylvie Naar:

Yeah. Well, I would say there's so many, I don't even know how to choose. Okay. I'll just go in order.

Sylvie Naar:

Sylvie Naar:

So, one of the early findings I thought was really interesting is we were using MI to target medication adherence, sexual risk, and substance use. Right? When you do MI, you have specific target behaviors and you're really focused on those target behaviors. But one of our earliest findings was that the MI group significantly improved in their depression scores. We were not targeting depression per se. This isn't our HIV kids, but it was clear that this approach with this spirit and affirmations and everything that MI includes really helped with depression. Again, these kids were not necessarily diagnosed with full-on depression, but they all had depressed mood from just virtue of what they were struggling with. We've seen that finding a couple of times across a couple of different studies, and I think that's really powerful. So, that's one.

Sylvie Naar:

I'm still going to say how hard it is to have people deliver MI with fidelity. We get people to beginner-level competency pretty easily but getting people to that more advanced-level competency, I'm not sure, especially with my work with community health workers, how often we get to that point. You can still get really good outcomes with beginner-level competency. That's the good news. We're doing lots of research in trying to figure out how to get people to that place. That's another one.

Sylvie Naar:

I have been just fascinated with the communication science studies that really pull apart what are the key elements of MI that are most powerful, at least from my populations, which is the minority youth. In our communication studies where we are doing all of that coding that I talked about what we're calling as a skill, and it's not labeled as a skill in traditional MI, but we call it "Emphasizing Autonomy". So, in spirit MI talks about autonomy, but I think it's a mistake that we don't say, "Well, how does that translate to a micro-skill?" So, we actually teach a micro-skill. You've got OARS, but we teach "Emphasizing Autonomy" as a micro-skill, because it just came across so strongly in our sequential analysis, and not only with the adolescents. Everyone is like, "Oh, adolescents' autonomy." But the parents too.

Glenn Hinds:

Right.

Sylvie Naar:

So, we actually did the same study with the parents, and that still came out really strong. So, we teach very specifically how do you emphasize autonomy with youth statements. How do you emphasize autonomy in the opening statement? We have a bunch of specific skills around that, that will probably be in the second edition of the MI adolescent book, which I am supposed to be starting this month, by the way.

Sylvie Naar:

So, that is huge for me. Then, the last one, which we can talk about later is what we are finding now about implementation science and why some individuals and some organizations uptake MI so well and some don't.

Glenn Hinds:

So, quite significant that findings are given that a lot of people who listen to podcasts are multidisciplinary 1 practitioners who don't necessarily have the opportunity, or maybe don't even plan, to go on and specialize in Motivational Interviewing practice. But, what it sounds like is that what your research shows is that even by making small changes to practitioner behavior can and does, have a significant influence on patient behaviors and quite interestingly, also unplanned benefits in their own experience of themselves and their mood.

Sylvie Naar:

I think that's absolutely true. My study that I'm working on right now is that we're taking 10 adolescent HIV clinics, and we're randomizing them two at a time to get two-day Motivational Interviewing workshop with follow up coaching. Everybody in the clinic comes, doctor, nurse, physicist, psychologists, social worker, outreach worker, paraprofessional staff. Basically, we're using beginner-level competency as our cut point. If you hit beginner-level competency then follow up coaching is optional, because these clinics are extremely busy. Then, maybe, one or two people might want to move on to become internal facilitators. But everyone else we're like, let's just get to beginner level, and that seems to be effective. Then, also an added benefit which people see is the experience of a whole clinic attending that two-day workshop creates this spirit of teamwork that everybody is telling us is just one of their favorite parts of the study.

Sebastian Kaplan:

So, you mentioned the levels of competency, whether it's beginning level or advanced level. People might be wondering...

Sylvie Naar:

About that?

Sebastian Kaplan:

How would I know if I was beginning level, or what is that?

Sylvie Naar:

Right. So, the original ideas of competency came from the MITI, the Motivational Interviewing Treatment Integrity codes and there's competency levels based on that. So, in our early trials we were using MITI, and you had to hit at least that beginner level of competency in order to be cleared to see participants. We've now developed this coach rating scale with item response theory methods, and I presented it at the conferences and we're going to have a paper out. It's actually in the MI and CBT book too. It's a 12-item measure that we use and based on the data we've actually identified four competency levels. It's novice, beginner, intermediate, advanced.

Sylvie Naar:

So, we actually now call it intermediate because before the MITI was below competency, beginner competency, and advanced and our implementation science studies said people get really discouraged when they see below competency. They hate it. Also, there was a lot of variability in those that were below competency. You had people that were just like really doing bad stuff and then you had people who were just not doing anything. I think there's a difference. And so, we actually go with beginner, novice, intermediate, advanced, and so that's where those cut points are. We did it in a data-driven way.

Sebastian Kaplan:

Mm-hmm (affirmative). And so, for those who don't know much about the MITI, it's both global elements of how the person is conducting the overall conversation, and then some very specific behavioral targets to achieve those proficiency levels. Right?

Sylvie Naar:

Right. Yeah, our rating scale includes items that are more global, and it includes items that are more specific, but it's not a behavior count. It's meant to be a one pass, like you listen to 15 minutes of interaction and you rate it and go. It's meant to be able to be done by a supervisor in a real-world setting.

Glenn Hinds:

So, there's something about being judged as well that perhaps learners are feeding back to us not just patients. That idea that you're messing around. It seems like to be in control of their own lives. It's not just kids that like autonomy, it’s adults as well. Perhaps it’s also true of us practitioners as well. We like to think we're doing a good job. We don't like being told we're not doing a good enough job.

Sylvie Naar:

Yeah.

Glenn Hinds:

And it sounds what you did as well, I wondered about the expectations that if you're saying to people, "Look, we're not trying to train you to be experts, so don't be leaving here trying to be an expert. But here's some things that might be helpful."

Sylvie Naar:

Right.

Glenn Hinds:

The people who took that away got on with it, and the people who were a bit more curious came back and asked for more.

Sylvie Naar:

Exactly. It becomes really important too because we do get a lot of, "Well, I'm not a therapist. I don't do this. Why do I have to learn this?" Versus really seeing MI as a method of communication. Yeah.

Sebastian Kaplan:

That seems like a really important and interesting point that while a lot of people do MI are mental health practitioners of various backgrounds, what MI ultimately is a form of communication. Anyone having a conversation with someone who is considering a change, or trying to make a change, this would be relevant for.

Sylvie Naar:

Mm-hmm (affirmative). Right.

Sebastian Kaplan:

So, one thing that you had mentioned too that I was curious to hear more about, and I imagine some people in the audience are wondering about, this "Emphasizing Autonomy", not necessarily the coding aspect of it. But this seemed like a really powerful thing that you were observing and were finding maybe some links to outcomes. So, what are some examples of how your clinic staff and the therapists that you're working with, how do they emphasize autonomy?

Sylvie Naar:

Well, one is emphasizing autonomy with youth statements. Like, "This is really your choice." In the MI book, they talk about emphasizing personal responsibility, but we really like to get to specific language, so that's why we call it the youth statements. We teach people it's not your problem or your diabetes, but your choice, your plan. And, we always laugh about how we're trained to say, "we". "We're going to figure this out." "We're going to make up a plan." But we want them to take responsibility, it's not my plan it's your plan. So, using that kind of language is one thing.

Sylvie Naar:

We actually teach provide elicit as a strategy of emphasizing autonomy. "What do you know about diabetes?" "What do you think about this plan?" You know, eliciting feedback. That's another one. Then the clarifying your role as a guide. "I'm not here to tell you what to do or how to do it. But, to figure out what changes you want to make and what's the best plan for you." Those are some examples.

Glenn Hinds:

Again, it's about the spirit of collaboration.

Sylvie Naar:

Yeah.

Glenn Hinds:

These "you" words, this is some of the language that communicates our desire to be collaborative. But, it also sounds like when you're doing this it's not just from the teeth out, as they would say, it really is a case of, "I do trust in you that you can work your way through this with some support. If I can be supportive of you. I can offer that to you, but I'm not going to force this change on you."

Sylvie Naar:

Right.

Glenn Hinds:

I think that's one of the things that I think a lot of people hear what it is that MI talks about and they recognize the words, and they say, "Oh, we already do that.", because they recognize the words.

Sylvie Naar:

Yeah.

Glenn Hinds:

It's the actual being collaborative, rather than talking collaboratively.

Sylvie Naar:

Yeah. You have to do both. We still teach MI spirit first, but then we move pretty quickly into this language of emphasizing autonomy. Yeah.

Sylvie Naar:

And then, I guess the other thing is, we don't teach reflection as a general thing that you do. We teach reflections of change talk. In the old days, I used to just do what we did, which is like, "Let's do batting practice here until you learn reflections." And you'd reflect everything. Now, I think our research is confirming what's been out there, that it's reflections of change talk that really leads to more change and reflections of counter change have led to more counter change talk.

Sylvie Naar:

So, we only teach reflections in terms of change talk because I believe when you're learning, you latch on to the first thing you learn. You really do. Then, you may not get anything else, and then if I teach reflections of everything, that's what you latch on to. Then when I later on try to fine tune it to change talk, I lose that.

Sylvie Naar:

So, it's not that we don't want to reflect other things. We teach expressing empathy, but we don't teach just generic reflection.

Glenn Hinds:

It's very targeted with a particular emphasis, knowing the outcome in advance. So, why in inverted commas waste their time reflecting the stuff when the gold is over here. Let's reflect the gold.

Sylvie Naar:

Right. We still will teach reflections of feeling as part of expressing empathy, because I don't want to lose that. Just because your only reflection change talk, it doesn't mean that if someone is expressing pain you don't acknowledge it. So, we teach that almost separately. Then we focus on reflections of change talk.

Sebastian Kaplan:

I see. I was curious what the distinction was with expressing empathy and not focusing on reflection. I guess in my mind, the way we express empathy is through reflection.

Sylvie Naar:

Right. I try to teach expressing empathy around things that are around emotion, but I really don't want my folks going like, "You really don't want to do this. You really don't want to quit smoking weed." I don't want them to focus over and over on that. I want them to maybe express empathy and say, "This is really hard for you." In that way I try to kind of frame those as feeling reflections and keep those separate as part of expressing empathy. Then focus my basic reflections as change talk.

Sebastian Kaplan:

I see. Yeah, this might be a really important point for someone who's first wanting to use MI with some of the challenging health behaviors in their work. As we know, clients aren't all just going to sign up for change right away, and they might say something like, "But I really want to keep smoking marijuana." And you have moved away from reflecting that content directly and more so a reflection of the difficulty in change. But not necessarily even mentioning marijuana use per se.

Sylvie Naar:

Well, what I would do, because we still teach them about how to respond to counter change talk and discord, but we focus on autonomy. So, if someone says to me, "I don't really want to quit smoking weed. I don't see a reason for it." I don't want to reflect, "you don't see a reason for it." I want to reflect, "It's really up to you. It's your choice, when you're ready." I would much rather my practitioners respond to that with emphasizing autonomy than with a simple reflection of counter change talk. Because the research shows that those emphasizing autonomy statements tend to lead to change talk more, whereas the reflections of counter change talk don't.

Glenn Hinds:

There's quite a few different steps in the dance that we endeavor to do to help with people. The more aware of what it is we are trying to achieve and learning from what researchers like yourselves is showing that if you reflect this then chances are your patient is going to move particular direction, if you do this it's going to move in another direction. Which

direction are you trying to get them in? Follow these steps or be aware of this when you're dancing with them.

Sylvie Naar:

Yeah. And because I'm a researcher, this came directly from our data. When I looked at the correlations between these different kind of provider statements and what the very next thing the client said was, "That's what came out." If I'm going to believe in my data, I should be adapting my training accordingly.

Sebastian Kaplan:

Right. So, Sylvie, what would you say to people, particularly practitioners that work with teenagers, that at least having a little bit of back and forth around counter change talk. Or, the fact that they might want to keep using drugs or alcohol or cutting or whatever the behavior might be, that being okay with a reflection or two around the behavior itself, to not shy away from it, to maybe perhaps learn more about their world and how it relates to drug use for instance. That that's actually valuable from an engaging standpoint. Then, you could lay some of the foundation for discussing change a bit later on. What would you say to that?

Sylvie Naar:

I still think you can do a lot of that without directly reflecting counter change talk. Again, I think you can do it with emphasizing autonomy. I think you can do it with summaries that have both for and against change. I still do believe in doing a pros and cons, but only if other stuff doesn't work. I find that if you are, again, that with expressions of empathy and with the emphasizing autonomy you go pretty far and you don't ever really have to get to that directly reflecting counter change talk. "So, I'm getting that this is really important to you." That's just a much more general way than saying like, "You really like smoking weed." You know, "This is really important to you. This is really part of your life."

Sylvie Naar:

Then also, we don't count reflections of barriers as reflections of counter change talk. So, if someone says, "I really want to quit drinking, but every time I hang out with my friends, I want to drink." You're going to focus in on, "You really want to quit drinking." Then, you're going to be like, "So, having a plan to figure out how to make it work with your friends is something we'll have to talk about." So, again, it's not ignoring it, but it's finding different ways of talking about it instead of a direct reinforcement.

Sylvie Naar:

What I just said right now is an advanced skill to teach people, so that's why for early, two-day trainings I just don't teach reflections of counter change talk. Just like I don't teach amplified reflections either any of my workshops. I think it's a much more advanced and nuance skill. You can do a lot without ever reflecting the counter change talk directly.

Glenn Hinds:

Yeah. It's just that learning to connect in a meaningful way.

Sylvie Naar:

Yeah.

Glenn Hinds:

If they leave doing that after two days, that's a good two-day workshop.

Sylvie Naar:

Yeah. Just responding without judgment. If I can be able to get that done. When I was in Australia, they taught me don't "should" on yourself, and don't be a "muster Bator". Don't do the "should's" and the "must's". If I can just get you to do that then we have come a long way. Yeah.

Glenn Hinds:

And talking about coming a long way, you're now in quite a prestigious job and leading innovative work around behavioral science. And I wonder, could you tell us a bit about what it is the center that you're working for and what you're discovering there?

Sylvie Naar:

Well, it's brand new, so I only came to FSU about a year ago and I've hired three new faculty so far, four. The focus of the center is what we call Translational Behavioral Research. So, rather than just doing clinical trials, we want to do early based translation, which is look at basic behavioral and social science and develop new interventions, or do these communication science studies I talked about and look at new adaptations of MI. Then we also want to do later-phased translation, which is taking evidence-based treatments moving them into practice and studying what works and doesn't work that implementation stuff. The idea is that there is 15 years gap between what happens in the research lab and what actually gets out into practice. By doing this kind of translational work, we want to shorten that gap.

Sylvie Naar:

Yeah, I'm really excited about it. I have some really dynamic people. Being in Tallahassee is interesting, because it's the state capital, and so there's a lot of opportunity to work with the state health department in what's one of the largest states in America, that has not always been progressive in terms of social change. That's been interesting. Also, Florida has the highest rates of HIV in the country. Four of our cities are in the top 10 for new infections, and so we have a real problem here, both in the cities and in the rural populations, so that's one of the things that I'll be working on over the next few years. Looking at state-wide implementation of some of our interventions.

Glenn Hinds:

What's interesting is that you're saying that medical research typically takes 15 years from the lab to bedside intervention, but what you're endeavoring to do with behavioral science is speed that process up. That sounds really exciting because it offers, I imagine, both

practitioners and their patients and their clients real hope about things improving in the short term, in the near future.

Sylvie Naar:

Yeah. I think what's important is that there's been this translational phased model for the medical field for a long time with lots of money going into early-phased translation and developing new treatments, but we don't see the same phased, careful approach with behavioral interventions, and certainly the funding isn't there. I've been working pretty closely with NIH on what are some methods for very early phased trials that are fundable and same thing with the later phased trials and see what we can do. I'm really motivated in terms of now training the next generation of researchers as I move into the later phases of my long career.

Sebastian Kaplan:

It sounds like you're just ideally placed in the state of Florida with, both your background, and energy around implementation and addressing the HIV concerns that are unique to Florida.

Sylvie Naar:

By chance, two of my favorite MINTies, John Luther and Heather Flynn were both in Tallahassee, so.

Sebastian Kaplan:

Quite a synergy there.

Sylvie Naar:

Mm-hmm (affirmative). Yeah.

Sebastian Kaplan:

So, as far as your MI and CBT work, I'd be curious to hear a bit more on your focus on combining these two approaches.

Sylvie Naar:

Yeah. In terms of my background, I was definitely trained more carefully in more behavioral kinds of CBT. So my first trial of true integration…Well, MST also has a lot of CBT in it… but it was around obesity and it was around developing a full manual of MI CBT integration and skills and it was very focused on behavioral skills training. Although, there was some stuff around managing thoughts and more traditional cognitive restructuring. But we found that most of our kids were responding to more of the behavioral skill components. When I wrote the book, I had to re-immerse myself on all kinds of different CBT. We did include the DBT approaches, mindfulness, and relapse prevention. We decided to keep ACT separate. I just felt like I wasn't enough of an expert in it to try to pull that into the book. Although, there's some really nice literature coming out now on integrating MI and ACT.

Sebastian Kaplan:

Could you just say a moment, like DBT, ACT?

Sylvie Naar:

Oh sorry. Yeah, yeah. Dialectical Behavior Therapy. We did kind of pull that more into the book, because that we felt that a lot of the things that were happening within Dialectical Behavior Therapy could get pulled in, same with behavioral activation. But, ACT, Acceptance and Commitment Therapy, we decided not to pull in, because it was newer, and I didn't feel that I was an expert in enough in it to do that.

Sylvie Naar:

So, when I first started presenting on MI and CBT, the late Guy Azoulai said to me, "Which CBT?" I said, "I'm a lumper, not a splitter. That's just my style."

Sylvie Naar:

So what I did, I talked it over with Bill Miller, and there was a big push for this common elements approach, which was like, you've got all of these different kinds of psychotherapies and a million different approaches. To try to have a poor practitioner become an expert in even five of them, is really difficult. This was not just my idea; this has already been in the literature. Could we distil common elements? So, Bill, being Bill, said, "Well, you think they're common, but they're not so common, because people aren't doing them the way they're supposed to." So, we called them "shared elements". Basically, I poured myself in the literature of behavioral activation, the Dialectical Behavioral Therapy, more traditional CBT, like cognitive restructuring kinds of approaches, and behavioral skills training, and relapse prevention. I read a lot of Barlow's Unified treatment approaches.

Sylvie Naar:

I felt like we could distil some common elements. Every single one of those CBTs had some sort of assessment process, maybe it was a functional assessment. Every one of them had some sort of treatment planning process, where you figure out what are the different thoughts and feelings that are contributing to the behaviors, context, etc. Then, most of them had a skills piece. Even Dialectical Behavior Therapy would focus on distress tolerance, that's still a skill. Or behavioral activation, where you have to plan pleasurable activities, that's a skill. So, I felt like if we could come up with how do you integrate MI in assessment, how do you integrate MI in treatment planning, and how do you integrate MI when you're trying to teach a skill, that would get at a lot of what the different approaches to CBT do.

Sylvie Naar:

That's the approach we took. We tried to come up with more of a unified approach of how to integrate MI with the more common elements of CBT.

Sebastian Kaplan:

It wasn't an effort to figure out how to do MI first and then to do CBT when you're done with doing MI, it was weaving MI through these critical shared elements.

Sylvie Naar:

Exactly. I felt that there had been enough out there already on how to do MI as a prelude. Also, I didn't think that was as hard, right? You'd do MI, and then you'd do CBT, and you'd shift. Although, Moyers and folks have talked about how it is hard to shift and when do you shift back and forth, I felt that there was enough out there on that. But, because I'm such a believer in MI as a foundation and a method of communication, it seemed to me why wouldn't you want to do full integration. That is just how I think. That was the approach. So, we talk about some of the other ways you could do it, but the book is supposed to be almost like a unified treatment manual for integrating MI and CBT approaches.

Sylvie Naar:

Then, what we did in the book is I took five cases that were totally different target behaviors, alcohol use, medication adherence, obesity, depression, and anxiety. Every chapter would talk about how you would use that integration for each of those five cases, again, showing that you can really take this approach and utilize it across different behaviors without huge adaptations. Because to me, again, a practitioner in the real world is seeing all those things all the time.

Glenn Hinds:

Mm-hmm (affirmative). That in itself sounds like a huge piece of work. With the dedication, the focus, and essentially, the thoroughness of what it was you did. That dedication you have too. What is it that we can discover from this that can help the people we're working with and for us? I wonder if I can refer them to the question that Rory Allott, one of our MINT colleagues texted us. It was a question. You've alluded to some of it already. CBT is a big church. I'd be interested to hear whether Sylvie thinks that certain CBTs are easier to integrate with MI than others, and in what ways?

Sylvie Naar:

Yeah. I remember having conversations with Rory and Paul Earnshaw around early stages when I was first writing the book. I'm not surprised that Rory came with that question, so thank you.

Sylvie Naar:

Yes, CBT is a big church. Again, I'm a lumper, not a splitter, so I think that if you distil things into common elements that still makes a lot of sense to me. Most CBT approaches do focus on some sort of skill. I think you can integrate MI into any CBT approach. I think that for me the cognitive restructuring and the metacognition CBT. Those were harder for me to write about. I think it's because the clients that I work with don't respond to it as much. They don't respond to like, "Here's my thought, now I have to counter thought." The whole concept of maladaptive cognitions is very counter to MI. A lot of what I do is reframe the language. Instead of saying "relapse prevention" we talk about maintenance

and slips. Instead of saying "maladaptive thoughts", we say "unhelpful thoughts", because that's all about MI. Some it is just reframing. I should say, I went through CBT therapy while I was writing the book, and I didn't do my homework hardly at all. [inaudible] all that struggle. I'm probably one of the most compliant patients. So, very heavy homework focused CBT's are tough.

Sylvie Naar:

But I tend to prefer more of the distress tolerance and mindfulness approaches to the cognitive restructuring. I don't know if I can say that MI is harder to integrate. I just think, personally, that's my preference. So, I hope that answers the question. I have a whole chapter in the book on how to integrate MI with cognitive restructuring, and the basic skills of shared expertise and not labeling, affirmations, and eliciting the client's ideas using Elicit, Provide, Elicit, when providing information. Those work for everything.

Sebastian Kaplan:

I remember many years ago hearing Bill talk a bit about one of the ways MI and CBT go together. It fits with the shift within MI that, obviously, it started and continues to be very behaviorally focused. But now people are starting to think about change in other ways. So, changes in thinking, for instance, is something that people are starting to apply some of the MI concepts to. I do remember Bill saying that. I don't remember the exact quotes, but that's one of the ways that he might approach a combination of MI and CBT is rather than change talk being focused around a behavioral target per se, it's change talk around a different way of thinking or perhaps using a more helpful style of thinking.

Sylvie Naar:

Exactly. See, to me, that's still a behavior. Right? If I'm always seeing the glass half empty, it's a thought, but it still comes out in a behavior. I don't make that huge distinction between thoughts and behaviors.

Glenn Hinds:

Mm-hmm (affirmative).

Sebastian Kaplan:

Okay.

Sylvie Naar:

In fact, my communication science people talk about language as a behavior. So, to me, that's my target now is those thoughts, whether it's black and white thinking, or always seeing the negative. So, my change talk would be around, "What are some reasons why you want to think in black and white? Why would it be important to you?" See, CBT never quite does that, it just labels them as an unhelpful thought, but doesn't really get at, "Why do you think that might be unhelpful?"

Glenn Hinds:

Right.

Sebastian Kaplan:

How is it unhelpful to you?

Sylvie Naar:

Yeah. Give me an example. Tell me about a time when black and white thinking wasn't helpful to you. Because, if it is helpful for them it's not going to change, assuming that it is. So, to me, I think that's still a really important target.

Sylvie Naar:

Now, I must say, at the end of each chapter of the book, I do talk about dilemmas, and that came from Terri, again, her recommendation to me was, "Someone needs to talk about the dilemmas. When do you get stuck?" It's funny, after having a dilemma in every chapter, it still boiled down to the same thing, which is when a client doesn't want to do what the CBT says is the thing you're supposed to do. So, logging, self-monitoring. So, what do you do?

Sylvie Naar:

You basically have options. You can say, "Well, this is the treatment I do, and if you don't want to do it, then maybe come back another time when you're ready." You could do MI around that thing and try to wait until you get there, or you can keep moving forward, and say, "Okay, forget the self-monitoring." I have to provide information. The evidence suggests that it's harder to change this behavior without self-monitoring, but let's see. In a couple sessions if it doesn't work, we can come back and revisit it. That's to me, the key dilemma. I don't say what you should do. I think every practitioner has to make that decision for themselves.

Glenn Hinds:

Yeah. Just that fluidity in your response to the circumstances that you find yourself in. How are they responding? Is it a thought that they're struggling with? Again, what's really interesting is that idea that, "My smoking may be harmful, but my thinking may be harmful too." To approach it from that perspective. Yeah. Really interesting.

Sylvie Naar:

Then you have to decide if you have to have a preliminary target. Before you can stop the smoking, you have to change this other target behavior quote thought.

Glenn Hinds:

I'm conscious about time. There are so many more questions that we could explore, but I suppose one of the ones I'm curious about is that given the fact that you've been so immersed in so many different ways of helping, what is it that you may have discovered when exploring CBT or MST that you have brought back into your MI practice as much

as anything else? What can we learn from those other approaches that as MI practice as it may help us in the future?

Sylvie Naar:

Pulling in certain things. I do believe that self-monitoring is a key skill for behavior change. Other than bringing in those skills, when I do planning, I'm always really careful to do "If then" plans. My plan is to start working out at the gym on Mondays, so I always want an "If then" plan. So, what are some things that might get in the way, and how are you going to overcome them?

Glenn Hinds:

Right.

Sylvie Naar:

So, even though that's not officially part of MI, it's something that I always do in the planning phase.

Glenn Hinds:

So, almost contingency planning if things don't work out.

Sylvie Naar:

Yeah. When we teach the change plan or the planning, we always include an "If then" plan part.

Glenn Hinds:

Right.

Sylvie Naar:

I always say that coming to sessions should be part of that. What's going to get in the way of you coming and how are you going to overcome it? Yeah.

Sebastian Kaplan:

So, the "If then" plan is specific to barriers for this person making a change or maintaining a change?

Sylvie Naar:

Its target behavior, so right. If our target and our plan for the next time is around physical activity or around substance abuse or, "I'm only going to smoke marijuana at night, and I'm not going to smoke during the day." What might get in the way? "Oh, well if my friend calls up and says, 'Well, let's to a wake and bake.'" How am I going to handle that? That kind of thing.

Glenn Hinds:

So, another question then. Where is your research taking you now? What other questions did you ask that you're hoping to answer?

Sylvie Naar:

Well, I'm still really interested in the whole uptake of MI across different setting and populations. How much effort do you put into trying to teach MI to fidelity? Do you really put everything into teaching an entire clinic everything? Or do you just say I'm going to teach everybody a little bit, and then I'm going to find the people that are really going to take to this. Because it's costly, it's energy, it's trying to get people to do follow up coaching in almost any setting is really difficult. So, I'm really interested in that. I always used to believe that you wanted to train people in the organization to uptake MI so that they could train the trainer. I used to spend so much effort trying to train what we call "internal facilitators and supervisors", and some agencies just don't take to it. They're like, "You know what, can you just come back every year and do it?" Or "Can you just be our coach, because we just don't have time?"

Sylvie Naar:

So, my thinking has started to shift where I always thought, of course the best way to approach sustainability is to have people in the organization be able to continue the MI process. I'm not sure that's for everybody. Sometimes having a centralized expert and trainer that delivers may be better. I'd like to see more data for that and figure out when and where and whom that makes sense for.

Glenn Hinds:

So, a coalition of the willing? George Bush's "coalition of the willing"? Work with the people who want to, rather than making people do it because they're supposed to, or they have to, or they must.

Sylvie Naar:

Right. Some of our organizations just don't have the resources or the time or the ability to take it on, that it's okay to then say, "For this five or 10 thousand dollars a year that it would cost for you to do it, that's more sustainable for us than trying to have internal people that may leave anyway."

Sylvie Naar:

I think there could be some really good work on cost effectiveness of the different approaches to sustaining MI practice with integration.

Sebastian Kaplan:

So, this seems like it would be really valuable, both for the community agencies that trainers are trying to reach out to and affect some changes in, because it gets at what do agencies really need?

Sylvie Naar:

Mm-hmm (affirmative).

Sebastian Kaplan:

The assumption is, we need to do these big workshops for everybody involved and teach everybody the same thing, but perhaps you'll find out that actually, no, that's not the case. Maybe it's just specific components or small pieces for everyone.

Sylvie Naar:

Right. Or maybe everybody gets the one day, and then a handful of groups get day two. Or everybody gets the workshop, but the follow up coaching is only for a certain degree. Yeah.

Sebastian Kaplan:

I could certainly see it changing the way trainers think of their work. Challenging some of the assumptions that we have about what the gold standards are. The truth is, we may think we know what the gold standards are, but that just might be because that's what we're always doing.

Glenn Hinds:

Yeah.

Sylvie Naar:

Well, exactly. The other thing is, I don't think people realize how low the competency is in the average treatment setting. I'm involved in a study in California where we give everybody a two-day workshop in MI, and we then code sessions, we give the coding to the supervisors and they're supposed to supervise them. The quality of these recordings that we're listening to, this is after the two-day training, is so low for many that I am just shocked at the treatment that our substance abusers are getting in this country, and this is in California, which is one of the more progressive states. As trainers, we always want our patients and clients to be happy with small changes, and we are so much tougher on ourselves. So, this whole concept, Glenn, that you keep emphasizing about the small changes that you can make in your practitioners is critical, because the baseline is really, really lower than you might realize.

Glenn Hinds:

A scary thought.

Sylvie Naar:

Yeah.

Glenn Hinds:

A sobering thought. For us all. Yeah

Sebastian Kaplan:

I guess I wonder also as part of your implementation work, Sylvie, do you think it's possible that we might find someone with low competency relative to the MITI standards, if that's much better than what they were doing before, that's actually quite significant as opposed to really alarming and concerning?

Sylvie Naar:

Yeah. When I'm going to look at my analysis for my study, I'm not going to look at... The competency scores are cut points for us to deliver coaching. I'm not going to run my analysis on competency scores. I'm going to do it on the raw mean data. Our measure is on a five-point scale, so if I go from a 1.5 to a two, I may not have moved up in competency rating, but I guarantee you I'm doing a little bit better work.

Glenn Hinds:

Mm-hmm (affirmative). Yeah.

Sylvie Naar:

That's how I'll be looking at it. Yeah.

Sebastian Kaplan:

Well, exciting stuff to come. As Glenn mentioned as we start to wind down our conversation today, usually our last question for our guests is to let us know about a project or a recent interest. You already mentioned one about the [crosstalk 01:00:59] MI and the second edition to the MI and adolescent book, maybe you want to talk a bit about that or, certainly, something else if it comes to mind.

Sylvie Naar:

Well, I'm excited about the second edition of the MI adolescent book. I've never done anything like that before. It's supposed to be about 50% new content. I know that I have learned so much in the last seven or eight years in terms of how I train. A lot of the stuff we've been talking about today. You'll definitely see more stuff around this emphasizing autonomy and some of our communication studies. We've learned a lot about the adolescent development and the adolescent brain and FMRI and all that kind of stuff that I think could influence how MI works with adolescents and young adults. So, I'm excited about that. Yeah

Sylvie Naar:

The format of the book is going to be different. We're not having guest edited sections. People wanted a more integrated book, but still addressing special populations. We're probably going to take the approach that we did from the CBT book of five cases and carrying them throughout to show the flexibility of MI for different populations. We have to start talking about MI with parents of adolescents, and that could be a whole book. There's nothing written so much on working with parents, working with parents and teens together. I'm not going to be able to address it fully, but that will have to come through more strongly than it did the last time. Yeah.

Glenn Hinds:

Yeah. Exciting times. Something to really look forward to then, Sylvie.

Sylvie Naar:

Yeah.

Glenn Hinds:

Fantastic.

Sebastian Kaplan:

These things are unpredictable but is there a rough estimate of when people might expect these... [crosstalk 01:02:50].

Sylvie Naar:

Right. So, Guilford Press expects it from us by Fall, and then it's usually about a year to editing and production. I'm supposed to do a chapter a month starting this month. It's already the 18th of March. Theoretically, a year from the Fall. So, Fall of 2020.

Sebastian Kaplan:

Great.

Glenn Hinds:

So, we'll be getting it at the MINT forum, 2020?

Sylvie Naar:

Well, I submitted a pre-forum workshop. I don't know if it will go through, but on sneak peek into the second edition. That would be my hope by next Fall by the MINT forum if the workshop gets accepted, then by the Fall of 2019 we will have written most of the chapters and we'll be able to do a workshop on it.

Glenn Hinds:

Exciting. Yeah. Fantastic.

Sebastian Kaplan:

Yeah. That's great, Sylvie.

Glenn Hinds:

Giving how much you talked about the date, Sylvie, very often people will want to follow up and we always ask our guests, if people who listened to the podcast were curious and they wanted to find out more, would you be willing for them to reach out to you? And, if they were to reach out to you, what's the best way for them to do that?

Sylvie Naar:

Yeah. You can reach out to me with Naar N-A-A-R @behaviorchangeconsulting.org. Behaviorchangeconsulting.org is the training company I work for, and you can find us on their website or just email me directly that way.

Glenn Hinds:

Fantastic, and we'll add that link to the blurb on the podcast as well. Certainly, just to remind people for contacting us or feedback or this or any other podcast that they've listened to the Facebook is Talking to Change, the Twitter handle is @ChangeTalking, and email is podcast@glennhinds.com.

Sebastian Kaplan:

Excellent. Well, Sylvie, this has been a pleasure. We've learned a lot about the work that you've done. You've made a huge impact on the field of MI, and we thank you for that. We thank you for coming on our podcast.

Sylvie Naar:

Thank you. It was a pleasure.

Glenn Hinds:

Thanks, Sylvie.

Sebastian Kaplan:

Alright, and Glenn, until next time.

Glenn Hinds:

Indeed, good to see you, Seb.

Sebastian Kaplan:

Alright. You too.

Glenn Hinds:

Thanks, everybody.

Sebastian Kaplan:

Bye bye.