Talking to Change: An MI Podcast

Glenn Hinds and Sebastian Kaplan

Episode 19: The Role of Feedback in MI, with Denise Walker, PhD

Glenn Hinds:

Hello again everybody, and welcome to Talking to Change, a Motivational Interviewing podcast with myself Glenn Hinds, joined as always with my good friend Sebastian Kaplan. Hi Seb.

Sebastian Kaplan:

Hey Glenn. How's it going?

Glenn Hinds:

Going the best, man. I'm recording today away from my home in Derry. I'm working in Surrey with Surrey County Council in Woking in the South of England. We're looking forward to this conversation and we're joined by Professor Denise Walker. I'll invite Denise to say a little about herself. Before we do that Seb, how can people contact us on the social media platforms?

Sebastian Kaplan:

Sure. Right. Thank you. So on Twitter, our handle is @ChangeTalking. Facebook page is Talking to Change, and email address, if you want to send us a question or comment directly, podcast@glennhinds.com. As always, we invite feedback, rates and reviews. And we've had some good interaction thus far on Twitter, for sure. People posting comments and making suggestions about past episodes and suggestions for future ones. So we really appreciate all that interaction and commentary.

Glenn Hinds:

And we're delighted, we just checked our feedback online and up to this date, 45,000 people have listened to the podcast. So we really appreciate everybody's willingness to come along and listen to ourselves and our guests. And to hopefully have learned a little bit about Motivational Interviewing in a way that can be of benefit to them. So on with today's show, like I say, we're joined by Professor Denise Walker from the University of Washington. Hi Denise. How you doing?

Denise Walker:

Pretty good. Thank you.

Glenn Hinds:

Good. Good. So tell us a bit about yourselves. Who are you?

Denise Walker:

I'm a research associate professor at the University of Washington School of Social Work. I'm a licensed clinical psychologist and I mostly do research and all of my research is pretty much focused on intervention development with a focus on usually some kind of component, including Motivational Enhancement Therapy, either combined with other interventions or alone. I have two primary areas of expertise. One is in marijuana intervention development both for adults and adolescents. We've applied, developed and evaluated Motivational Enhancement Therapies for cannabis use disorders that are pre-treatment like for treatment seekers and then also aftercare interventions. And then I also have sort of an area of expertise that is centered on the check-up model, which we might talk about a little bit today, but the idea is designing interventions that attract that far majority of folks who are struggling with the behavior, but not engaging with treatment.

Denise Walker:

So that work has been applied to military populations with either substance use disorders, PTSD and then other types of populations like domestic violence perpetrators, usually a topic that oftentimes is highly stigmatized and people have a lot of ambivalence about seeking treatment for that particular behavior that we're interested in.

Sebastian Kaplan:

That's great. There's a few things that we're really interested in and look forward to hearing from you about with today's episode. So you've mentioned a couple of MI related methods or programs that will be familiar to people within our MI training community, for sure and perhaps some others, but it may also be new to others and that is Motivational Enhancement Therapy and the Check-Up Model. So we will hear a bit about that, which will be great. And one of the features of both of those models or those approaches is the particular emphasis on feedback and how feedback is delivered to clients about whatever potential target behavior is in the mix.

Sebastian Kaplan:

So I guess in thinking about our episode today, we'll talk a bit about some of your programs and then hopefully by the end, we'll have had a nice opportunity to talk about feedback in MI and what are some important takeaways for the everyday practitioner out there who's trying to incorporate some feedback in their work.

Denise Walker:

Sure, absolutely.

Glenn Hinds:

So from what you're saying as well, it sounds like your programs are targeting people in advance of them engaging in a process of helping. And then very importantly, once they're engaged potentially how to keep them engaged in the process of recovery. And it sounds like there's maybe things that you're doing differently at both of those points on the recovery journey for people. So again, that maybe something for us to be

interested in, but the beginning with, you mentioned MET, Motivated Enhancement Therapy, and perhaps for the audience, if you could say a little bit about what Motivational Enhancement Therapy is and how if at all, it differs from what we would normally call Motivational Interviewing?

Denise Walker:

Motivational Enhancement Therapy differs from Motivational Interviewing because it necessarily involves the provision of personalized feedback. So, it includes everything that Motivational Interviewing includes the spirit, the skills, the techniques, and the counselor brings all of that to the session. And the client tends to complete some type of an assessment prior to the session, a personalized feedback report is created, and that is included within the session. So that counselor and the client look at a personalized feedback report together within that session. The counselor during the whole time, the feedback is looked at and discussed is using all of those Motivational Interviewing skills.

Sebastian Kaplan:

And so this emphasis on feedback is something that's well, maybe not unique to MET, but it's a really important component to it. I guess, as you are teaching people about the delivery of feedback within the context of Motivational Enhancement Therapy, what are some of the key things that you try to emphasize or impart on a trainee learning this method?

Denise Walker:

Well, sometimes counselors can get really focused on the feedback report and so can the clients, but the way I think about a good feedback report is that it's an opportunity to look at the behavior from different angles. When you're constructing a precise feedback report, it might include topics that may not come up just naturally within the conversation, but you might want to hear from the client on, or it can include things that are new to the client such as like normative data or information about treatment effectiveness, if the goal of the intervention is really to get someone into treatment. So it differs in that way.

Denise Walker:

One of the main things for counselors to be really thoughtful about is that it's still evoking and engaging the client's perspective all throughout. Even though there's a bit of an agenda, it's still flexible, it's still MI driven, it's still client-centered. And it's really all about getting the client engaged with the material and hearing their perspectives, their thoughts, their ideas, how they think it applies to them. So it's really about that process versus, "Oh, look on this page, we've got normative data, blah-blah-blah. You're in the top 5% of people who use marijuana." That's not interesting, or MI spirited. So it's about really maintaining that client-centered spirit and engaging and invoking throughout that process.

Glenn Hinds:

Something quite scientific about the feedback that you're describing in the sense that you mentioned normative data, and perhaps if you could just say a bit about what that means for people. And because again, it sounds like the feedback that you're given is gathered in a particular way and then related to specific other information. So perhaps you could share a bit about what that means from an MET perspective?

Denise Walker:

I've been involved in developing these personalized feedback reports for a lot of different behaviors, and it's really a fun exercise to think about what sorts of conversations or what topics of conversations or what types of feedback can really prompt an individual to think about change or think about their behavior in a new way. Normative feedback has been involved in the earliest of Motivational Enhancement Therapies and really began in the alcohol field. So oftentimes we thought from social norms theory that people might be interested to know how their drinking compares to other people in the nation or in their age group, those kinds of things. And so normative data, especially within substance use has been a key component of feedback.

Denise Walker:

And we try to personalize it depending on the population we're working with. For example, my adolescents in The Teen Marijuana Check-Up, they'll see what national data we have as far as age of first use. So if they started at 13, they'll get information about how many 13-year-olds in the United States have tried marijuana, which is usually 1% or 2%. And then we'll talk about that. Then they might also get a piece of data that gets more focused to where they are at county level data, where you're using about 25 days out of the month, 85% of kids your age in the county are not using at all in any given month, about 5% are using at your level. That's one example of normative data.

Sebastian Kaplan:

Just thinking about this particular method of delivering feedback in relation to how feedback is often used or how assessments are often used in day-to-day practice and I guess a couple of things strike me. One is that it's shared, assessment data may not be shared all the time. It may be something that's purely for the use of the clinician or the clinicians team, or to place the client on some level system that makes them eligible for X, Y, or Z service. And that's not necessarily shared all the time. So that's one distinction. And another is just the way in which it's delivered it. I imagine oftentimes assessment data is delivered in a “Here is a truth about you” kind of manner. And the way you seem to be incorporating feedback is conversationally and as a way to elicit a client's reaction to this piece of information that they might accept, they might reject, whether they do or they don't isn't really the point. It's just to engage them in conversation about their behavior in relation to what others are doing.

Denise Walker:

Absolutely. So the common theme with any piece of feedback that we discuss is take it or leave it. What do you make of it? Is this helpful for you? It's really up to you to do

what you want or don't want with the information. Normative data oftentimes is tricky, especially with kids. They don't believe that their use is at a certain extreme level. Everyone they know uses. So there oftentimes can be a lot of throwback on that kind of data, but it's an opportunity to engage, to model that spirit of it's not pushing anything. And it's really trying to avoid labels, but bringing in certain information that they might not have considered, or they might just not know.

Glenn Hinds:

So the invitation would be the way you describe your substance use or your behavior on a national level, with the data we have, it would suggest that you're smoking much, much more than most kids your age. And I wonder what that means to you? And they either say, "Oh, that's really strange. I don't think that," or, "Well, everybody I know is at it."

Denise Walker:

Mm-hmm (affirmative) Exactly.

Glenn Hinds:

But whatever it is they say, you work with that. So the level of your smoking's quite normal for you. So I imagine then us having a conversation about you changing it must be quite strange or uncomfortable or frustrating for you that somebody else thinks you should be doing differently when everybody else is doing the same as you.

Denise Walker:

Right. That second piece that you said is really common. "Well, everybody that I hang out with is smoking at the same level." So being able to reflect something like, so this does feel odd to you, because everybody you know, the people you hang out with, that are in your social circle are doing the same things that you're doing. And then again, they can react and discuss and think and chew on that in way that makes sense to them.

Sebastian Kaplan:

And as you said, much of the MET work has been in the substance use world, whether it's alcohol, marijuana and maybe other substances. Are there other examples of clinical settings or clinical areas of focus where feedback has been used either in your work or in work that you're familiar with?

Denise Walker:

Well, I would imagine, I haven't seen personalized feedback reports from these areas, but I would imagine that it's being used in like diabetes or some of the health related fields, maybe with hypertension or weight management, exercise, eating those kinds of things. That seems like a natural fit although I'm not super intimately familiar with those types of feedback. We've applied it, again like I suggested earlier, to a number of different clinical populations. Right now we have a study that's working with active duty military who are experiencing PTSD, but may know it or may not know it, but they're not

engaged in treatment. And so this is a new thing that we have developed and are currently evaluating, but the personalized feedback report there was really interesting to come up with really fun to think about how do you create a personalized feedback report for PTSD and people who are going about seeking treatment?

Denise Walker:

That topic is also different because within substance use, the target behavior is assumed that a good outcome could be a number of different things. First, it could be you motivate self-change and that oftentimes is all you need, but another positive outcome might be that they engage in formal health or other types of self-help. So the outcomes are different within substance. For PTSD, we believe that if people want to... if they could change their PTSD on their own, they would have done it. And so the target behavior there is really more about helping them or helping to motivate them to engage in formal care and specifically in evidence based treatment, helping them make decisions around that.

Denise Walker:

That's another example of feedback and the feedback looks very different with that. The normative data, I don't think that it's really going to be helpful for someone with PTSD to know what percentage of the population has PTSD or what percentage of soldiers have PTSD. That's probably not helpful in helping them make that decision or motivate them towards treatment, but data around treatment effectiveness for particular types of treatment and seeing that sort of graphically represented and engaging them in a conversation about what they've heard about treatment, what they've experienced and what they think about those numbers is definitely a target because helpfulness about treatment effectiveness we know is a predictor and a barrier to seeking treatment. So it's kind of a neat opportunity when you develop these personalized feedback reports to kind of look at the literature and say, "Are there any clues in the literature about what might be particular targets that could help move them along toward being motivated to change or take steps towards treatment?" And that's one example

Glenn Hinds:

Really quite interesting what you describe. In some ways, one of the thoughts coming into my head was it sounds like that when we think about people who use substances, that it can be useful to understand their behavior in the context of people of their own age or in a context that they recognize. But their seeking help may not be driven by the fact that they're smoking cannabis or whatever else, but that people with PTSD, and this is something I want to clarify with you, is your sense of people who are experiencing PTSD can recognize the shift in what their life was like before the traumatic event. They know there's something going on that they want change, but they're not quite sure how to do it. And then very, very interesting was the way you described the different forms of feedback, so that if I come to a weight management clinic, then there's normative data about what is a healthy range of my BMI? And you can relate that to that.

Glenn Hinds:

But I think how you're expanding this is saying, you can talk about the choices that this person has in their recovery journey. What we know from the research is if you do CBT, these are the sorts of outcomes. If you do a group work, these are the sorts of outcomes. If you do self-care, these are sorts of outcomes. How does that sound to you? And I think that has really helped me and I imagine will help a lot of listeners think about their own practices, that if they don't have normative data about the behavior, they may have research about the outcomes from different interventions that people then can be given choices about and to explore their ideas about how they would feel about a 12 step group, how they would feel about a CBT intervention, how they would feel about psychodynamics or whatever.

Denise Walker:

One of the things that you highlighted was what might be differences for PTSD and what might be associated with the ambivalence for seeking treatment? And it does feel different than substance use within that population. So even taking a step back a little bit, the Check-Up Model, which the PTSD intervention that I'm describing is part of, is a little bit different because the Check-Up Model really is intended to reach folks who are not in treatment seeking, but maybe ambivalent about something that's going on in their life. So the main elements include some type of advertising campaign. How do you get to that 90% of folks who are struggling outside of a treatment office? And how do you create ads that help people see themselves in that ad and is welcoming, creating sort of overview of the intervention.

Denise Walker:

So first, advertising campaign then assessment of use and then a Motivational Enhancement Therapy intervention, which all of the advertisements usually emphasize all the ways in which you're trying to decrease barriers to participation. So this should be a low burden opportunity for someone to dip their toe in the water and check out what they're thinking or experiencing or having questions about. In our advertisements, oftentimes they'll say confidential, anonymous. Sometimes they even participate anonymously. One or two sessions, so it's brief. A lot of our interventions are conducted by phone. So they don't even have to walk into an office, but they can do it in the luxury of their own home or their own car or on a break, that kind of stuff. A lot of that is emphasized, the non-judgmental nature, and it's also not treatment. So it's kind of talked about as not treatment, they're not making a commitment towards treatment.

Denise Walker:

The MET interventions usually are between one and three sessions long. If you back up and think about the Check-Up Model and why we even are targeting soldiers with PTSD, it's because in part PTSD within the military is highly stigmatized still that there is a lot of fear that seeking treatment has repercussions for their military career, that it goes on their record, command might be notified and that it might affect their career in certain ways. For example, it might... Well, the fear oftentimes of the soldiers is that they'll get kicked out of the military. So those kinds of barriers you're trying to decrease with that opportunity for the intervention.

Denise Walker:

PTSD itself, oftentimes even if people do understand that they have PTSD, they're scared about the treatment, but from the clinical sessions, you get this sense that folks are worried that the treatment is going to be super hard because they're going to have to relive the traumatic event and that it might actually make it worse. So there are these different fears that you don't really get with substance use or even domestic violence perpetrators, or high-risk sexual behavior that you do kind of have to put on the table and talk about with PTSD.

Sebastian Kaplan:

We're thinking about the categories of feedback or the types of feedback that we've hit on today is assessment data about substance use, or maybe other things that we might be evaluating in a client and the other being types of treatment, possible outcomes, if they engage. It's making me think about all the other kinds of conversations that go on in clinical settings, or even in other settings that aren't necessarily clinical like educational settings, for instance. Students are evaluated all the time and there's all kinds of data generated from grades to standardized tests, to discipline records and all that. And what a rich opportunity it is for educators, for instance, to use some of the strategies that you're developing in a way to engage students in discussions about their academics or their behavior or whatnot.

Sebastian Kaplan:

So I guess it's not really a question I have, it's just thinking about, on paper, types of feedback that we might give and not to mention just observations that might occur in a conversation that could be considered feedback or advice that really this work is really far reaching, certainly within the MI world.

Denise Walker:

And one area too that my beloved colleague, Bob Stevens, really introduced to the personalized feedback reports when they first started doing this work with marijuana was to include personal goals. So our feedback reports seem to be novel in that way. He's the one that sort of introduced looking at broader goals for their life and then putting it into context of the problem behavior, the target behavior. And I really appreciate that piece because first of all, that's obviously really easy to do within an MI session and we are oftentimes trained to do that within an MI session, but to have it included within a personalized feedback report is really powerful because it is oftentimes positive when some of the feedback is less positive or is seen a little bit more on the negative. And it also directly can be used like, okay, so first of all, it gives that perspective to the kid or the person, we're looking at you as a whole and we want you to think about what you're wanting for you and how this target behavior relates to that.

Denise Walker:

So with regard to marijuana, you want to graduate high school. You want to make the varsity basketball team. Tell me about how reducing marijuana use would help or hinder that goal of graduating from high school. So you can draw directly back into the target

behavior, but put it into that context and not on paper, which I think is a little bit more powerful. With our soldiers and PTSD, we actually got feedback from the soldiers of bring that to life whilst earlier because they were sick of feeling broken and crazy. And so we start actually the PTSD intervention with we know you're a whole person, we'd love to know what is meaningful to you. What do you value? What are you working on? What do you hope and aspire to in the next few years?

Denise Walker:

Just pass them that and then go into pieces of feedback that are related to PTSD and then circle back. So how would it be if you were to get rid of these symptoms that we've been talking about? How would that affect your ability to accomplish this goal? And so there does need to be some kind of a balance around positive and negative. And if it's not overtly there, you're kind of bringing it in with that MI style.

Glenn Hinds:

And the mention there of the positive and negative, what strikes me is that the characteristic of the feedback style is that it's the absence of judgment, that I'm not judging what you're doing negatively or positively. The judgment of positive or negative is the impact it has on you becoming who you want to be. Those life goals are measured against how does this current behavior help you achieve this or not? And what does that mean to you if that's the case? So it seems like you keep inviting the client or the patient to be the one who draws conclusions from the information, rather than us putting an outcome on, well, if you keep smoking cannabis, you're not going to graduate. And I think that's the point that I think Seb's identifying there. I think the real potential there in education and other aspects where we have this data, but we approach it from finding out, “who do you want to be in your life? Who do you want to become? And so how does this either help or hinder you achieving that for yourself? What could I do, if anything, that would help you make the changes necessary for you do calm yourself?”

Denise Walker:

It's one way to facilitate a conversation around values. Personal goals usually are tied. You can hear the values that are important to the person within their goals. And that personal approach, like, okay, so the behavior is happening, what do you want to do about it? What does it mean to you? Was particularly important within the marijuana intervention field because first of all, most people don't even think marijuana is addictive. So there are just a lot of beliefs and things. And even when we started doing this work, it was pre-legalization, so a lot of people were fighting for their right to party, but really what was important was, okay, let's get rid of all of the policy landscape that what people say is good, what people say is bad. Let's get rid of the rhetoric. This is what you're doing and how does it relate to you? Is it helping you? Is it hindering you? Is it helping you get where you want to be? Is it representing your goals, your values, the things that are important to you, and just learning that I think from the marijuana population, it really fits with pretty much every population, but we really had to... It was really important, super important to do that with cannabis users, particularly adolescents who weren't seeking treatment for their cannabis use.

Sebastian Kaplan:

So many important lessons from really understanding your population and what are the nuances of connecting? What are the risks and perhaps damaging potential for connection all as the sort of unspoken parts of it or maybe the parts that don't maybe get the headlines, like treatment outcomes and such. And I think it wouldn't be great to hear about specific outcomes to some of the studies with the populations, before though you've mentioned the personalized feedback report. Could you talk a bit more about the report, what it consists of, is it shared? Do they take it home with them? All of those kinds of nuts and bolts of it.

Denise Walker:

Sure. The personalized feedback report is the report that you review with your client about the particular behavior. And the personalized feedback report is specific to the intervention that you're administering, whether it be marijuana for alcohol or PTSD or domestic violence. The personalized feedback report is created based on an assessment that the client does and going old school, the original personalized feedback reports would be calculated and done by hand. Now, oftentimes we have them computer-generated based on the responses, assessment responses that they're giving on a computerized assessment, so the construction's pretty easy. And if we're doing in-person interventions, we each have a copy. So the client has a copy, I have a copy and we look at them and together. If the intervention is done by phone, we send a copy to the client and then of course the counselor has one. So it's absolutely shared, there's no mystery about the information. And then we usually create a complement to the personalized feedback report that we provide to the client after this session, that's called understanding your personalized feedback report. And it's something that I think was originally developed with Project Match, but then understanding your personalized feedback report goes through in sort of a narrative way about describing what the different topic areas are, what they mean, and maybe potentially like an open ended question to help them consider what that means to them.

Glenn Hinds:

So there's that whole endeavor to assist the individual, understand the process, the choices in relation to themselves all the way through this intervention. And I'm really enjoying listening to what you're sharing and that's stimulating so many thoughts for me. I'm doing a lot of work here at the minute with Family Services in England and I can see the potential of being curious when we go to visit a family about what's your goals as a parent? What type of parent do you want to be? Or what are your personal goals for your children? And then looking at some of the data that you could offer them, which is about the development stages that we would be looking for at a child at a certain point in their life, and then relating it to, well, this is where your child is at, and I wonder what that means to you and how you feel about that, or how does the family living like this help them become who you want them to be? Without us going, "You're done it wrong and we're worried about the way you're doing it. You shouldn't be doing it that way. You need to buck up your ideas because if you don't, we're going to take your kids off you."

Denise Walker:

Absolutely. And so I could imagine, as you're talking about this, a feedback report around parenting, including some of the big areas that are related to positive parenting and positive outcomes for kids, so monitoring, parental monitoring. And if there was some kind of measure for that to be able to say, "How often do you know what your kid's doing when they're afterschool? How many hours are they alone?" That kind of stuff, but that could engage in a conversation with what we know about parenting and that monitoring is really important for good outcomes. It's linked to reduced substance use and reduce high-risk sexual behavior. And how are you doing in this area? What are your thoughts?

Sebastian Kaplan:

Yeah, I agree, Glenn. It's making me think of pretty much every clinical area that I'm in and how it can enhance the things that I do or perhaps colleagues of mine and just the transmission of feedback across multiple settings. We talked briefly, I maybe primed the question earlier about what are some interesting outcomes that you've found with some of the research that you've done. So perhaps you could share about a study or two that you've had some interesting findings with.

Denise Walker:

Sure. The Teen Marijuana Check-Up is one of the interventions that we've done most of our research on, and that work was started by Roger Rothman and Bob Stevens, beloved colleagues of mine. Point of The Teen Marijuana Check-Up is to engage adolescents who are using marijuana heavily in a conversation to help them to consider changing their use of marijuana. So again, these are non-treatment seekers and across the four, three of which were randomized control trials that have been completed on this intervention, the intervention itself, again, with the Check-Up Model, we were thinking, okay, so how do you attract kids into an intervention? Well, with our adult trials, we would rely on newspaper ads or social media ads, but for work with kids, we thought, why don't we go to them? So offer it in the school day, during school, without parental consent, that was not required. And they could do it during class time. So again, trying to decrease any barriers to participation.

Denise Walker:

So, one of the questions was, would kids volunteer for this? And all of our trials suggested, well, we never had any problems recruiting kids into this intervention. So it was two sessions long. We would go into the schools and do a particular marijuana myths and facts presentation within the classroom. And at the end, describe The Teen Marijuana Check-Up, its availability in their school and provide everybody with a two question survey on what they liked or didn't like about the presentation. So everybody got one and they were told that if you were interested in hearing more about The Teen Marijuana Check-Up, write your name on the bottom and we'll contact you confidentially out of class. So everybody fills those out, regardless of whether they're interested or not, folds the paper up and submits them to the presenters. There was an anonymous way of indicating whether they were interested in participating in the intervention.

Denise Walker:

I say all that because again, trying to think about ways to reduce barriers to participation. Those were some of the ways that we worked with them, The Teen Marijuana Check-Up. The two sessions of Motivational Enhancement Therapy were provided within the school day. The first session was pure MI, this is a little bit different than most of our MET interventions, but the first session was pure MI. The second session introduced the personalized feedback report. And what we found with that intervention was that first of all, kids were eager to participate and that the participants looked very similar, if not more severe on marijuana use, marijuana use consequences, the use independent symptoms and also internalizing externalizing behaviors as the populations that were reported in the marijuana treatment literature. So it attracted a high severity group of kids, but a little bit more diverse. So more female representation specifically.

Denise Walker:

And that two-session intervention made statistically significant reductions in their use compared to an active control condition or delayed treatment control. So that particular intervention is on like the NReC website. It's considered an evidence-based intervention. Now we're trying to do the really nasty work of trying to figure out dissemination implementation issues around getting it into the hands of people who can use that.

Glenn Hinds:

So something quite profound happened during those conversations for those young people, first of all, to want to engage in a service that was coming to their school. But as a consequence of doing that intervention with those kids, you saw a change in their behavior. And I'm wondering, what is it you've identified that made that change happen for those kids?

Denise Walker:

I think there's so much to be proud about the Motivational Interviewing literature and I think therapy process, the way we attend to therapy and active mechanisms is one of those areas. However, there isn't a ton of research done on like the active mechanisms of Motivational Enhancement Therapy. We've really tried to look at that in the best ways we can, some of the methodologies just don't have randomized controlled trials. The way we've done tests, the intervention hasn't really allowed perfect ways of looking at what works within the Motivational Enhancement Therapy, but one of the indicators that we are finding is the normative data seems to be a mediator of change. So while kids oftentimes fight with us about the normative data and some will express disbelief about it, we roll with that. And some of the data suggests that the normative piece really is impacting or mediating the changes that we're seeing.

Sebastian Kaplan:

You sort of hinted at it just then, but maybe a brief mentioning of what a mediator is just from a statistical standpoint?

Denise Walker:

Yeah. I wonder if I can do that, Sebastian.

Sebastian Kaplan:

Yes. Sorry to spring that on you. I always mix it up, mediator, moderator.

Denise Walker:

Yeah, mediator. Basically when you see a relationship between baseline use and follow up use in marijuana, what we also see the relationship is the change in normative perceptions so that the change in use over time seems to be driven by that middle point of, Oh, they were using three out of 30 days before and they thought everybody used marijuana. Then their perceptions around norms changed. They don't think everybody's using marijuana and they're using last at the next follow up point.

Sebastian Kaplan:

So you measure not only the number of days of use or those kinds of things, but there's also a measurement of their perspective or their beliefs, I suppose, around norms. And that was something that's linked to the ultimate treatment outcomes of use. Got it.

Glenn Hinds:

What strikes me is there's a potential that when you bring this normative data to these young people, that it resonates with potentially something that they already knew themselves, which is this isn't necessarily the way I want to be and now, I know that it's not the way other people are, that it normalizes that or introduces or increases their own experience of the discrepancy of who they are and who they want to be in relationship to everyone else. We want to fit in, we want to belong. We want to be "normal." And what brings these kids to the intervention? And I wonder is it people come to these interventions because at some level they know themselves, this isn't normal, me smoking every night, isn't normal because in some ways they know there are kids at school who don't do it that way. Okay. All their mates do it, but there's lots of other people around them who aren't doing it.

Glenn Hinds:

So there is that awareness either on a conscious or unconscious level that this isn't what everybody does. And then the information just increases that space and that's where the opportunity to go, well, how would you like it to be?

Denise Walker:

That's right. And the advertisements for check-up interventions really focus on exactly what you're saying. They focus on, do you have questions? Do you have concerns about your marijuana use? It's not saying, do you think you have a problem? Do you want to change your marijuana use? That's all sort of action stage language. It's more about, it's really tapping into that ambivalence that they might be experiencing that itch that they're getting or has been there and they don't know what to do about it. A

treatment program doesn't feel like a great fit for that, but this might be a brief opportunity to talk with folks. And so, yes, I mean, social norms theory really influenced that normative data piece and social psychology has really taught us that giving information that oftentimes is surprising to people can turn out differently depending on how you deliver it. So if I give you information that is surprising to you and is different than perhaps what you thought or what you wanted it to be, but I give it to you in a non-judgmental, loving, caring, compassionate way with this sense of you can make of this what you will, that that combination, social psychology suggests, is really ripe for people digesting that information and increasing the believability of it.

Denise Walker:

That's I think where MI really contributes to the provision of information, whereas like Sebastian, you were talking about in health behavior, sometimes we get information from our doctor that is not very MI consistent. You need to quit smoking. That's why you're coming in here with this bronchitis all the time. Okay. There's a lot of different ways that maybe I might react to that information versus if it was done in a MI consistent way.

Sebastian Kaplan:

So the combination of both information that is not what someone expects or has some element of surprise to it paired with, not in isolation, but paired with that kind of compassionate interaction style seems to be a key to this. And I was just thinking too about the dynamic of working with adolescents and how there's these two things that are seemingly opposite maybe that are at play, that you have normative data. So teens being very interested in what other teens are doing, how does my use relate to how other teens are using and that sort of piece, but there's also this element of autonomy and individualism and sort of doing it on your own that I would imagine they are experiencing. They don't need their parents' permission, which is an interesting part of what you were describing because it's not treatment per se. And I guess, because it's not treatment, I hear many teens talk about wanting to do it "on their own," and whether they're maybe reluctant to engage in therapy or perhaps they're uneasy about taking medications, a lot of that idea of doing it on their own comes up and maybe the Check-Up Model and MET is tapping into that piece as well. So both the individualism and the sort of doing it on their on-us, as well as what's everybody else doing? It's kind of both things together.

Denise Walker:

And of course like any good MI session, we would be really curious about that with the kid. If we did hear things like, "I want to do it on my own." We would follow that up with all of the natural questions. "What have you found that has worked so far? What sorts of breaks have you taken in the past and what did you find worked? What could you imagine working? Or what could you imagine needing if you found yourself in a position to be committed to making a real different change in your marijuana use?" So those kind of questions would be within that intervention as well. And it's, again, focused not on me telling them what is helpful, what I know about the literature, what treatment they

test, all of that. It's really focused on, "What do you want to do? What have you done? What have you learned?" Very supporting sorts of messages.

Sebastian Kaplan:

I just appreciate you have offering some follow ups to how you'd respond to the doing it on your own position because there's certainly potential traps there of, "Well, taking medicine it is doing it on your own and trying to convince them of other things, but just nice examples of just rolling with that concept and just fitting it in pretty seamlessly.

Glenn Hinds:

Just really promotes the autonomy and continuously communicate your belief in their own resourcefulness, that they are the masters of their own destiny and they know where they're at. They know the pressures and the supports in their own lives. And you're just inviting them to look into those places and say, how does that support help you and how to adapt pressure hinder you? And what ideas have you got of how you want to use that awareness for yourself?

Denise Walker:

Yes. And I think within all of our check-up work, we spend a lot of time training our clinicians to be really good at affirming, helping the counselor be super sensitive and attending to whatever strengths the kid is bringing or the client, regardless, because it's so important that a teen understands that you're having this conversation about marijuana, they think that you have all these perceptions about what they should do about their marijuana use, but their experiences of that counselor really looking for and identifying and noticing the whole person. What is strong about that kid? What they bring to the table? And I think that is also really, really important, especially with our adolescents, but with all of our check-up work, with all who are feeling a little fragile and having questions or concerns about maybe some stigmatized behavior.

Glenn Hinds:

It's overcoming their Righting Reflex that we often talk about in Motivational Interviewing, which is I can see a person in distress and my concern for your distress is heightened because you are a young person and I'm an adult and I have responsibilities in the society to look after young people. And the instinct is to say, "Look, this is the best way forward." What you're describing is that one of the things that I as an adult can do when I'm looking at teenagers is to be curious, how did this person survive this long? And the answer is going to be their own strengths, their talents, abilities, and gifts, resources. That recognizes that one of the resources that they are currently using is the decision to use marijuana for some reason that has a positive intention. Can I understand the positive intention and explore how they can achieve that positive attention in a different way that doesn't involve so much marijuana? But it's that trust and belief in the who you are. And that my job is to support you grow from that place rather than me put the answer into you.

Denise Walker:

Yes.

Glenn Hinds:

It sounds like that's the work that you're doing with your practitioners is helping them to hold that space more comfortably and to practice that ability to notice the strengths, the talents, abilities, and gifts of the other person. Not just to notice them, but to name them to help the young person themselves or the adult begin to recognize it themselves. And from that place then they can make more confident decisions about themselves because they're learning to believe in themselves and the confidence of someone who already believes in them.

Denise Walker:

About creating that environment that will allow someone to look at something that they may be defending pretty heartily, creating an environment where it opens them up to be honest with themselves and with you to create that space that is going to allow for that, where it feels safe to explore what it might be like if I change my use? What might there be advantages?

Glenn Hinds:

Can I follow up with the question? I'm curious when you are working with the practitioners and I'm thinking about the people that are listening to this today, how do you help people to develop that openness, that space to overcome their righting reflexes? If you were to give the audience today some ideas or pointers to what they might try after listening to this to help them develop that environmental approach, what might you suggest to us?

Denise Walker:

Well, all of the things that we've behavioralized within the spirit of MI and the techniques really contribute to that creation of that atmosphere, but in it, I think affirmation sometimes gets lost in the training. So that idea of you're positioning yourself to look for the good, you're positioning yourself, and not in a dishonest way, but you see what you're looking for and so make sure that you are really looking for and trying to uncover and dig around for the strengths, the values, the things that are important to the kid or the client generally. But just that kind of understanding Rick Bes did a great workshop at the Ireland MINT Conference. I don't know if either of you attended that. But there was an exercise where he had us close our eye... look around the room and look for everything that is the color orange, and then close your eyes and tell me what is in the room that's blue? And just that whole idea of like you really do see what you're looking for. And so make sure that you are attending to your clients in a way that really honors all of the things that they're bringing to the world in a positive way.

Sebastian Kaplan:

One thing in particular amongst many things perhaps that clinicians and those learning about MI can really keep in mind is the importance of affirmation and something to be really on the lookout for in your conversations as a way to facilitate this provision of

feedback and subsequent discussion about where does that leave someone. As we begin to start wrapping up, I wonder if you might talk a bit, Denise, about your research with veterans and with the military and what outcomes you've found with that research?

Denise Walker:

Sure. So the PTSD study that I've partly described is ongoing. And so I won't necessarily talk a whole lot more about that, but we've completed a study that was focused on reducing substance use within active duty military here in the United States. And that intervention we developed because the army specifically has treatment resources and programs that are free to soldiers who have a substance use problem, but pretty much only people who get in trouble go to those programs because it goes on your record and command is notified. And so it can have a deleterious effect on your career if you go to treatment within the military. The other thing is even if you volunteer for substance use treatment within the military, your commander is often notified. And so again, we were thinking, okay, so there might be a number of barriers to soldiers seeking care for a drinking or substance use problem. And so might a Check-Up model be an interesting addition to the services that they have? Which were prevention and treatment already. And my thoughts resonate with soldiers.

Denise Walker:

We developed an ad campaign, again, focusing on active duty military and asking, do you have questions or concerns about your alcohol use or your substance use? Give us a call at U-Dub. It's confidential, command isn't notified, it's free, all of that. So this intervention was all by phone. Our participants, we recruited about 240 soldiers, active duty soldiers, 89% had a substance dependence disorder, mostly alcohol. And we provided one session of Motivational Enhancement Therapy over the phone. The feedback included normative data, information on tolerance level consequences of use. We tailored it specifically in a number of ways, but it looked pretty similar to an alcohol Motivational Enhancement Therapy intervention delivered over the phone.

Denise Walker:

We followed these folks up for six months. And of course it was a randomized control trial, so they either got Motivational Enhancement Therapy or they got education, really good education, but they got education. This one session intervention, first of all, attracted a highly clinically significant population. Most had a substance use disorder. All of them had a substance use disorder, but most had alcohol or substance dependence. On average, they were drinking 34 drinks a week and not seeking treatment. So not engaged in treatment. Also high levels of PTSD, depression, other clinically relevant behaviors, but really outside of the therapeutic system. This one session Motivational Enhancement Therapy reduced drinks from 34 drinks per week to 14 per week, which is within normal limits of drinking as established by the National Institute on Alcohol and Alcoholism. And also, by the six month follow up, whereas 89% had alcohol dependence, only 24% had alcohol dependence at the six month follow up.

Denise Walker:

This one session intervention attracted a highly clinically significant population within the military. It allowed an opportunity that was free from fear to evaluate their alcohol use and their substance use, and it made significant differences in their drinking. But I would also say are clinically significant differences

Glenn Hinds:

Again, fantastic results from what most people would consider a very brief intervention for a very complex presentation. And I imagine that would be exciting for a lot of people out there to hear. This doesn't have to go on for years and years and years for some real significant change to happen for people.

Sebastian Kaplan:

It's really just striking. And it's not just the one conversation, of course, it's all of the components that you've described, but still nonetheless not using tons of resources and tons of time can produce some really important and significant results. So really exciting stuff. Well, Denise as we get closer to the end point today, one of the things we ask our guests as we approach the end is what are some things that you're up to lately? What's a project or some fun, new idea that you have on your horizon that you'd like to share with us?

Denise Walker:

Well, right now I'm working with a team on an application around using Motivational Interviewing or adapting our Teen Marijuana Check-Up intervention for folks who are experiencing first episode psychosis. So we know that marijuana has a lot of contributory effect on the development of psychosis and that it interferes with treatment outcomes for psychosis. So it interferes with medication compliance, it interferes with symptom reduction, all of those sorts of things. And so right now, I'm working with a team who has expertise in psychosis and severe mental illness and we are developing an application to adapt The Teen Marijuana Check-Up for that particular population. So it's interesting to think about having those conversations in the context of another disorder that's going on.

Glenn Hinds:

And is it in relation to the psychotic episode in relation to the marijuana use or it's simply a psychotic episode on its own?

Denise Walker:

Well, it could have been influenced by cannabis use, but it also could have just occurred naturally, but oftentimes around 30 to 50% of folks who were experiencing their first episode of psychosis are using cannabis.

Sebastian Kaplan:

Well, that's exciting to hear and quite relevant for us. We've tentatively scheduled our next podcast interview with a colleague in the UK around the use of MI with people who

experience psychotic experiences. So it maybe a nice segue to that session that we hope to produce in the next few weeks.

Denise Walker:

Awesome.

Sebastian Kaplan:

Well, we are approaching the end of our time here or maybe arrived at the end of our time. But Denise, we really appreciate all of your wisdom and all of the work that you've been doing and sharing that with us. I know as Glenn has mentioned, I can speak for myself, it's really stimulated a lot of thought in the work that I do and I would imagine with our listeners as well and how to deliver feedback in a really effective and compassionate way. So Denise, thank you so much.

Denise Walker:

Thank you.

Glenn Hinds:

And we also offer our guests the opportunity or invite our guests to allow people who are listening to the podcast who maybe interested to hear more about what it is you do. If they were able to contact you directly, if that was okay, how would people reach out to you?

Denise Walker:

Sure. Email is probably the best. And my email address is edwalker, W-A-L-K-E-R, @uw.edu.

Glenn Hinds:

Fantastic. And Seb, if you just want to remind people how they can contact us in the social media platforms.

Sebastian Kaplan:

Absolutely. So @ChangeTalking on Twitter, Talking To Change on Facebook and podcast @glenhinds.com. Rates and reviews are very much appreciated. Thank you for listening everyone.

Glenn Hinds:

Thanks, Seb. Thank you, Denise.

Denise Walker:

Thank you guys.

Sebastian Kaplan:

Bye and until next time.

Glenn Hinds:

Absolutely, Seb. Take care, man. Bye-bye.