Talking to Change: An MI Podcast

Glenn Hinds and Sebastian Kaplan

Episode 22: MI in Emergency Settings, with Ravi Maharajh, MA, EdS, LPC, ACS

Sebastian Kaplan:

Hello, everybody, and welcome to the latest episode of Talking To Change: A Motivational Interviewing Podcast. My name is Sebastian Kaplan, and I am based in Winston-Salem, North Carolina, and as always, I'm joined by my good friend Glenn Hinds from Derry, Northern Ireland. Good morning to you, Glenn.

Glenn Hinds:

Yeah, good morning, Sebastian. Good afternoon from a very wet and windy Derry as storm Brendan passes through. So you might here some whirls of wind in the background, but all is good here.

Sebastian Kaplan:

Yeah. Yeah, we had a wet and wild weekend over here, so maybe we're sharing our experiences there. So we have another episode today, which we hope everyone will enjoy, and before we get into our introductions of our guests, Glenn, can you orient the listeners to the various ways they can contact us?

Glenn Hinds:

Yeah, no problem. So our Twitter handle is @changetalking. Our Facebook page is Talking To Change, our new Instagram page is Talking To Change Podcast, and for emails about topics or ideas and questions, the email is podcast@glennhinds.com.

Sebastian Kaplan:

Excellent. Thank you so much, Glenn. Okay. Well, we'll get to it now. Today's episode, hopefully, will be an interesting one. We'll be touching on some topics we've not really discussed so far in the episodes up to this point. So, without further ado, we want to welcome Ravi Maharajh to the program. Good morning, Ravi, and maybe you could just get us started with a bit of a background on who you are, what you do, and tell us a bit about your early MI story, how you got into motivational interviewing.

Ravi Maharajh:

Absolutely. Good morning, Sebastian and Glenn, and thank you both for having me. I'm really excited about today and today's conversations. I'm a marriage and family therapist. I'm a licensed professional counselor in New Jersey, in the United States. I live in Somerset County, which is Central New Jersey, and my work has always been in emergency settings. From the beginning, when I first started and I received my Master's, I worked with children for a youth emergency services team where we would respond to homes, to communities, to group homes and there was an urgent mental health acute situation.

And our role, as practitioners, were to ... We used the word triage and assess. We would see what's happening with the child, with the family system, and make an appropriate referral. Sometimes that was immediate intervention, sometimes it was referring for a high level of care, as we say in New Jersey, perhaps in inpatient setting or an acute partial. So it's always been, for me, that emergency work that I've done for years working with children, working with families, and working with adults.

I'm also fortunate enough to be a member of MINT, Motivational Interviewing Network of Trainers, and I offer trainings on MINT, typically one to two days working with individuals in a behavioral health setting. A lot of the staff that we offer trainings to are direct care staff that work with adults, children, whether it be behavioral health or addictions, or just working in the larger mental health system in New Jersey.

Glenn Hinds:

So your experience sounds like it has been where an individual is experiencing an immediate crisis and that you're offering a conduit towards a service that is appropriate for their particular needs and your role is to engage them in that conversation?

Ravi Maharajh:

Absolutely. Anyone that comes through that either is in any type of psychiatric distress, experiencing acute symptoms, typically the way we look at it is that these individuals are likely at their worst. They're not sure what else to do. They may or may not be in treatment, and their symptoms are so overwhelming that they need an immediate evaluation, and that's something really important that I've always done my best to remind myself, that when individuals are in crisis, when they are struggling, they're likely at their most vulnerable, whether it's in a child, an adult, a family member or caregiver, a friend that's with someone, this person doesn't know what else to do. They are experiencing symptoms that are overwhelming, and they're looking for something.

If someone goes to the medical emergency room for a medical condition, they're looking to feel better. They're looking for an answer, they're looking for care, and the same goes for a psychiatric emergency, whether it happens to be a result of a mental illness or addiction, or even just the person not knowing, and the first time they're ever being exposed to the mental health system, and they don't know what to do.

Sebastian Kaplan:

Yeah. So there's a lot to hold onto there, I guess, as a practitioner, both the immediate needs of handling what is often at least a life concerning situation, if not life threatening, but then also keeping in mind that these are people that are in a particular state where maybe receiving a lot of information is not all that fruitful or maybe if there's a crisis, there may be tendency to think that you need to act for them or provide a lot of answers to them and keeping in mind that there's some level of autonomy support that's still necessary. And actually, Ravi, it'd be great to hear a bit of how you came to MI and when you first heard about it and how it fit with some of that emergency work that you have been doing throughout your career.

Ravi Maharajh:

Yeah, absolutely. Probably very similar to a lot of practitioners in the United States, I could say that when I was in my Master's program, I stumbled across a motivational interviewing. I was asked to read about Bill Miller, Steve Rollnick, and I remember looking at it and reading it and saying, "Okay, this makes sense." And I put it on the side. Didn't really follow up with it much. I was really into family system and working with children, and to me, it just seemed like another book that just came across my way.

Years later as I'm working in emergency services, I realize that so much of my core values, my foundation of being a marriage and family therapist had to do with the Spirit motivational interviewing, and it wasn't until I'd say about seven, eight years ago that I attended a training, and I stumbled across it again, and I said, "Oh, wow. I remember this," and these are things that I was doing, and I'm doing now when it comes to partnership.

A big part of my foundation is to partner with the individual that's in front of me, and although I might have some information that they might not be aware of, I'm, by far, the expert of them, and I'm really big on allowing that person to feel that their voice is being heard and that they're valued and that they are the expert in and of themselves. So after attending that training, I was intrigued for the training department where I worked.

I was asked if I wanted to attend a motivational interviewing program that was for advanced practitioners, which I did. I was excited, and then we had a champions series, and in that champion series, we had practitioners that would take the foundation of motivational interviewing, some core elements and bring it back to their units, and that's how I got involved. And then, within a couple of months, I started sitting in on trainings, and then the rest is history after I submitted my application to MINT.

Glenn Hinds:

Mm-hmm (affirmative). So as is often the case when we talk to guests, they describe, as you have done, Ravi, that they recognize something in what motivation was talking about from another place. So in your description there, that systemic family work, the crossover, it sounds like, for you was the importance placed on the relationship between the practitioner and the client, and that the work towards endeavoring to be supportive of the individuals' own resourcefulness and autonomy and that, because of that, that you recognized some of what you were already doing and what was being described as motivational interviewing, and that tweaked your interest enough for you to want to find out more about it and it has led you on a journey to the point now where you, yourself, are a MINT trainer.

And it sounds like you're endeavoring to integrate your MI practice in emergency rooms and in emergency settings, and that's really what we're keen to explore in more depth with you today. In what ways do you see yourself using motivational interviewing in those settings and how does that influence your conversations? Because I imagine that what most people would be interested in is, I guess, is your time limited, and how does MI work in those short, brief opportunistic interventions?

Ravi Maharajh:

Yeah. Yeah, absolutely. I think one of the things that I always remind myself is whether I have five minutes with an individual or 50 minutes, that person still deserves the same

amount of respect, and I think, too often, what happens is the individual in an emergency setting, many practitioners, whether it's nursing, physician, social workers, therapists, they are tasked with meeting with someone in a very brief period of time, making a referral, and helping the other 50 individuals that are waiting to be evaluated.

It's just one of these ... I call it a systems issue because there is no easy answer. We have individuals waiting, we have families, we have adults, children, and the practitioner is tasked with, "Well, I really just have a few minutes. I want to do the best that I can," thinking of the best interests of the individual. And what happens is that in that transaction, I've noticed that we tend to go into the expert trap of, "I'm here. Sure, I'm going to be nice. I'm going to offer you compassion, but I have a checklist that I need to make sure. I need to know what your chief complaint is in your own words. I need to know what you've tried, what treatment you're in, what medications you're on, and I need to find out what you'd like to do, whether you'd like to sign into an inpatient facility, if you'd like to be held overnight. I need to know as a practitioner what your motivation is."

And in that experience, in that transaction, so much is lost with taking a step back and saying, "Well, if I had 50 minutes with this person, would I treat them the same way? Would I take my time and get to know the person and ask them questions and offer respect and dignity in that five minutes?" And in an emergency room setting, it takes seconds to engage with someone, and the individual that's in crisis, they will know if you are coming in with your own agenda, if you are offering them respect, and if you are looking at them as though they have valuable information to share.

And that's where a lot of the work that I've done over the years, really drilling down to the core elements of motivational interviewing, and that's when we think about the processes of engagement, and we all know engagement never ends. It's an ongoing transaction, and even with a few minutes, it's that approach that practitioners, if they take a step back, they can really get so much more information and allow that person to feel heard by not being the expert and not coming in with their own agenda.

Sebastian Kaplan:

It really seems like there's a tension, maybe, between three different pieces of these conversations that you have. There's the systemic needs and requirements of asking certain questions with certain outcomes like "Where is this person going to go next?" And you, as a practitioner, or maybe as a broader team need to make a decision about that.

There's your own desire to strive towards maintaining the MI spirit alive in the conversation, and in addition to some of the things that you have in mind, that you think are important. Then there's the clients who are coming in. They may not know anything about MI, and they may not know anything about the system requirements. They just know that they're going to a place to, perhaps, get help with something that they may not be totally clear in their own minds about what's going on.

So I guess in trying to balance that and to resolve those tensions as much as possible, what are some specific MI-related concepts that you use? You already mentioned engagement, but just wondering for some of the listeners that are wondering, are there particular questions that you ask? Are there moments that are fairly predictable in the conversation that you try to capitalize on, reinforce, reflect to breathe some life into it, or what are some of those specifics, Ravi?

Ravi Maharajh:

I think a big part of approaching anyone in an emergency setting is to really take a deep breath before you go in, finding your authentic space and thinking about how are you going to, as a practitioner, prepare for a very brief exchange with an individual? We talk about it in trainings, we talk about what do we do, not just for self-care, but to be more mindful of how you're presenting yourself, and anyone can tell if someone's in a rush. Anyone can tell if someone's stressed out, and that same goes for the individuals that are in need of help.

So that's the first thing is really establishing a space where you can be more balanced as a practitioner. I think another thing that we tend to forget in these moments are open-ended questions. Too often we ask close-ended questions because we have a checklist and we have documentation that we have to complete, and it's typically long. It's probably overseen by a licensing agency, or a board, and we're thinking, "Okay. Well, I need this information." So really taking a step back and saying, "I can still ask open-ended questions, and if that takes us to a place where the client or the individual shares a little bit more than we're looking for, that's okay."

I think recognizing that an individual that is in crisis, as I said earlier, they're in their most vulnerable space, and that truly, truly is privilege for any professional to experience sitting in front of someone when they're having a hard time. So taking the time to offer some affirmations. The individual, they might be struggling, and as we all know, they have to come from an authentic space. They have to come from a space of caring, and I really believe that this person is strong. I really believe it took a lot for them to come here, and that goes into a whole other conversation of working in an emergency setting where there's a lot of stigma and there's a lot of judgment, and I say that as someone that has seen it and experienced it from the side of, even, the practitioners.

We can get caught up in the moment of seeing someone for the third time in a week. "Oh, it's this person again," and yes, we're having a hard time and we have our own stuff to unpack, but really taking a second to say, "Okay, this person is back, and they've probably been treated with judgment from the community, from their family, from their friends, from other people in the emergency department, and what can I do in this moment to stop the cycle?" instead of continuing to say, "Well, this person's here again, and you didn't follow up with the recommendation."

It happens very frequently with addictions. "Oh, you're just here because you need dot, dot, dot. You're looking for a particular medication," and really taking a step back. So this all comes back to not so much just the spirit of motivational interviewing, but really looking at some of the micro skills that we all know and we just need to remind ourselves that the person in crisis, they're deserving.

Glenn Hinds:

What's interesting is that when we spoke to Steve Rollnick a few episodes ago, he talked about the idea of rapid engagement, and you've been describing that in great detail for us, which is fantastic, and as you do that, you're also developing what Steve talked about, the attitude. And I think that was a very liberating way of describing and helping people to understand what we mean by the spirit of motivational interviewing, and what I hear you describe is the effort that the practitioner can make in advance of going to work with

the client, which is connecting with themselves, recognizing the sense of balance that they need.

They are working in pressurized environment. There are lots of other clients to be seen. This person they're about to meet is in crisis, and if you're around that all day, it's very easy to get caught up in that systemic experience, the dynamic of that rush. And the effort that you're describing for the practitioner to take a step back and reconnect with the caring, compassionate attitude of, "Okay, what does this person need from me in the next five minutes?" But it's also recognizing, "What must it be like for them to have to be back with us for the third time this week, and what's that experience like for them?"

You mentioned the use of open-ended questions and the use of affirmations, and I'm just wondering, not to put your on the spot, but can you think of the type of affirmations that you have heard yourself use in those situations that, perhaps, audience members can begin to consider when they're having brief interventions of things to notice, and the importance of things that they can consider articulating with their clients to help them feel heard and held and connected to?

Ravi Maharajh:

Yeah. Absolutely. So typically, the individuals that I've evaluated, they're usually in the space where they're feeling a lot of guilt or either not following through with the recommendation or an action that they've preformed because of their acute symptoms, whether it might be mania or they might resort to doing something that they usually wouldn't, stealing or yelling at a family member.

And for the most part, when an individual shares that they've been struggling, and even if they haven't done, necessarily, anything that warrants that guilt, we have individuals that come in that are just feeling so guilty that they feel depressed, and "I don't know why this is happening to me. I don't know why I can't get out of bed." And it's really just offering a statement to them in that moment, "This must be really hard for you," and you may not feel this, but I see strength in you." It's usually that authentic transaction of someone usually just breaking down and that's based, and we all know as practitioners, that doesn't happen with close-ended questions, and with a rapid assessment of, "Let me know why you're here, let me get to the chief complaint, and let me keep going," and go to the next person.

And I find that an individual that's going through a crisis from beginning to end, we're only seeing, as a practitioner, a very minuscule portion of their journey, and the beauty of those moments of offering an affirmation and looking at someone ... Another example is if a family member is with their adult child and really just looking at a parent and saying, "You're really doing everything that you can," and what you're doing is you're allowing to release a little bit even in that moment.

And for the bigger picture of their journey, that experience is likely going to help them for their next interaction with the next person. And not necessarily the next person they see physically, but their next moment, whether it's in treatment, whether they're discharged, that's another space for them to recognize to stop being so hard on themselves. I think we all get into that space, "How come I'm not feeling better?" And "I've tried everything. I've tried medications, I've tried treatment. It's not working for me. Every time I try and get ahead, I fall three steps behind," and it's really easy to fall into that place

of just struggling and questioning, and saying, "Why am I not able to function the way other people do, or why can't I function the way I want to?"

So those affirmations and those ... I like to call them those authentic spaces that you share with an individual, they can be so valuable to that individual for their larger journey. Anyone that's worked with an individual for outpatient and seen them more than once, you get a different ... You're working with that person in a different space, and you're likely going to get more dividends paid by having those moments when the individual is in crisis.

Glenn Hinds:

It sounds like what's really reinforcing is the authentic belief in this other person and just naming that articulating that, being able to open your eyes to the individual and appreciating that wherever they are on their journey has taken effort on their part, and it's just noticing that for them, the fact that the mother is sitting with her adult son or her child, that took effort on her part, and it's very easy for us to assume, "Well, that's what a mother is supposed to do." And it's going beyond that.

The fact that she's here is evidence of her desire for her son or her daughter to be well, and that arises from a place where she wants to manifest her love for her child, and just being here is that, and you just noticing that, too, you're working hard. You want the best for your child. It just helps them to feel noticed, and it sounds like the being noticed, that's where some of the relief on burdening themselves with the guilt or the fear or the apprehension, that then feeds their willingness to carry on and to feel lightened in that journey.

Ravi Maharajh:

Yeah, absolutely. I find that especially in the United States, we don't say it enough. We don't offer self-love. It's just something that, typically, when a parent hears that, their immediate response is, "Well, I wouldn't do anything else," or "This is my job." Not in a bad way, but in a way it's hard for them to receive an affirmation because they're still focused on their family member, on their loved on, on their child, and they want them to feel better first, and just like they say that the parents will put their kids first ahead of everything, regardless of what they've done, what they've felt, in their darkest moments, your children come first.

And what we have to remember is to take care of ourselves as a caregiver, and if we're able to take care of ourselves, what we're essentially doing is we're modeling what we'd like from our children and from our loved ones is, "Hey, I can say I wanted you to get better, and I can lose sight of the fact that I need to do certain things for myself. Eat." That's the biggest thing in the emergency department. The second question is, "Did you eat yet?" And they'll say, "No. No, no, no. I need to make sure that my child or my spouse or family member is okay."

So even the simple nourishment of feeding your body when you're pushing through is likely if they're in an emergency setting, it's been hours and days of trying to figure out what to do, and typically in New Jersey and the United States, the emergency department is a last resort. So individuals are that in crisis have likely been in crisis for a while. So it really is a fascinating journey for the individual, and I mentioned that I find it to be such a

common but terrible word, guilt. That guilt that the individual might be experiencing seeing their family member that's undernourished, not eating, worrying, not being able to feel better on their own. So, it really is this fascinating dynamic of alleviating guilt and self-care and self-love that we, as practitioners, with a small space of authenticity, can go so far with individuals and families.

Sebastian Kaplan:

Yeah. Sometimes I think about it as "What is a client leaving the room with, whether it's an emergency setting, outpatient, inpatient, whatever it might be?" And as providers, we can get easily lost in the transactions that are a bit more tangible like a referral or a prescription, if you're a physician, things of that nature, and the importance of an affirmation, and authentic affirmation done in a way that matches where the client might be because, sometimes, it's hard for people in a crisis situation, maybe, to see that part of themselves, but that offering of an authentic affirmation adds to what the client leaves the room with, and very often the strength that you're shining a light on there is something that would be relevant to the next part of their journey, as you say, whether it's the next placement or it's the next provider that they're talking with, or maybe a conversation with their child or another loved one.

It seems relevant for the practitioner, also, that it's so easy to get focused on parts of the situation, which are, perhaps, even true, like someone might be coming to see you because they are wanting pain killers, and they may have an addiction, and they see you as somebody who could help them access that. That might be true, and so as practitioners, if that's what we're focused on, if we think of them as med-seeking, manipulative, all those sorts of words that we hear practitioners use, that's what we're leaving the experience with. And gosh, string a few of those interactions together, that's not going to really be beneficial for us as healthcare providers. So the idea of affirmations and focusing on people's strengths, at least as part of the transaction, seems to benefit both people involved.

Ravi Maharajh:

Yeah, and you actually brought up a good point, Sebastian, is that as practitioners, we feel what we feel also, and very often in an emergency room setting, supervision is lacking and really true supervision of feedback and processing, I think there's administrative supervision of in the event there's a complaint or procedural ... That happens all the time. Scheduling, because we're all surviving. We're all doing the best we can.

But as practitioners, to model what we were just talking about, of self-care and knowing that if we take care of ourselves and we seek supervision, it's few and far in New Jersey where a true model of supervision is working and is effective and is implemented because of the systems issue of seeing more individuals in a shorter period of time and let's get them to where they need to go, because if not, there's going to be a backfill of clients that are waiting and waiting and waiting.

So we're tasked with running in there. Just like you said, we might have three or four interactions in a row where it may not have gone exactly the way we want it to, and it's not always kind words and special moments. There could be a lot of frustration from the practitioner side, and that's where truly, truly thinking about, "If I'm going to sustain a

career in an emergency setting or if I'm going to be doing this, even if I'm doing it for a year, what am I doing to access true, true supervision and feedback to process what I'm feeling so I can have someone else, in turn, offer me the same respect and dignity to say, 'You know what? You're probably having a hard time, too'?" And for the practitioner to release a little bit because then they're on their bigger journey of helping people, they're going to be able to be more effective in that space.

Glenn Hinds:

It sounds like the ideal situation would be that the practitioner has good supervision and has got to a place where they can have developed a very positive internalized supervisor, internal supervision, and I imagine that that's an art form, that most of us as practitioners are always working on mastering. And I've wondered, in your own experience, what have you seen yourself do over the years that has enabled you to continue to work in this environment without losing sight of yourself or having a negative impact on your emotional/psychological well-being?

Ravi Maharajh:

Oh yeah. A big part of my routine has always been on my drive home. That's where I do most of my unpacking. I like to make sure whatever that is for me, and it's always changed over the years, when I first started off, it was always sports radio. I wouldn't even want to think about what I just experienced for the day. I was physically tired, I was emotionally drained, and I just unpacked by listening to New York/New Jersey sports radio. Baseball, football, basketball, whatever it is. Get my mind off of things. And that short drive, 30 minutes, 20 minutes, allowed me to just not get into my car and think about my day to build it up because I don't really have a transaction to unpack it. I don't have someone else that can help me to release it and process it. So I would just not want to even think about it.

We talk about when you work in emergency services, there is no case load. You have no follow-up appointments; you don't have to make any calls. So that's the beauty versus an outpatient setting, but at the same time, your work needs to be done before you leave. Your documentation needs to be done. So if your shift is eight hours, it might be eight and a half, it might be nine because the documentation needs to be completed in the event the person comes back before your next shift.

So, knowing that, once I left, I left, and I made sure that I left everything at work. And I was really fortunate enough to be able to do that for many years, to just find spaces of thinking about other things. I had a golden retriever for many years, and after the sports radio, I'd come home and we'd go for a walk. Rain, sleet, or snow, or great weather. We would just go around, and it was great. So I found things that helped me that I was able to just remind myself, "Tomorrow is another day," and even if I see the same person, that's in holding. I'm giving myself a fresh start the next day, and that really helps.

Sebastian Kaplan:

Yeah. So important to have those routines that we might fall into naturally, but also to be quite intentional about how we take care of ourselves during the really difficult work that we all do. Ravi, I was curious about another MI related concept and how you see it fitting

in the work that you do and how you might go about it. So the notion of change talk, of course, that is one of the key features when one is doing MI as opposed to an assessment isn't necessarily motivational interviewing, per se, but you're certainly bringing the MI spirit and some of those important concepts to those conversations. But I guess I wonder if you could speak a bit to the moments of the conversation where you feel like you're listening for, perhaps asking questions that are designed to evoke change talk, and what does that sound like in an emergency setting?

Ravi Maharajh:

Yeah. I think that's a great point, Sebastian, in that whether you're working with a child or you're working with an adult, it happens more than it should, but these individuals that are in crisis, there likely have been ... From a good space, they've been offered advice. They've been lectured. They've been told what they're doing is wrong, whether it's treatment or behaviors or medications, and that's where we have our moments, especially when I'm working with children.

If you have a teenager come in and I'd like to get their experience from what they've heard so far, so I'll say, "Wow. You've probably spoken to a lot of people about this," and you get a little smile where you're like, "Yeah," because, typically, if a teenager is in the emergency department, they've spoken to their teacher, their guidance counselor, their assistant principal, their principal, their resource social worker, the security, whatever church or religious affiliating, parents, siblings, and then they get to the emergency room and they speak to a nurse, a triage nurse, a social worker.

And the beauty is really hearing from them, knowing that they've been exposed to this lecture and this expert trap of, "You need to do this," and all from a good place, but they've likely not been treated with respect, and they've likely just been told, "Hey, if you keep going down this road, this is what's going to happen." And the change talk can come in a simple statement of, "How would your life be different if this whole transaction changed? What would it look like?"

And you'll hear, especially with teenagers, and I think working with teenagers, it goes the same as working with adults. You hear individuals say, "Well, I just want someone to listen to me. I just want to be part of this, and if I don't know what to do, then I don't know. But everyone can tell me what to do," and when we're thinking about change talk, we're thinking about what does that person want to see change for themselves? And being aware of that assessment, and you have individuals that are frustrated, and they're like, "Nothing. I don't want anything to change." And they shut down, and you get the parents saying, "You see, I told you," and they're just reinforcing this cycle.

So I think the beauty of change talk from an MI practitioner's perspective is to think about what that person has been exposed to up until your interaction with them, and that's where you have such a beautiful opportunity because change talk, to them, and these questions that we ask, they've probably never heard this language. They think it's a foreign language.

"Wait, you're asking me how my life would be different? You're asking me what would be different if ...?" So I think we have amazing opportunities just by nature of what the individual has been exposed to. And again, all in good faith and coming from a good place. We could look at it culturally, and we could look at it generationally. Typically, when

we start to lecture, it's because we care. It's just that lecturing doesn't work for everybody, and it doesn't work for a lot of people, and that's where we have our opportunities.

Glenn Hinds:

And there's a lot in that Ravi, I suppose in your last point there. It's even just, again, that sensitivity to recognizing the motive behind a lecture, and that in itself presents an opportunity for you to offer an affirmation. It sounds like all those times where you've been really encouraging your son or your daughter or husband or your wife to be different, what's really important for you is for them to feel well and you want the best for them. That invitation for the patient to consider, "What is it you want?"

I suppose, the really important takeaway from that for me was that while they may be in a crisis, what they asked for was someone to listen. And that we do have five minutes, and during those five minutes, I can give them the very thing they're looking for, is to be listened to, as I do my work, as I do my assessment, as I make some decisions. I can be fully present to what it is they're describing and be really interested in things from their perspective, and including information from other people, and exploring with them, "What do these other people's ideas sound like to you?" And just keep bringing it back to autonomy and the respect for that individual.

Ravi Maharajh:

Yeah, absolutely. Again, these are the spaces where we have opportunities to recognize individuals typically respond to respect and dignity. They're less likely to respond to being talked down to, rolling of the eyes, body language of crossed arms. It happens all the time, and as practitioners, it's reminding ourselves and modeling for family members and other individuals, and even for colleagues, if we're in a space where it's difficult, we can model to be respectful, even when someone is having a very, very difficult space.

Anyone listening to this knows in an emergency room setting, there's a lot of things that can happen. There's a lot of things, you can be called every name in the book. You could be treated in a space where you ... It's a hard space to work in. It's a hard environment, and reminding ourselves, "This is not about me. I'm a small glimpse of a radar." This person has a larger journey, and not taking it personally and recognizing that we can model even when someone is at their worst, you could still offer respect and dignity to someone when they're at their worst, then you can also help them so that they feel heard.

Sebastian Kaplan:

So many wonderful messages and ideas for people to take with them, both in terms of maybe the technique and strategy of MI and conversation, but also in the reflection on what we bring in to the room and what we take out from the room for ourselves and for the people around us.

Ravi, as is tradition for us towards the end of our conversations, we like to ask our guests if there's anything new that's on the horizon for them, professionally, maybe personally, could be related to MI or not. But what's coming up for you that you're excited about?

Ravi Maharajh:

Oh, I always get excited around this time of year because I sign up for the Brooklyn Half Marathon, which is in New York. It's a 13.1 mile race, and I don't consider myself a big runner, but once a year, around January, I use this to get into the space of clearing my mind and do my best to be in a mindful space to prepare. So the race is in May. It takes a few months for me to get into a place where I can actually complete it. I am very comfortable in saying that I jog it. I don't run it full out, but that's something that's really exciting for me, and I think it will have a ripple effect of just taking care of myself and doing something that I enjoy.

So the Brooklyn Half Marathon is coming up in May, and I'm hoping to get to a space where I can just have another great experience. I've ran it twice, and this will be my third year. So that's a little bit of self-care for myself.

Glenn Hinds:

Relating back to what you said about after you come back from work, going for the walk with your dog, you've identified a very important way for you to connect with yourself, and that's the through the physical activities that you're involved in. Going for a walk, getting space, and it sounds like doing that, it not only is good for your body, but it's also good for your mind and your relationship with yourself, and it sounds like that's what's really important to you, taking care of all aspects of yourself enables you to be much more present and much more available as a good helper for the people that you're going to meet in your work in a day to day setting.

Ravi Maharajh:

Absolutely. Being able to be mindful in a space of running, whether you're listening to music, whether you're looking at people, and these races, you get so much support from the community, and people are holding up signs. And one of my favorite things is to just read as many signs as possible. It takes my mind off of having to run. Of course, you enjoy it, but at the same time, it can be a little bit of a push on the body, so just being mindful to your space, to the people around you, to the people that are cheering you on, to the pets that are watching you, the dogs and all these other things. But definitely being able to apply that to everyday life is just such a great ... I feel very fortunate to be able to do that.

Sebastian Kaplan:

Yeah. Wonderful lessons and wonderful strategy for how to survive a half marathon. For people out there who are maybe wondering and contemplating that, there's plenty to look at and watch and absorb from the onlookers. Ravi, also, as we start wrapping up, we would like to offer the opportunity for our listeners to contact you if they have any questions. So what would be the best way for people to reach you?

Ravi Maharajh:

Sure. I'll give two options. The first one is on Twitter. You could follow me or direct message me @RaviMaharajh, which is R-A-V, as in Victor, I, M-A-H-A-R-A-J-H for my

Twitter handle. And the second is the same for Gmail. So it's RaviMaharajh@gmail.com. And you can email me or direct message me, and we can definitely connect.

Glenn Hinds:

Oh, and just building on that, then, for our listeners, just to remind you that on Twitter you can follow us or direct message us at Change Talking. On Facebook, it's Talking to Change. On our Instagram, it's Talking to Change Podcast, and for direct contact with myself or Seb for ideas or questions, the email is podcast@glennhinds.com.

Sebastian Kaplan:

Fantastic. Thank you, Glenn. And Ravi, thank you so much for sharing your insights and expertise on using MI in the emergency setting. We really appreciate it.

Ravi Maharajh:

Oh, thank you both for having me. It was a lot of fun having a conversation and really great experience. Thank you.

Glenn Hinds:

Thanks, Ravi.

Sebastian Kaplan:

Well, Glenn, until next time, have a good day, a good several days, and keep yourself dry and warm out there.

Glenn Hinds:

Thanks. Take it easy.

Sebastian Kaplan:

All right.

Glenn Hinds:

Thanks, everybody.

Sebastian Kaplan:

Thank you.