Adapting MI for Cognitive Difficulties

The following are ideas from a variety of sources to adapt MI for cognitive difficulties, which can include FASD, severe mental illness, acquired brain injuries, etc. It is not meant to be a formal literature review, nor is it complete.

This is the first draft of a "living document" that will be updated when new ideas emerge. So… if you are reading this and have any feedback or more ideas, please send them to donna@kerrcreative.ca.

The references from articles are listed at the end. Many of the tips are from people working in the field who, through a lot of trial and error, have found what can work. Thanks to each of them for sharing this knowledge.

General tips/approaches

The relationship (engaging) is critical with people with cognitive difficulties as they may have had bad experiences with other service providers. Creating a safe, non-judgemental environment is truly the first step.

Take breaks. Take some breaks in your interviews to rest the brain. Consider shorter meetings.

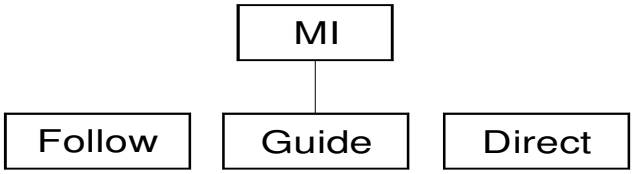
Ask for the behaviour you want, rather than what you don't want. For example:

> "Turn the stove off when you are done," rather than "Don't leave the stove on."
>
> "Please be on time for appointments," rather than "Don't be late."

Use simple sentences and visuals whenever you can.

Program modifications can be made at the practical level such as reminder calls and transportation assistance; consistency in program timing; flexibility for late arrivals or missed appointments; extended timeframes for program duration; and flexibility and/or adaptations in group programming and process, reducing noise levels or visual clutter and "care for the caregiver" such as smaller case loads and service provider supervision and support (Rutman, 2013).

Continuum of helping styles



You may have to take a more directive role with someone who has cognitive difficulties. Knowing when to switch styles is key.

Introduce the MI style

Martino et al. (2002) found that the general supportive and collaborative MI style of interaction was unfamiliar to people with dual disorders who may have become accustomed to a more directive and authoritarian style of traditional psychiatric interviewing. They recommend using an introduction that explains the different style with the following example:

> "Before we begin, I would like to explain what we will do in this meeting. I recognize that you may have talked with many professionals in the past about your use of substances and psychiatric issues. We also will talk about these areas today and any other areas that are important to you but perhaps in a slightly different way. My main interest is in understanding how you view your problems and get to know you better. I would like to talk with you about how alcohol or drug use and psychiatric issues have affected your life from your point of view. I may ask you a few questions along the way, but mostly I want to listen to what you have to say and make sure I have correctly understood what you have told me."

Focusing

An open question (e.g. What would you like to talk about today?) may be too open. You can provide some choices and ask the person to choose.

A menu of options can provide structure while allowing choice. Be careful not to have too many options which can overwhelm the person.

A bubble chart can help with focusing and returning to a focus in an interview. It can be blank bubbles or pre-filled (with some blanks).

If a person has a "one track mind with in the moment thinking," complete the current task and then refocus (Ory, 2015).

> Ask "What will happen next?" to test for one track mind with in the moment thinking. A sure sign is if they are confused.
>
> Try saying, "We need to do this now. Let's do this now."

Ask the person – evoke!

People with cognitive difficulties often get treated like they are stupid (and may believe it themselves). Yet they have many capabilities and ideas and they are the experts on themselves and what works for them.

> Try to draw out from them what would help them learn, remember, accomplish a task, etc. In MI, we call that evoking. If you have other ideas, ask for permission to share them.

It may take time to determine what the person can do, e.g. can they carry out the many complex tasks of getting to an appointment on time? They may not want to admit they don't know what to do. You can try to normalize this with something like, "Lots of people have trouble getting somewhere on time." And then ask for what would help them, e.g. What helps you be on time?"

Evoking change talk

People with cognitive difficulties may see more of the don't change side, especially barriers to change. Listen carefully for change talk when it's spontaneous and evoke it when it isn't coming forth.

You will hear change talk. Even with poor memory and attention, change talk will be present. If you are going to do repetition (through reflections), it's better if it is the change talk.

Avoid exploring the don't change side in great detail (this is just good MI).

Discord

Discord and the righting reflexes are key concepts for cognitive difficulties. Much of the discord and the resulting behaviours are created by the way people approach the person with cognitive difficulties.

Authority figure issues, constant prompting, correction, and failure to meet expectations are common triggers for discord.

Make it a safe place/experience, go slower, speak softly and avoid the righting reflexes.

Values Card Sort

It can be very helpful to ask about what people value and what's important to them, and what goals they may have.

There is a Values Card Sort for schizophrenia that is more concrete and has items related to schizophrenia.

Pictures work well in identifying values. You could have the person draw or collage their vision of what they want/value. Make your own picture card sort.

Strengths tool

Use a Strengths list or tool to ask about strengths.

One practitioner found a person got upset when they had too few strengths on their list. The tool seemed to highlight the strengths they didn't have. The practitioner recommended cutting the list into cards so the client only sees the strengths they do have and not the "missing" ones.

Use a Strengths list or tool that has more concrete and less abstract strengths listed. It might work better to shorten the list too (some tools have 50-100 strengths which might be too much).

The Rulers

If a person does not understand what the numbers represent, use pictures or a gradient.

> Examples include traffic lights, pictures for the target behaviour (park bench to apartment picture), hot to cold, the words stop and go, etc.

Showing progress over time using graphs can be very powerful as it shows the smaller levels of progress.

Summaries

If a person has cognitive disabilities, keep summaries short and concrete (good practice for taking out extra, unnecessary words from your summaries!).

Affirm

It can be easy to notice the areas a person with cognitive difficulties has difficulty in, but harder to notice the areas of strength.

The attitude underlying Affirms is that of being on the lookout for material to affirm, i.e. strengths.

The stigma, experiences of not fitting in, and negative judgements that people experience make affirms that much more powerful. Use them whenever you can!

Questions

Open questions can make the person feel they have the power to choose their answers. They can also be confusing and not provide enough structure. Keep them short and concrete.

Watch out for compound questions which ask about more than one thing, e.g. “Was that something you wanted to do or was there something else?”

Watch reactions to closed questions. Some people have an “automatic no” that protects them from getting into something they don’t want or gives them time to think. Ask open questions in this case (Ory, 2015).

If the person cannot identify his/her preference, questions that force a choice (e.g. “Would you rather stay at home or go to the class?”) might elicit resistance.

> On the other hand, people may respond well to limited choices or options instead of open questions.

Key questions (asking for a decision) can create stress and pressure to come up with an answer. Watch for resistance resulting from the stress rather than the choice for change.

Avoid “Why” questions (with everyone, not just people with cognitive difficulties!).

Reflections

Verbally skilled people may pick up on “parrotting” very quickly. Combine simple reflections with complex reflections and questions.

Watch out for metaphors! They can be taken literally or confuse the person.

Many people with cognitive difficulties feel like an outsider or judged. Empathy is the antidote to judgement. Reflective listening is the skill of empathy. It can be one of the most healing things you can do.

Reflections may “sound different.” They are not questions or directions. If they seem to confuse the person, try prefacing them with an introductory statement, e.g. “Help me understand this…” or “It seems you are feeling…”

Simple reflections may give the person more processing time and be easier for them to comprehend. Allow extra time for people to respond.

Keep reflections short and simple to reduce information processing demands on the brain.

References

Martino S; Carroll K; Kostas D; Perkins J and Rounsaville B. (2002). Dual Diagnosis Motivational Interviewing: a modification of Motivational Interviewing for substance-abusing patients with psychotic disorders. *J Subst Abuse Treat.* 2002;23:297–308.

Ory, Nathan. 2015. *How you give choices and ask questions makes a difference.* Downloaded Dec. 2015 from www.knowfasd-wikipro.ualberta.ca/Negative behaviours: Intervention options.

> Nathan Ory has a number of tip sheets available from the above web site and at a variety of FASD sites. The tips are concrete and useful and worth checking out in more detail.

Rutman, Deborah. 2013. Voices of women living with FASD: Perspectives on promising approaches in substance use treatment, programs and care. *First Peoples Child & Family Review*; Vol. 8 Issue 1, p108.