Motivational Interviewing: Practical Strategies for Speech-Language Pathologists and Audiologists

Technique D'entrevue Motivationnelle : des Stratégies Pratiques pour les Orthophonistes et les Audiologistes

KEY WORDS
COMMUNICATION
COUNSELING
MOTIVATIONAL INTERVIEWING
CLIENT-CENTERED PRACTICE
SPEECH-LANGUAGE PATHOLOGY
AUDIOLOGY

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Abstract

Effective counseling and communication skills are essential in the disciplines of speech-language pathology and audiology, yet many clinicians receive limited exposure to counseling skills in their training programs or professional development opportunities. There have been advances in evidence-based counseling practices in rehabilitation settings. This tutorial will discuss Motivational Interviewing (MI), with specific focus on the disciplines of speech-language pathology and audiology. It will discuss the background and evidence supporting MI use, and provide guidance for basic techniques that can be implemented immediately into clinical practice. Resources for continued learning are also included.

Abrégé

Des habiletés efficaces en counseling et en communication sont essentielles pour les disciplines de l'orthophonie et de l'audiologie, mais de nombreux cliniciens ont une exposition limitée aux techniques de counseling lors de leurs programmes de formation ou de leurs activités de perfectionnement professionnel. Des progrès ont été réalisés en ce qui a trait aux pratiques de counseling fondées sur les données probantes en réadaptation. Ce tutoriel présentera une technique d'entrevue motivationnelle (Motivational Interviewing (MI)) et sera particulièrement axé sur les disciplines de l'orthophonie et de l'audiologie. Nous examinerons les antécédents de cette technique et les données probantes en appuyant l'utilisation, et nous présenterons des techniques de base pouvant être mises en oeuvre immédiatement dans la pratique clinique. Nous fournirons aussi des ressources pour poursuivre l'apprentissage.

MOTIVATIONAL INTERVIEWING TUTORIAL OUTLINE

"Why didn't I say that?" This question probably enters the minds of many clinicians as they reflect on their communication and counseling interactions with clients and their families. This question was also the title of a tutorial on counseling in speech-language pathology (Vargo & McFarlane, 1994). That document highlighted the importance of counseling skills in our professions, and lamented the lack of coursework on counseling provided by most training programs and the lack of confidence in counseling skills reported by clinicians (Culpepper, Mendel, & McCarthy, 1994). Unfortunately, the situation has not resolved; in a recent survey, 60% of clinicians in their clinical fellowship year in American programs reported that counseling was not an integral component of their graduate programs or clinical practica (Philips & Mendel, 2008). While the paucity of counseling training may not yet meet the need of our professions, there have been substantial advancements in evidence-based practice related to counseling. In a review of counseling theories and their application to rehabilitation counsellors, five criteria were identified as critical for application of counseling in rehabilitation (Olney, Gagne, White, Bennett & Evans, 2009). The approach should be: 1) goal-oriented, with a specific outcome targeted for the counseling interaction; 2) collaborative, with the client and clinician sharing decision-making; 3) client centered, as evidenced by skilled listening and clinician responses contingent on the client perspective; 4) brief, with the clinician using techniques that are effective in small doses; and 5) evidence based, with techniques that research has shown to be effective. This review of counseling theories concluded that one approach to counseling, Motivational Interviewing (MI), fit all five criteria (Olney et al., 2009).

This tutorial will provide an introduction to MI, with specific focus on the disciplines of speech-language pathology and audiology. It will discuss the background and evidence supporting MI use, and provide guidance for basic techniques that can be implemented immediately into clinical practice. Resources for continued learning are also included.

REFLECTION

Before providing the background and techniques of MI, it will be helpful for the reader to reflect on their typical communication patterns with clients. Appendix A contains three brief scenarios to assist with your initial reflections. Provide responses to those scenarios before continuing with this tutorial.

Responses to client statements like those in Appendix A typically fall into one of five categories: providing information, providing suggestions, asking questions, reflecting client comments or saying something "supportive". Categorize your responses within these categories. You may have used more than one category in each response. Identifying your typical response patterns will assist you in selecting goals for development as you proceed through this tutorial.

MI BACKGROUND

MI is defined by Miller and Rollnick (2002) as a "client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (p. 25). MI is a person-centered approach consistent with Rogers (1992) but includes goal-directed aspects also found in approaches like Solution-Focused Therapy and Cognitive-Behavioral Therapy (Olney et al., 2009). Unique to MI is an emphasis on recognizing, eliciting and supporting discussion of change with clients (change talk). MI has a philosophy, theoretical framework and a broad range of techniques to assist clinicians and counsellors in developing effective communication strategies to support clients through change.

The fundamental spirit of MI has three elements: collaboration, evocation and autonomy (Miller & Rollnick, 2002). *Collaboration* is a recognized component of patient-centered intervention. Collaborative interactions acknowledge that both participants have knowledge and perspectives to be considered. Clinicians who are effective collaborators in their clinical interactions do not rely on their authority or expertise to influence client decisions. Instead, they are interested in client perspectives and work effectively to learn about those perspectives (Moyers, Martin, Mauel, Miller, & Ernst, 2010). *Evocation* represents the clinician's acknowledgement that reasons for change, and decision for change, resides with the client. The evocative clinician works skilfully to elicit and reinforce consideration of change and plans for change from the client. Finally, respect for the *autonomy* of the client is highlighted, along with the responsibility of the clinician to convey that autonomy. Clinicians who are skilled in conveying autonomy can not only acknowledge it, but expand their clients' perceptions of control and self-efficacy. When the spirit of MI is present, the techniques of MI become part of a grounded and principled approach.

MI was originally developed for addictions counseling (Rollnick & Miller, 1995). The evidence supporting its effectiveness in that context resulted in a rapid growth in use of MI and extensive application in a diverse range of settings and client types (Resnicow et al., 2002). MI approaches have expanded to such varied areas as cardiovascular health (Beckie, 2011; Brodie & Inoue, 2005), diabetes (West, DiLillo, Bursac, Gore, & Greene,

2007), diet (Brug et al., 2007), brain injury (Bombardier & Rimmele, 1999), and health promotion (Bennett, Lyons, Winters-Stone, Nail, & Scherer, 2007). MI has also been adapted to be an "add-on" to other healthcare services and for use by those whose primary role is not as counsellor, with research support for its effectiveness in these contexts (Dunn, Deroo, & Rivara, 2001).

Despite the varied uses and adaptations of MI, systematic reviews and meta-analyses have found positive outcomes resulting from its use. Rubak, Sandbok, Lauritzen and Christensen (2005) found a positive effect of MI in 74% of the randomized controlled trials included in their analysis. No negative effects were found. The most recent meta-analysis (Lundahl, Kunz, Bownell, Tollefson, & Burke, 2010) examined outcomes related to substance abuse, increasing "healthy" behaviours, risk reduction and measures of emotional health. They concluded that, "MI does exert small but significant positive effects across a wide range of problem domains, although it is more potent in some situations compared to others, and it does not work in all cases" (p. 151). In fact, either no effect, or a negative effect was noted in 25% of the studies reviewed. Examination of these results did not reveal any definite factors that may predict positive outcomes. Despite this, the authors supported the use of MI in health care and concluded that MI may be more "cost effective" as it is typically more efficient and its effects are found over a shorter treatment period than other interventions (Lundahl et al., 2010). Results also indicated that the format of MI delivery, whether it was used alone or as part of another health program, did not appear to affect results (Lundahl et al., 2010).

MI has evidence supporting its use in a variety of clinical settings and can be included within other rehabilitation programs. Although there are few reports of its use in communication disorders (Behrman, 2006), its adaptability and categorization as goal oriented, collaborative, client-centered, brief, and evidence-based make it a good fit for speech-language pathologists (S-LPs) and audiologists.

APPLICATIONS RELEVANT TO SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

Medley and Powell (2010) suggest that MI can be used throughout the rehabilitation process to encourage a "therapeutic alliance", facilitate goal setting and encourage engagement in therapy. One or all of these purposes will be part of any service provided by S-LP s and audiologists. Examples of applications to clients typically served by S-LP s and audiologists are presented below.

MI's application to services for those with traumatic brain injury (TBI) has been explored by several authors (Bell et al., 2004; Giles & Manchester, 2006; Medley & Powell, 2010). It has been effective in ameliorating the lack of engagement in rehabilitation common in treatment of individuals with brain injury and other areas of deficit (Medley & Powell, 2010). One application of MI for TBI clients was use of telephone interventions using MI techniques as part of follow up for clients. The telephone interviews occurred six times over a nine-month period beginning soon after the TBI and resulted in significantly less depression in those that received the intervention (Bombardier et al., 2009).

A similar result was found in a randomized control trial providing MI sessions to stroke survivors to assist them in adjustment (Watkins, et al., 2007). Clients were provided with up to four individual MI sessions, 30-60 minutes in length. Measures taken three months post-stroke indicated that MI had a positive effect on "mood". Researchers also reported a "protective effect" of MI against depression.

Behrman (2006) explored applications of MI in voice therapy. MI was proposed as a supplement to a voice therapy program, and used throughout intervention to assist with treatment adherence. Initial results indicate that MI "holds promise as an approach to address patient adherence to vocal behavioural change" (Behrman, 2006, p. 215).

Many S-LPs and audiologists work extensively with children and their families. Although there are no studies of MI use in pediatric practice in these disciplines, there have been reports and studies from other health care providers. MI has been used in programs providing support and education to parents of children with health or psychosocial needs (Gance-Cleveland, 2007). Its use in parent education contexts supports a move from the education and persuasion typical of an expert approach towards a more family-centered approach with a focus on supported problem-solving. Ingoldsby (2010) reviewed methods for supporting family engagement and retention in mental health programs for their children. They reported good outcomes from programs utilizing MI as measured by improved motivation and greater attendance at education sessions. Sindelar, Abrantes, Hart, Lewander and Spirito (2004) also reviewed MI use in pediatric settings and concluded that MI supported current patient-centered approaches to healthcare and was an appropriate method for use by pediatricians and other health providers.

Evidence from a variety of settings supports the use of MI by non-counsellors as a part of their rehabilitation or educational services. Miller and Rollnick (2002) emphasize that effective application of MI requires an understanding of the substance of the approach, not

just mechanical application of specific techniques. The substance includes the general principles presented in the next section.

MI PRINCIPLES

MI is more than just a collection of techniques. The essence of MI is described through four guiding principles that are used to encourage active participation in change: express empathy, develop discrepancy, roll with resistance and support self-efficacy (Miller & Rollnick, 2002).

Express Empathy

Empathy is a key concept in helping professions and is emphasized in humanistic approaches to counseling (Miller & Rollnick, 2002; Luterman, 2008). The expression of empathy is accomplished through reflective listening where the clinician "clarifies and amplifies the person's own experiencing and meaning" (Miller & Rollnick, 2002, p. 7). The deliberate use of reflective listening to develop and communicate accurate empathy is an approach used throughout MI as the foundation on which other principles and skills are layered. A sense of acceptance is essential to effective reflection and expression of empathy.

Develop Discrepancy

Although acceptance is a key concept in MI, it is also recognized that the client may need to make modifications to his/her behaviours or perspectives in order to make positive health choices. These modifications can be prompted when the clinician guides the client to see the discrepancies between his/her current behaviour and goals, and/or values. Discrepancy leads the client to verbalize reasons for change and methods for change.

Roll with Resistance

Informing and persuading are techniques often used in counseling interactions with clients. Unfortunately, those techniques reinforce the expert role of the clinician and can result in resistance from the client (Luterman, 2008). In fact, Miller and Rollnick (2002) suggest that resistance from the client is a signal for clinicians to change their communication techniques. Rolling with Resistance acknowledges that resistance is a natural part of the change process. Rather than persuading or educating, the clinician shows respect for the client and emphasizes their autonomy to reduce resistance. Discussion will then be focused on supported problem-solving. Careful listening and reflecting of resistant statements can lead to statements of need for changes and possible solutions.

Support Self-Efficacy

Self-efficacy in this context represents the client's confidence in their ability to make a change or follow through with a change plan. This belief is related to positive treatment outcomes (Miller & Rollnick, 2002), and is an essential component in the change process. In order to support self-efficacy, it is also important for the clinician to perceive the client as capable of change.

Application of MI involves layering specific communication skills and techniques onto a framework of MI spirit and general principles. Key skills for use are discussed below.

KEY SKILLS

The key skills in MI overlap with other counseling and communication frameworks. In fact, clinicians exposed to these skills often state, "I already do this." (Rosengren, 2009). The difference is that MI is an integrated, goal-oriented approach and guides skillful, strategic use of communication techniques to achieve specific therapeutic outcomes. The key skills of MI as presented by Miller and Rollnick (2002) are: Open Questions (O), Affirmations (A), Reflections (R), and Summaries (S). The acronym OARS is used to highlight the skills. As questioning is an overused strategy in S-LP (Luterman, 2008), and reflections are a fundamental skill of MI, this tutorial will emphasize reflections. The information shared below is from a compilation of sources including Miller and Rollnick (2002), Rosengren (2009) and the author's own experiences in clinical application of MI and MI instruction for students and clinicians.

The following scenario will be used to highlight some of the different types of open questions and reflections presented in this tutorial:

> Mary is the mother of a 3-year-old boy (Ryan) who has just been diagnosed with severe speech and language delay and suspected developmental delay. Ryan is also demonstrating aggression with other kids. The S-LP has recommended enrolment in an early education program, which would provide interdisciplinary preschool experience four days per week. She has also talked about service options within the community. Finally, she has recommended referrals for further testing with occupational therapy, physiotherapy and psychology. On a follow-up visit, Mary appears very upset and says the following:
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> > *"I've talked with my family about this and they think we should just wait a bit and see if he gets better on his own. My husband and parents were really upset that we were "labelling" Ryan. I can definitely see that he is behind other kids, but they just don't think it's that bad. I am really frustrated by his speech and I know he is frustrated that he can't tell us what he wants but I guess*

we will just have to be more patient and let him grow out of this."

Open Questions (O)

Open questions are those which allow the client to determine the nature of the response; they set the stage for the client to provide information that is important to them. By contrast, a closed question narrows response choices and is typically used to gather factual information that is important to the clinician. For example, when asking a parent about their commitment to completing homework assignments the clinician could say, "How many times a week will you be able to practice?" (closed question), or "How might home practice fit into your family schedule?" (open question). Questioning is a communication strategy used often by S-LPs and audiologists to gather information during information-getting interviews. We can also use open questions to encourage clients to generate goals, rationale for change and strategies for change. With reflections, most clinicians could benefit from increasing the number that they use. With questions, it is not an increase in number that is the goal, rather a focus on using questions for new purposes. The following "tips for questions" will assist clinicians in using questions more effectively.

Don't ruin a perfectly good question. It is not unusual to see clinicians and students provide their client with a great open question, and then tag on a closed question. For example, "How does your family react when there is a difference of opinion in the family? Would it help if I explained things to them?", limits the possibility of getting a more complex answer from the client. The tag questions can still be used, but should be saved for follow-up after the client has had an opportunity to respond to the initial open question.

Use questions to set an agenda in a patient-centered way. Questions can be used to ensure that conversations are directed towards topics that the client perceives as most important. For example, rather than stating, "Today we are going to discuss ...", the clinician can say, "We have some time today to discuss your assessment, what things are most important for you to know?"

Combine reflections and questions. A combination of reflections and questions can be a very effective communication strategy. In this format, the clinician provides a reflection of the client statement and then uses a follow-up question to move the conversation in the direction of change. For example, in response to Mary, the clinician could use a reframing reflection with a follow-up question as follows: "You and your family need some more time to consider how intervention might fit into Ryan's education. What information would be helpful?"

Use hypothetical questions. Hypothetical questions can be used to encourage deep exploration and to guide the client to verbalize areas for change and reasons for change (Miller & Rollnick, 2002). They can also be used in conjunction with reflections. In response to Mary, a hypothetical question could be, "If Ryan doesn't grow out of it, what might the effects be on his education and relationships?" Other possible hypothetical questions that encourage consideration of change are presented in Table 1.

Table 1

Hypothetical question examples

"If you continue with things as they are, what do you think might happen?"
"If this pen were a magic wand and could change one thing (but couldn't change the fact that Ryan is having speech and behaviour difficulties), what one thing would you change?"
"If you were in my position, advising someone like you, what would you suggest?"
"If you decided to try an education program, what might some of the benefits be?"
"If you decided that education was something you wanted to try, what support would you need to get your family on-side?"

Use key questions. A "key" question in MI can be used to move from exploration of thoughts and ideas towards *change talk*. One example of a key question for the scenario with Mary might be, "You have a discrepancy between what you think is best for your son and the wishes of other members of your family (reflection). What now? (key question)". Other examples of key questions would be, "What will you do between now and the next time we meet?", and "What are the first steps in accomplishing your goals?".

"Tell me more." This is a generic statement that functions as an open question. It can be used by clinicians when they are having difficulty generating a more specific open question. It can also be used to keep the conversation moving forward while the clinician formulates a reflection for a challenging situation.

Affirmations (A)

Affirmations are genuine statements of appreciation and recognition of client skills. Affirmations are not just compliments. Compliments often connote that the speaker is evaluating and passing judgement. In contrast, affirmations represent factual statements that highlight

strengths in others. Examples of affirmations for Mary might be, "You are acknowledging the concerns of your family and continuing to consider what you think is best for Ryan; this is a difficult task." Or "You really care about your son and are taking this decision very seriously." In MI, affirmations can be used to increase the client's sense of self-efficacy, which is an important condition for change.

Reflections (R)

Reflections are a key element of expressing empathy. Reflections convey to clients that they have been listened to, which facilitates a therapeutic alliance. Reflections are included in many communication enhancement approaches, but are very difficult to do well. An awareness of the various types of reflections and their uses will assist clinicians in using a variety of reflections effectively. Target levels for the ratio of reflections to questions is 1 to 1 for beginning proficiency and two reflections to each question for "competence" (Moyers et al., 2010). Clinicians typically fall well short of this mark, with two questions for each reflection (Rosengren, 2009; Baer et al., 2009).

Simple reflections involve paraphrasing or restating the client's utterance, often using many of the same words. A simple reflection for Mary could be, "Your family is concerned about labelling Ryan and so you've decided to wait before starting treatment." Simple reflections can convey active listening, but if they are the only type of reflection used, the conversation will quickly sound repetitive and redundant.

Complex reflections are ones which add substantial meaning or interpretation to the client's utterances. In an MI framework, complex reflections can be used to assist the client in acquiring a deeper level of understanding. A selection of complex reflections and their uses are presented below (Miller & Rollnick, 2002).

Reflecting affect. There is often a great deal of emotion present during assessment and intervention in rehabilitation disciplines. This emotion may be an undercurrent in the statements or questions from clients. Reflecting affect is one way of conveying to the client that you have received the emotional content of their words. A reflection of affect for Mary could be, "You are feeling conflicted about your concerns for your son and the feelings of other members of your family."

Hypothesis. This type of reflection moves conversations forward by making hypotheses about what the meaning of a statement might be. For the scenario provided, a hypothesis reflection could be, "It sounds like members of your family have differing ideas about what the best course of action is."

Double-sided reflection. This type of reflection is a key strategy in MI. It addresses ambivalence directly by highlighting for the client disparities in their behaviours and their goals, or differences in statements that they are providing. Double-sided reflections fit into the framework of *on one hand* and *on the other hand*. It can be helpful to think in those terms when generating this type of reflection. A recommended double-sided reflection for Mary would be, "Your family is concerned about the effects of labelling Ryan and you have concerns about his communication and his behaviour." The order of the two sides is important. It is recommended that you start the reflection with the statement that indicates the status quo – the thoughts that are resistant to change. The reflection should end with the desire to change, the reasons for change or ideas about change. In this order, the comments supporting change are those mentioned last. This approach can lead to further discussion about change, rather than a focus on resistance.

Reframing reflection. Reframing can be used to encourage motivation by rephrasing client statements with ones that are more amendable to change. For example, a client's comment that, "This is too hard, I just can't do it any more," could be reframed by stating, "You are needing a break from this right now." Mary's statements could be reframed to support continued consideration of intervention by saying, "You and your family need some more time to consider how intervention might fit into Ryan's education."

There are other types of complex reflections. The ones presented here are intended to provide a variety for initial practice.

Summaries (S)

Summaries consolidate information and discussion for the client and the clinician. They can enhance understanding by drawing attention to important ideas or by highlighting change talk. Clinicians can support clients' perception of their self-efficacy by focusing their summaries on the more positive aspects of the conversation, highlighting client strengths. There are three broad types of summaries. Collecting summaries consolidate discussion and help the conversation move forward. Linking summaries highlight connections for clients by relating one idea to another. These links can highlight similarities in areas of discussion or discrepancies. Transitional summaries can be used by clinicians to communicate that information has been understood and to signal a change in the focus of conversation (Miller & Rollnick, 2002).

TIPS FOR APPLICATION OF MI

When exposed to the OARS techniques, clinicians will sometimes wonder how the provision of information to clients fits into the framework. It is helpful to make

a distinction between providing information to educate and providing information as a form of motivation or counseling. It is appropriate to use information to educate and possible to do so in a means consistent with MI spirit. Rollnick, Miller and Butler (2008) highlight two areas for MI applications in healthcare; determining the priorities of the client and conveying "autonomy". These considerations can guide clinicians when they are in the position of needing to provide information, advice and suggestions to their clients.

A simple technique to convey autonomy is to always seek the permission of the client before providing education or information, for example, "I have some information about hearing aid use in young children. Would it be all right if I shared that with you?" Seeking "permission" is also recommended before setting an agenda, or providing advice and suggestions, for example "I have seen clients with similar difficulties. Would you be interested in hearing about things that have been helpful for them?"

As clinicians are increasing their use of MI skills, it is also important that they reduce the use of verbal behaviors inconsistent with MI. Apodaca and Longabaugh (2009) summarized evidence from a review of studies and found that lower levels of such "MI inconsistent" behaviours were associated with higher levels of client engagement and more positive outcomes. Behaviors considered inconsistent with MI are advising without permission, confronting, and directing.

FURTHER LEARNING

Miller and Moyers (2006) describe an eight stage process in acquisition of MI skills. The first two stages were the focus of this tutorial: conveying MI spirit and learning client-centered communication through OARS. The next three stages are: recognizing change talk and resistance, eliciting and strengthening change talk, and rolling with resistance. These stages assist clinicians in using their OARS skills to specifically focus on change. Familiarity with techniques to elicit change talk and the stages of change (Prochaska, Norcross, & DiClemente, 1994) are key components of an MI approach and are valuable additions to the skill and knowledge base for S-LPs and audiologists. The final stages of acquisition are: developing a change plan, consolidating commitment and transitioning between MI and other counseling approaches.

As with other complex clinical skills, reading tutorials and workbooks alone is insufficient for long-lasting behaviour change. The acquisition of MI skills and effective training methods have been investigated extensively (Lane, Johnson, Rollnick, Edwards & Lyons, 2003; Martino, Haeseler, Belitsky, Pantalon, & Fortin, 2007; Rosengren, 2009). The current recommendation for training is participation in a two-day workshop with follow-up coaching and practice (Rosengren, 2009). This format provides opportunities to learn and practice OARS skills but also explore techniques specific to eliciting change talk. Some health regions within Canada have developed MI training modules. For those that are unable to attend a workshop through their work setting, the MI website provides resources, articles and notices of workshops (www.motivationalinterview.org). Formation of an MI learning group is another way for interested clinicians to continue skill development. The workbook by Rosengren (2009) provides practical activities for development of key skills and could be used in conjunction with a learning group to facilitate organization, practice and discussion. Ongoing learning and reflection can begin by going back to the scenarios in Appendix A and editing your responses to be more in line with MI principles and techniques.

Communication and counseling skills are part of the scope of practice for S-LPs and audiologists (American Speech-Language-Hearing Association, 2007; Canadian Association of Speech-Language Pathologists and Audiologists, 2008). They are used with clients and families across disorder areas, ages and work sites. Effective counseling and communication skills can enhance clinical interactions from initial meetings through discharge. Counseling with techniques, spirit and principles of MI is a method of supporting clients as they envision what is possible and make plans to achieve their goals.

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Received date: Jan 24, 2011
Accepted date: Apr 13, 2011

APPENDIX A

Reflection Exercise

Read each of the paragraphs below and imagine that you are in a conversation with the individual portrayed. Provide a written response 1-2 sentences in length.

Scenario #1

During a session, a teenage fluency client says to you: "I hate going to school. I don't understand what is going on in most of my classes and I am too embarrassed to ask questions. There are a few people who talk to me, but most people just avoid me. I just can't do it anymore. I want to drop out of school."

Your response:

_____

_____

Scenario #2

During a session a client's spouse says to you: "I am feeling really overwhelmed. As the sole caregiver I am trying to do the best I can, but it is just not enough. By the end of the day I am exhausted, and I often don't have a chance to work on your suggestions with my wife. My wife is so important to me, and I feel like I am letting her down. As much as I try, I just can't do it all."

Your response:

_____

_____

Scenario #3

During a session a mother says to you: "My son had a huge temper tantrum. He was throwing his toys around the room, screaming at the top of his lungs, and when I came close to him he started swinging at me. He broke his toy truck and a mirror. He was out of control. I don't know how to handle him".

Your response:

_____

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