

# Motivational interviewing: modifications for psychosis

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## 1 The relational foundation

The key features of partnership, acceptance, compassion and evocation are unchanged from standard Motivational Interviewing (MI). The clinician may have to work a little harder to see the sense in what the patient is saying.

## 2 The core techniques: client centred counselling

### Open questions

Open questions can elicit thought disorder. A higher proportion of closed questions than usual can be helpful but risks undermining autonomy. 'Menu' questions are a useful third option.

'Why' questions can sound interrogatory. They also presuppose an understanding of causality which may be absent if the patient is cognitively impaired: 'what happened before she hit you?' is easier to answer than 'why did she hit you?'

### Affirmations

Affirmations are important in people with psychosis, particularly as they may have thin social networks and receive few affirmations in other areas of their lives. When patients are particularly impaired by illness, be careful with strength based affirmations as these can come across as patronising or demeaning. Values based affirmations are safer.

### Reflections

In general, reflections should be short and grammatically simple.

**Overmentalising patients (typically with prominent persecutory delusions):** in general MI coaching, practitioners are encouraged to 'take a small risk' and go slightly beyond what the patient has said. For overmentalising patients, this is unhelpful: stay on safe ground and avoid anything that might seem like 'mind reading' to the patient. When making reflections, make your reasoning transparent, i.e. explain how you have come to a conclusion about the patient's mental state, e.g. 'from the look on your face, I guess you are angry with me'. Note this is also an exception to the general rule about not using 'I' when making reflective listening statements (not 'putting yourself in reflections').

**Undermentalising patients (typically blunted affect, emotional and social withdrawal):** make your reasoning transparent. The aim here is to coach mentalisation.

### Summaries

Frequent short summaries can be very helpful, especially in patients with cognitive impairments who can lose track of the consultation.

### 3 The strategic direction

The strategic aim is reality: where possible, aim to tie your reflections more firmly in to reality. This can be objective reality but also non psychotic aspects of the patient's subjective truth, particularly around affects, goals and values. Where there are no theory of mind deficits, one particularly useful technique is third party perspectives: 'why do you think your doctor referred you?' or 'what does your wife make of all of this?'

Avoid the twin traps of confrontation and complicity. Affective reflections are often a good starting point for doing this.

### 4 Structure

The basic four phase model of engage, focus, elicit and plan works well. Budget plenty of time (10-20% of total) for engagement. This is particularly important in psychotic patients. Most people lose reasoning ability when emotionally aroused; in psychotic people this loss of reasoning can lead to more psychotic speech. Engagement is partly about getting a calm mental space with which to continue the consultation.

In structuring the consultation, if there are cognitive impairments, extra scaffolding of the process is helpful.

### 5 The short form tactics (structured therapeutic tasks)

The structured therapeutic tasks that rely on higher level cognitive function (especially abstraction and seeing future consequences of present behaviour) may be less rewarding. In particular, confidence and importance rulers can be harder to do, as can the two futures exercise.

### References

There is a basic handout on MI at [guyundrill.com](http://guyundrill.com) as well as a more detailed consideration of integrating MI with psychiatric practice.

The main textbook is Miller, W R and Rollnick, S (2013) *Motivational Interviewing: Helping People Change* (3<sup>rd</sup> Edition).