Closed Body Language	Open Body Language
Crossed arms or legs	Uncrossed arms and legs
Body turns away from th	
Body leans back	
Head faces away from th look at the ground or sta	
Eyes are tense	
Lowered eyebrows	Raised eyebrows
Frowns	Smile
Mouth is closed	Mouth is slightly opened
Muscles are tense	Muscles are relaxed
Tight clothing	Loose clothing
Expressionless face	Expressive face

Behavioral Response Chart

BEATV	Positive - Truthful	Negative – Deceptive
Behavior	Open Point to self Relaxed Maintain Norm Turing in Full expressions Leaning in showing interest Become and Stay Angry At Accusation	Stop Movement, Turn Away, Close Up Lock Legs, Tight Position, Point Away Grooming gestures, Lean back, Partial Expressions, Arms Tight Lack of Anger When Should be Expected
Eye Contact	**Good Eye Contact During Answers** Eye Contact While Listening Break Eye Contact To Think Break Contact In Frustration	**Break Eye Contact During Answers** Examples: Blink, Roll Eyes, Close Eyes Glance Away, Hand Over Eyes Lint Picking, Look at Fingers, Glasses Or Other Objects, Rub Eyes
Answer	Direct Answers, Full Sentences Include Self, Use Harsh Words Focus Suspicion, Lack of Flag Phrases Stay on subject, Clear Answers	Partial Answers, Flag Phrases, Stuttering Exclude Self, Use Soft Words, No Answer Spread Suspicion, Incomplete Sentences Repeat The Question, Unclear Answer Interrupting Speech, Change Subject
Timing	On Time For The Question Thinking When Required No Thinking When Not Required	Too Fast Or Too Slow For The Question Thinking When Not Required No Thinking When Required Answer before the question is completed
Voice	Normal Speed, Even Tone Clear Speech, Loud When Angry	Pitch High = Fear Pitch Low = Emotion Voice volume low, Mumble

B) Vocal communication 38%

Volume / Clarity and Variety:

Tone = a particular quality, way of sounding, modulation, or intonation of the voice (Rhythm)

Pace = speed which somebody speaks (Rate of delivery)

Pitch = rate of vibration of the vocal folds

Emphasis, Stress or Articulation (Power): ex:-

"**I** didn't tell the patient you were wrong." (Somebody else told the patient.)

"I **didn't** tell the patient you were wrong." (I emphatically did not.)

"I didn't **tell** the patient you were wrong." (I implied it.)

"I didn't tell **the patient** you were wrong." (I told someone else.)

"I didn't tell the patient **you** were wrong." (I told the patient someone else was wrong.)

"I didn't tell the patient you **were** wrong." (I told the patient you're still wrong!)

"I didn't tell the patient you were **wrong**." (I told the patient something else about you.)

I did not tell the patient take this medication three times a day.

I didn't say the hospital service was bad.

C) Verbal communication 7%

Patient will not remember what you say ... the patient may remember how did you say it.

However, Professional pharmacist should use professional and scientific vocabulary.

To build Rapport with the patient.

Emotional Fulfilment: Giving your customer 'the experience of being understood.'

Rational Fulfilment: Sharing knowledge & facts / product specifications and information.

Rapport	Relationship
Established quickly. Based on the immediate interaction and how you behave.	Long-term effort. Based on common experiences or other connections between people.

Rapport + consistency = Trust.

Match and Mirror to build rapport	
If the customer (patient, provider, friend, manager …etc)	**You might…**
Makes a large gesture with his arm.	Make a similar, smaller gesture.
Talks quickly and with great passion. (or vice versa)	Subtly match his pace and level of enthusiasm.
Shifts from leaning left to right.	Lean the same direction, either matching or mirroring.
Nods a lot.	Nod occasionally.
Makes eye contact frequently.	Mirror the level of eye contact the customer uses.

Advanced Communication: Motivational Interviewing

1) Definition/ 2) Principles/ 3) Strategies/ 4) Techniques and approaches/ 5) Change formula

6) example of resistance 7) levels of training.

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1) Definition & Background:

Motivational interviewing is an intervention designed for situations in which a patient needs to make a behaviour change but is unsure about it, sometimes to the extent of being quite hostile to the idea. The first paper on MI, written by a psychologist in New Mexico called Bill Miller in 1983, tackled this issue, and was rooted in his own clinical practice.

In summary Bill Miller suggested that rather than seeing patient's (Alcoholic) denial as poor willpower or lack of motivation to solve the problem, it might be more helpful to see this outcome as a product of the situation in the counselling session. When we confront anyone with something, we are likely to increase their resistance and hear them argue the opposite side.

These ideas started to circulate, and came to the attention of Stephen Rollnick, a clinical psychologist originally from South Africa but then working in (Addictions) in the UK.

A commonly used definition of MI is: 'A goal directed, patient-centred counselling style for eliciting behaviour change by helping patients to explore and resolve ambivalence.' (Rollnick and Miller, 1995)

(Note **Goal directed is better than the originally written definition directive).

2) Principles of Motivational Interviewing:

1) Principle 1: don't tell people what to do.

People do what they want to do in most cases, they rarely do what they have been told to do

2) Principle 2: listen is more important than talking

3) Principle 3: let the patient tell you they need to change

'People believe what they hear themselves say'. Blaise Pascal noted that: people are much better persuaded by reasons they think up themselves than those thought up by others

4) Principal 4: cognitive dissonance

People are struggling with a choice about changing, which is making them feel uncomfortable

5) Principle 5: Most people need to feel confident before trying to change

Someone will feel confident and are much more likely to succeed. Mi is explicit about the need to keep morale high

6)Principle 6: Ambivalence is normal

3) Strategies in Motivational interviewing

The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative

The four principle strategies of MI are:

1. Get a conversation going - express empathy through reflective listening.
2. Develop discrepancy between a patients' goals or values and their current behaviour.

Develop discrepancy between patients' goals or values and current behaviour, helping patients recognize the discrepancies between where they are and where they hope to be.

3. Avoid argument and direct confrontation and adjust to resistance rather than opposing it directly.

4. Support self-efficacy and optimism; that is, focus on patients' strengths to support the hope and optimism needed to make change.

4) Techniques and approaches

OARS Technique/ Approach

- **O**pen Questions (Not simple the WH questions VS the Module questions.
- **A**ffirmations (to make statements of recognition of patient strengths)
- **R**eflective Listening
- **S**ummaries

FRAMES Technique/ Approach

- **F**eedback regarding personal risk, which is given and usually includes normative (descriptive) of implications
- **R**esponsibility for change is placed squarely and explicitly with the individual. Patients have the choice to either continue their behaviour or change it.
- **A**dvice about changing is clearly given in a non-judgmental manner. It is better to suggest than to tell. Asking patients' permission to offer advice can make patients more receptive to that advice.
- **M**enu of patient self-directed change options is offered.
- **E**mpathic counselling, showing warmth, respect, and understanding, is emphasized.
- **S**elf-efficacy or optimistic empowerment is engendered in the person to encourage change.

Closed Question	Open Question
So you are here because you are concerned about not using your nebuliser?	Tell me, what is it that brings you here today?
Do you agree that it would be a good idea for you to use your nebuliser regularly?	What do you think about the possibility of using your nebuliser regularly?
First, I'd like you to tell me about the medicines you take. On a typical day, what do you take?	Tell me about your nebuliser use during a typical week.
Do you like to smoke?	What are some of the things you like about smoking?
How has your use of medicines been this week, compared to last: more, less, or about the same?	What has your use of medicines been like during the past week?
How long ago did you use your nebuliser?	Tell me about the last time you used your nebuliser

5) Change Formula: Equation of Change

$$\text{Change} = \frac{D*V*F}{R+C+1}$$

D = Dissatisfaction with how things are now, i.e. the Need for change

V = Vision of the new status

F= First, concrete steps that can be taken towards the vision

R= Resistance of change

C= Cost of change or change requirements

Note the original theory Gleicher, Dannemiller , Beckhard---Harris (D x V x F > R)

6) Examples which indicate a resistance mood:

There are many examples of resistance talk, many of which you will be familiar with:

Disagreeing. "Yes, but..."

Discontinuing "I've already tried that."

Interrupting "but..."

Side-tracking "I know you want me to do my airway clearance, but did you notice I gained 5 pounds? You have to admit I've been doing a great job with my weight!"

Unwillingness "I don't want to have to do that as well"

Blaming "It's not my fault. If only my parents...Or if the government Or if the Dr …etc"

Arguing "How do you know?"

Challenging "Well the medication doesn't make a difference to MY lung functioning"

Minimizing. "I'm not that sick"

Pessimism. "I keep trying to do better but nothing seems to help."

Excusing: "I know I should eat more calories, but with my job I'm always on the go and it's hard to prepare and then sit down for a big meal"

Ignoring.

7) Six levels of training

1. Introduction to MI – Experience the bases of MI and decide level of interest in learning more
2. Application of MI: To learn one or more specific applications of MI
3. Clinical Training: To learn the basic clinical style of MI and how to continue learning it in practice
4. Advanced Clinical Training: To move from basic competence to more advanced clinical skillfulness in MI
5. Supervisor Training: To be prepared to guide on ongoing group in learning MI
6. Training for the Trainers: To learn a flexible range of skills and methods for helping others learn MI

Highly advanced communication Personal tailored communication

Section will be moved to final year students, i.e. graduated students.

For successful rapport building through matching and mirroring it is fruitful to understand how patients describe their medication (individual patient's trait, preference and perception)

For example; patient memorised the actual names of medication, or described the physical appearance (as colour or shape) or referred to the name of health care providers, or name of places or the purpose of medication … etc.

Moreover, **for advanced skilled practice**: special concern should be there also to understand the insight of patient's and the cognitive orientation (introverted[1] or extroverted[2] approach) as well as patient attitude toward receiving information (intuition[3] or sensing[4]).

[1] - Inward, the personal energy moves from outside to inside, Need Privacy, tend to receive actions and avoid starting communication, preference for inner self and ideas to understand and protect or nurture it, find people draining, less people interaction.

[2] Outward, the personal energy moves from inside to outside, need people and communication more than privacy, tend to start and initiate actions with others, preference for the outer world and one's own action and effect on it, find people energising, more people interaction.

[3] See the big picture with imagination and framework. Interpreting patterns, possibilities and meaning from information received.

[4] - See the details, with realistic down to earth facts. focusing on facts within information.