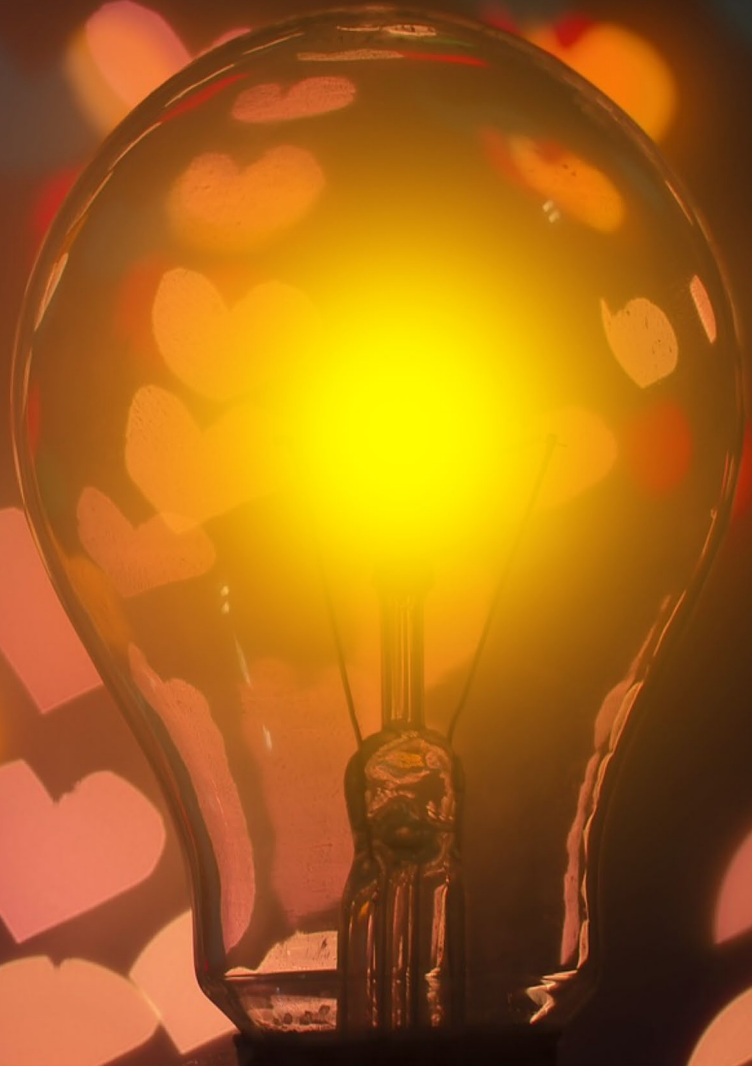Conversations about Intimacy and Sexuality:

A Training Toolkit using Motivational Interviewing (MI)

By Dr. Julie Tennille

with contributions from Dr. Casey Bohrman

This toolkit contains informations related to preparing direct service personnel for discussions on topics of intimacy and sexuality with persons with mental health conditions. Informed by MI, the toolkit includes experiential exercises with instructions, evaluation forms, hyperlinks to resources, and references to be used by trainers.

Temple University Collaborative
On Community Inclusion of Individuals with Psychiatric Disabilities

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The Results Are In

In June of 2018 Dr. Julie Tennille and Dr. Casey Bohrman gave two separate day-long workshops on motivational interviewing techniques regarding conversations about sexuality and intimacy for individuals with serious mental illnesses to around 80 participants in New York. Trainings were based upon the 2017 Sexuality and Intimacy Toolkit. In order to evaluate the effectiveness of the trainings and the toolkit, participants filled out a post-training evaluation form.

- **94%** of participants agreed that they were better able to describe importance of embracing sexuality.
- **86%** agreed that they were better able to describe challenges service users experience.
- **88%** agreed that they were better able to use clinical skills in broaching topics.
- **92%** agreed that they were better able to utilize skills of MI.
- **100%** of trainees had a positive reaction to the training!
    - 61% of users rated the training as excellent, 31% rated the training as very good, and another 8% rated the training as good.

In order to further evaluate the effectiveness of the trainings and the toolkit, participants also filled out forms both before and after the training that asked about knowledge and attitudes toward sex and intimacy with clients.

- There was a significant increase in agreement that discussing sexuality and intimacy is essential to a person's health outcomes.
- There was a significant increase in agreement of the understanding of how a persons mental health conditions, treatments, and medication side effects might affect their sexuality.
- There was a significant increase in the trainees' agreement that they will make time to discuss sexual concerns with service users.
- There was a significant increase in the confidence of trainees' ability to address service users' concerns with sexuality and intimacy.
- There was a significant increase in the agreement that service users expect their mental health provider to ask about their concerns regarding sexuality and intimacy.

Sexuality and Intimacy are important aspects of life for most people. Having the skill to address these topics can signal inclusive practice and even serve as a gateway for addressing other critical life domains in collaboration with persons with serious mental illnesses. The TU Collaborative is proud to partner with Dr. Julie Tennille and Dr. Casey Bohrman to lead the charge in this area.

Contents

Introduction

Welcome!

If you are reading this, you are probably engaged in training a professional and responsive workforce in the service of collaborating with persons who live with mental health conditions to achieve their recovery goals. You may be working at a community mental health center, an inpatient setting, or any of a variety of service contexts where persons with mental health conditions receive services. This manual contains information related to the universal importance of intimacy and sexuality and highlights a systematic path forward toward developing your workforce capacity to have productive conversations about these topics. Guided by the recovery framework and Motivational Interviewing (MI), this toolkit contains experiential exercises designed to build clinical skills that, though specific to conversations about intimacy and sexuality, can extend broadly to other important topical areas in your milieu.

The manual begins with an overview of the intersections of intimacy, sexuality, and recovery for persons with mental health conditions and details idiosyncratic obstacles (many of which come unwittingly from our mental health systems of care) to expression of this cherished part of adult life. Also contained in the manual is a condensed overview of MI and the accompanying four-process model applied to having conversations about sexuality and intimacy. Herein you'll find tools to conduct a one or two-day didactic and experiential workshop that can be broken into smaller modules or team-taught. Our aim is to assist you in increasing the comfort of your workforce through clinical skill development. We hope this toolkit is a vehicle to opening doors to clients in ways that have been elusive in the past to create more deliberate, sensitive, and inclusive spaces for clients to live lives with purpose and meaning as defined by them.

Overview of Intimacy and Sexuality in Mental Health

For persons with mental health conditions, forming intimate relationships and expressing sexuality can be really challenging. There is evidence that persons with mental health conditions do not feel supported in treatment settings (Wright, Gronfein, & Owens, 2000) and approximately 50% report unhappiness with their sex lives and describe social lives lacking in warmth, intimacy, and satisfaction (Cook, 2000). Sexual side effects of medication taken to manage symptoms of a mental health condition are a leading reason for medication non-adherence (Deegan 1999; Kodesh et al., 2003).

Related to sexual side effects of medication, it's important to know that:

- There is frustration and anger with a lack of physical desire
- There are worries about the fragility of sexual response such as getting or keeping an erection, or having trouble with lubrication and achieving orgasm

- Persons described *forgoing* use of condoms to better predict sexual performance. To overcome this unpredictability, many bought sexual stimulants 'on the street' to counteract the side effects (Tennille, Solomon, Fishbein, & Blank, 2009) and risk what may be delicate physical health (Colton & Manderscheid, 2006)
- Body size norms are a battle
- Heteronormativity is a frustration
- Weight gain as a consequence of adhering to psychotropic medication negatively affects self-image and worsens a sense of mental illness stigma (Davison & Huntington, 2010)

We pay close attention to issues of sexuality and intimacy for persons identifying as LGBT since mental health conditions can be magnified due to added stigma toward sexual and gender minorities. There is an extensive literature on higher rates of mental health and substance use disorder conditions for persons identifying as LGBT (Haas et al., 2010). In fact, in a systematic review combining results from over 25 studies, anxiety, depression, and substance use disorders were 1.5 times more common in LGB people than in heterosexual individuals (King et al., 2008). Transgender and gender non-conforming persons experience even greater rates of prejudice, discrimination, and violence that lead to negative mental health outcomes (Carmel & Erickson-Schroth, 2016). Mayer and colleagues (2008) explicate barriers to care for LGBT persons in their research as including: (1) hesitance by some LGBT persons to disclose gender or sexual identify when receiving care, (2) providers not competent to include LGBT related health issues as part of services, (3) structural barriers impeding access to health insurance and, (4) a lack of culturally inclusive prevention services. Thus, central to this toolkit is the deliberate inclusion of vignettes representing LGBT persons coping with mental health conditions. Based on your needs assessment, you may want to incorporate foundational LGBT training for your organization to develop capacity to provide affirming services.

Though it is challenging to broach sensitive and taboo topics like sexuality and intimacy with clients and we recognize that it can feel clunky and awkward to begin with, it's important! Work to use language and terminology according to the guidelines of the APA for working with Trans and Gender Non-Conforming populations. When providers and entire service systems ignore how meaningful intimate relationships and sexuality are to mental health recovery, they are essentially engaging in microaggresssions.

Microaggressions are covert and subtle cues to marginalized communities that communicate negative and exclusionary messages toward members of those communities (Sue, 2010). These 'messages' run counter to the recovery movement and interfere with client well-being.

In fact, research has demonstrated that recipients of mental health services want attention paid to this critical domain of their lives across aspects of policies, programs, and practice and there are tremendous benefits to intimacy and sexuality. Going all the way back to 1975, the World Health Organization (WHO) proclaimed human sexuality as integral to an individual's overall physiological, psychological, and social well-being (WHO, 1975). In fact, sexuality and intimacy can:

- Foster development of new relationships and correlate with social integration (Lukoff, Sullivan, & Goisman, 1992)
- Increase quality of life (Eklund & Östman, 2009)
- Improve treatment outcomes (Ailey, Marks, Crisp, & Hahn, 2003; Dobal & Torkelson, 2004; Shildrick, 2007; Welch & Clements, 1996)
- Lower hospital readmission rates (Binder, 1985)
- Decrease mental illness stigma (Davison & Huntington, 2010; Shanks & Atkins, 1985).

By establishing a standard of care that increases intentional conversations about sexuality and intimacy (Quinn, Happell, & Welch, 2013) you may improve therapeutic alliances and working relationships (Tennille, Solomon, & Blank, 2010) with persons you serve. This type of recovery oriented care may decrease stigma and enhance overall efforts to create a more robust culture of community inclusion. Your ability to communicate *verbally and nonverbally* that you are interested in having such discussions can literally enhance your client's health and sense of well-being. This is where Motivational Interviewing comes in!

What is Motivational Interviewing?

Motivational Interviewing (MI) is not new! Close to thirty-five years ago MI was born as a means of intervening with persons with substance use disorders and today there are hundreds of randomized controlled trials and over 25,000 articles citing the use of MI for all sorts of conversations about making changes. Practitioners including social workers, nurses, physicians, correctional officers, clergy, peer providers, and many others have learned MI to engage in collaborative, respectful partnerships with clients designed to evoke the client's own wisdom and motivation for making changes (Miller & Rollnick, 2012).

As the creators of Motivational Interviewing assert, MI is first and foremost a collaborative conversation about change (Miller & Rollnick, 2012). It is important to note that wonderful MI looks deceptively simple from the outside but it is not a natural skill in the possession of even the best of clinicians. You will need some outside MI

training and supervision before undertaking a training leadership role in your organization as it will be important for you to demonstrate the skills of MI. (See hyperlink to be able to track down your local Motivational Interviewing Network of Trainers (MINT trainers) to take advantage of training opportunity).

Miller and Rollnick (2012) discuss that MI can be brief or extended, occur in many types of settings, focus on myriad behaviors, can be with individuals or groups, but it is always collaborative and conversational in nature and never a lecture or monologue.

What is the Spirit of Motivational Interviewing?

The Spirit of MI is a posture that the practitioner embodies, an underlying perspective and heart and mindset of humility with four key elements (partnership, acceptance, compassion, and evocation). We will experientially thread the Spirt of MI throughout this toolkit.

Beginning Your Workshop and Setting the Tone

Trainer note: If you decide to create a Power Point presentation, craft slides with an agenda overview of the day(s). You can use some of the introductory material preceding this section as well as other context specific material you deem important. We have samples of a one-day or two- day training agenda in our appendix for your perusal. Keep your slides to a minimum and your lectures brief. Participant engagement is paramount! Once you've laid out your plan and checked in with your audience, we suggest an ice breaker.

The MI Spirit is joyous and open and you will want to use an ice breaker that provides a foundation for this atmosphere to kick off your 1st workshop day. This icebreaker can be one of your choosing or can be our Musical Questions icebreaker described below.

Give This a Whirl!

Musical Questions Exercise

In this activity, you will determine the number of attendees for your workshop and develop just as many unique open-ended questions. Below we provide examples of 17 such questions. In advance of the workshop, you will print out a paper full of your

questions and, using a scissors, cut them into individual pieces, folding over so that your attendees cannot read questions before receiving them.

On the day of your workshop, place questions into a hat or container of any sort and pass them around, each attendee taking one. Let attendees know they are not to share the question with a neighbor, this is their unique question and no other is in possession of the same one.

Next, (you may play music in the background or not) we suggest instructing attendees to stand, look around the room and identify individuals they may not know.

When all are ready to begin and there are no more questions about the icebreaker itself, we instruct attendees to begin by introducing themselves to another person and to ask their unique question, listening very carefully to the answer and attempting to remember much of what is said. The other member of the pair then returns the act by asking their unique question, listening very carefully to the answer and so forth. We suggest doing two additional rounds of this exercise. Each round will require you to instruct a change of partners after a few minutes.

Have attendees return to their seats for a debriefing session. Remember, you are modeling good MI, so, as you debrief, use reflective listening.

Sample debriefing questions:

- What was this exercise like for you?
- What did you notice about the questions? (Some are more whimsical/some require more thought)
- How does this exercise connect to what we have discussed so far about MI?

Allot 20-30 minutes for this exercise depending on the size of your group.

If you had a button to wear that described your outlook on life, what would it say? (Less than 5 words)

If you could spend an entire evening with anyone in history, who would you choose to spend it with? What would you want to talk about?

What is an interest you have outside of your work or profession? How could you combine this interest and your present profession?

If, like a product, your professional behavior came with a guarantee, what could you honestly guarantee about yourself?

What motivated you to get into the work that you do?

When you think of the most inspirational teacher/mentor you have ever had, what stands out as their most important quality? Why this quality?

If you were a wealthy philanthropist, what would you invest your money in and why?

If you could change your profession in one specific way, what change would you make? Why?

What are the top two things that get you through a bad day at work/school?

Describe an experience that you view as your biggest adventure.

What do you miss most about childhood?

What was the most interesting class you have ever taken (can be elementary school) and why?

What's the kindest thing you've seen one person do for another?

What is the most important quality a parent can possess? Why?

What is one value you have kept in mind that has allowed you to get to this point in your life?

What characteristic will you need to possess in order to accomplish your goals?

What superpower would you love to be in possession of? Why?

The underlying spirit of MI is not automatically present for all who are introduced at first and requires a good grounding in compassion for self as this can lay a foundation for openness to the messiness of life's challenges and possibilities for others. The exercise below promotes some exploration of participants' relationship to the joy and excitement of love and attraction.

Give This a Whirl!

Guided Imagery Exercise

Trainer note: In this activity you will need to distribute blank pieces of paper and ensure that your participants have something to write with. Once the group has settled, read the instructions for this guided imagery slowly and clearly.*Furthermore, we suggest mentioning that this activity may be "triggering" for some. Invite participants to *observe* rather than participate if they wish.

You should have a single sheet of paper in front of you. In a few minutes, I'll ask you to write down some thoughts and feelings connected to this exercise.

At this time, I'd like to do a brief guided imagery to link our hearts and minds to this topic for today. If you are comfortable, I'd like for you to close your eyes. I want you to spend a few extra moments getting into a more relaxed position in your chair, dropping your shoulders, paying attention to breathing and just generally softening your sitting position. I want to set a stage for you that links you to what may be a recent, or possibly distant, memory of love and attraction.

Go back in your mind and recollect the feeling you had when you developed a strong attraction or fell in love for the first time... or the last time. If this type of memory does not resonate with you, I want you to focus instead on the memory of meeting someone for whom you had an instantaneous attraction to or admiration of and wanted to become friends. You were excited about a new intimacy. It's all you could think about and you couldn't wait to share this exquisite feeling. Spend some moments dwelling in this memory. What are the feelings inside your chest and stomach? What do you see, what do you hear? How does your body feel? What music, if any, comes to mind? Do you have one outstanding memory of something you did together? Spend a minute more with this experience. Now, open your eyes.

Okay – I'm going to ask you to make a few notes on the paper. I won't ask to collect the papers or for you to share them with another person. The paper is yours.

1. First, jot down a memory of this person that brings a smile to your face.
2. Next, underneath the memory, make a note of people in your life that you shared some of the details with.
3. Now, make a few notes about the feelings you had when you talked about this new person.

(Debrief)

Elicit responses from participants in each of the three categories. Reinforce the highly unique experiences (using reflective listening) that your participants share if they choose to share. As the trainer, you may want to share an experience to get things started and of course it is not necessary to share details that are far too intimate or sexual in nature.

Allot 30 minutes or more for this exercise depending on the size of your group.

Review of Principles, Processes, and Micro-Skills of MI

Trainer note: Review these following principles in an engaging fashion – tell a story – invite reactions from your audience!

The spirit of MI is completely consonant with person-centered care and Miller and Rollnick suggest eleven principles that spring from this broader framework (Miller & Rollnick, 2012, p. 22-23). These principles are:

1. Our services exist to benefit the people we serve (and not vice versa). The needs of clients (participants, patients, consumers, customers, etc.) have priority.
2. Change is fundamentally self-change. Services (treatment, therapy, interventions, counseling, etc.) facilitate natural processes of change (Prochaska & DiClemente, 1984).
3. People are the experts on themselves. No one knows more about them than they do.
4. We don't have to *make* change happen. The truth is that we can't do it alone.
5. We don't have to come up with all the good ideas. Chances are that we don't have the best ones.
6. People have their own strengths, motivations, and resources that are vital to activate in order for change to occur.
7. Therefore, change requires a partnership, a collaboration of expertise.
8. It is important to understand the person's own perspective on the situation, what is needed, and how to accomplish it.
9. Change is not a power struggle whereby if change occurs we "win." A conversation about change should feel like dancing and not wrestling.
10. Motivation for change is not installed, but is evoked. It's already there and just needs to be called forth.

11. We cannot revoke people's choice about their own behavior. People make their own decisions about what they will do and what they will not do, and it's not a change goal until the person adopts it.

The processes of MI include engaging, focusing, evoking, and planning and can proceed in a sequential manner but are more likely to be like human beings are – not entirely tidy, overlapping, and even starting anew from time to time. Miller and Rollnick (2012) describe MI as a confluence of these four processes.

- The first process of engaging is so critical, with the work involving continual attention to a respectful working connection. Of course, this is done in earnest at the outset of a relationship and frequently renewed and refreshed.
- Focusing is developing and sticking to a direction in relationship to client identified goals. Importantly, the goals may or may not relate to behavior change ~ goals could be about finding peace or accepting an enduring state of ambivalence.
- Evoking is curiously eliciting a client's highly unique reasons for considering making a change and trusting their lived wisdom.
- Planning is when the brink of readiness is upon a person and steps to move forward are collaboratively formulated. This fourth process may recede temporarily or periodically to make room for more engaging, focusing, and/or evoking.

The Micro Skills of MI (OARS) extend across the four processes described above and are needed for competent person-centered practice. Beyond developing capacity to have conversations about intimacy and sexuality, these basic skills are fundamental to sound clinical practice no matter the topic.

Asking **O**pen-ended questions is a first and most basic skill to develop. Open-ended questions invite more expansive responses and play a key role in evocation. In using the Musical Questions icebreaker, you have already begun the conversation about the value of open-ended questions.

Affirming is an ability to identify strengths in clients no matter the client presentation. Merely having the courage for a client to share something personal about a struggle or worry is something affirmable. Developing skill in reflecting back highly specific strengths observed in a client to that client instantly puts an individual on notice that you hold them in regard and invite them to as well.

Reflective listening is fundamental to good MI and involves making statements that communicate close listening and understanding of the unique goals, perspectives, and feelings of clients. This type of listening allows a client to hear, possibly in somewhat different language, what they are communicating about an issue or topic and an opportunity to correct or modify understanding and the communication progresses.

Summarizing are more succinct collections of reflections that may occur at the end of a session or as a transition is about to be made. This skill offers a second opportunity to make corrections, promote understanding of the path ahead and clarify the collaborative journey on a topic.

Give This a Whirl!

Practicing Open-ended Questions Exercise

Trainer note: Project slides of open and closed ended questions related to intimacy and sexuality and have your participants first decide whether the question is open or closed and second, if the question is closed, invite the group to create open-ended questions together or in pairs. This is surprisingly challenging as we live in such a fast-paced society and are used to rapid fire questions (often closed) and frenetic service environments. You can use the examples of closed and open- ended questions we have below plus make your own as they fit with your clientele.

- Are you protecting yourself?
- Do you have safer sex?
- Do you use condoms?
- Are you in a romantic relationship?
- Do you hookup from time to time?
- Tell me about the sexual side-effects you experience.
- Does your partner punch or hit you?
- Have you told your partner about your alcohol use?
- Do you have any diseases?
- Why aren't you using PrEP?
- Do you identify as having a different gender identity than the one you were born with? (Hint: this is an opportunity to clarify not only how to ask open-ended questions that are more direct but also an opportunity to provide education on

improving capacity for inclusivity and signaling understanding of trans and gender non-conforming persons.

- You seem straight, but I have to ask, do you identify as being gay or trans?

✏️ Trainer note: This exercise provides us another opportunity to educate on LGBT identities. Set the stage with participants by communicating that they have experience identifying what constitutes healthy relationships and that those abilities and skills should be extended to the broadest range of clients. Being equipped for such discussions involves understanding that falling in love, butterflies in stomachs, and the pain of loss are common experiences everybody shares.

We never want to make assumptions about gender identity or sexual orientation. This is crucial to inclusive practice! We recommend asking all persons served, "How would you describe your sexual orientation? Are you straight, gay, lesbian, or bisexual?" Allow for some silence – don't jump in; then say, "do you want me to go over those choices again? How would you describe the kind of persons you are attracted to?" Also ask, "How would you describe yourself in terms of being masculine or feminine?" If a person makes a disclosure of an LGBT identity, it's a good idea to say, "I'm glad you told me that." You can also ask, "What else would you like me to know about your background or identity?"

✏️ (Debrief)

What was it like to form open-ended questions? Elicit responses from participants. Reinforce how challenging it can be and suggest that participants practice this in their own lives and 'tune in' to the preponderance of closed-ended questions in daily life and in their work contexts. What impact do these types of questions have at intake, at points of assessment? Whose voices are privileged when we ask closed-ended questions?

⏱️ Allot 20-30 minutes or more for this exercise depending on the size of your group.

The Stages of Change AKA Transtheoretical Model

The Stages of Change model (Prochaska & DiClemente, 1992), often confused to be part of Motivational Interviewing, does complement MI by offering clinicians another way

of gauging a clients' readiness to make a change. Miller and Rollnick (2012) describe MI and the Stages of Change model as incredibly compatible yet mutually exclusive. However, it can be helpful to use the model in facilitating greater understanding of targets of change and ferreting out points of ambivalence, so key to assessing a client's relationship to the prospect of making a change. We suggest describing the Stages of Change Model in your training (using examples that relate to your setting) and offering up vignettes for analysis and discussion individually or in pairs.

Give This a Whirl!

Stages of Change Exercise

Trainer note: Explain the stages of change in an engaging fashion. Invite participants to offer a "behavior" that is frustrating for them in their contexts. Make connections! Project a slide onto the screen that shows all of the stages of change. Pass out these vignettes and have participants read them on their own and answer the questions on their own. Next, have them turn to a colleague and discuss/debate for a few minutes. As the group begins to quiet, debrief together.

1. **Jay** recently contracted HIV. They have had multiple partners, so they are not sure how they contracted the disease. Jay rarely used protection before and now that they have HIV, they feel like there is no need to use protection. When you first meet with Jay, you try to explain the risk of superinfection and of other STIs, but they respond "I'm sick of talking about condoms. Nothing could be worse than what I have now. The only benefit to being positive is that I don't have to worry about protection anymore. What I really need to do is find housing. I can't keep living on my brother's couch."

What is the target behavior for Jay?

What stage of change is Jay in?

How would you engage them based on their stage of change?

2. **Demetrius** is a 40 year old man married to Mimi. Demetrius has been living with a diagnosis of bipolar disorder for many years and continually stops adhering to medication when it impacts sexual performance with his wife. He says his wife is the most important person in his life. When he "can't perform," their relationship gets strained and his wife thinks he is having sex with someone else. Demetrius then discontinues his medication and starts experiencing paranoid thoughts that his bed is full of bedbugs and cancer-causing carcinogens. Demetrius ends up getting hospitalized and re-prescribed medications. Demetrius is interested in approaching his psychiatrist about this but has never had this conversation and feels embarrassed.

What is the target behavior for Demetrius?

What stage of change is Demetrius in?

How would you engage him based on his stage of change?

3. **Terrance** is a 28 year old man who attends the drop in center just about every day. He has a diagnosis of schizophrenia and takes medications to manage his symptoms. Terrance has never had a girlfriend and is self-conscious about the shaking and tremors he has as a result of his medication. He wants to have a girlfriend to have sex with and to spend time with but does not know how to begin this process. He wants to learn to ask someone out and thinks that he needs some "social exercise" since he never learned how to do this as a younger man.

What is the target behavior for Terrance?

What is Terrance's stage of change?

What evidence do you have to support that he is in this stage of change?

4. **Maria** who identifies as bisexual has been seeing a counselor for a few years to talk through her struggles with depression. Recently she has been feeling more irritable than normal and was wondering if maybe she needs to do something else to treat her depression. Her husband also told her that he was getting frustrated dealing with all of her mood swings. He suggested she talk to her doctor about going on anti-depressants. Maria was hesitant about it and so before making an appointment, she did an internet search about side effects of anti-depressants. She saw that some side effects included weight gain, vaginal dryness and loss of sex drive. She wanted to figure out a way to feel better and to improve her relationship, but she was worried that taking anti-depressants would actually make things worse with her husband. She made an appointment with her doctor, but was thinking of cancelling it because she was embarrassed to ask the doctor about the sexual side effects of anti-depressants.

What is the target behavior for Maria?

What stage of change is Maria in?

How would you engage her at this stage?

5. **Cynthia** is a 27 year-old woman who identifies as straight and has been in a relationship with her boyfriend, Jake, for 5 years. Jake was very sick and unable to have sex with Cynthia for over 6 months. At this time, Cynthia began to go online in search of potential partners and has had numerous sexual affairs. She noticed that the powerful feelings of attraction and love would decline quickly with these men and there would be a rather dramatic breakup. This would be followed by powerful symptoms of depression, and before long, Cynthia was in the process of engaging with someone new online. She loves Jake deeply and is beginning to connect these 'cycles' with her bi-polar illness. She is contemplating

telling Jake but feels very afraid that he won't understand and will feel tremendously betrayed by her infidelities during his time of illness.

What is the target behavior for Cynthia?

What is Cynthia's stage of change?

What evidence do you have to support that she is in this stage of change?

Trainer note: Debrief. Elicit responses from participants. Reinforce that persons can be in various stages of change regarding many behaviors. There may be some disagreement about a behavior or a stage of change. Have participants argue their rationale and validate the strengths in the arguments (Remember: there is significant parallel   process happening   in   this   training   and   you   are   modeling   the   MI   spirit and your humility as a co-learner).

Allot 20-30 minutes or more for this exercise depending on the size of your group.

The key skill in Motivational Interviewing is reflective listening. Again, this is not a natural skill and must be practiced and "reflected on" {No pun intended} over time and with supportive supervision. **R**eflective listening is not just repeating back what someone has said, although it may involve the repetition of a few words the practitioner judges will communicate that deep listening is occurring. It also involves offering complex reflections that communicate an additional or different meaning that the client has not explicitly stated. Seasoned clinicians may be a bit better at this skill as it involves reaching for a deeper meaning that the client may not be communicating with words. Trust us, if you are off base, the client will let you know! **S**ummarizing involves a succinct representation of reflections to give your client another opportunity to check understanding before focusing, or planning to prepare for change.

Give This a Whirl!

Reflective Listening and Real Plays Exercise

Trainer note: This exercise is broken into 2 steps.

Step 1:

Have your trainees look at a list of statements in a Power Point slide or on a pre-printed paper. These should be statements that are tailored to the setting and population that workers are seeking to provide services in. Invite participants to create short reflections in groups of two and debrief with the larger group.

Step 2: (Real play)

Instruct trainees to think of an innocuous behavior that they would like to change in their lives (i.e. Binge watching Netflix, drinking too much caffeine, procrastinating on paperwork). These behaviors would have to be substantive enough that they could spend a few minutes sharing specifics. Have the dyads of trainees take a few deep breaths and, each taking a turn for 8 minutes, one person speaks about their behavior while the other one listens and *only* uses reflective listening with an occasional open-ended question.

Trainer note: Debrief. Elicit responses from participants. Many of your participants will have no experience in trying out reflective listening. Reinforce that it doesn't feel quite comfortable (for most) to begin with. Also say a few words about the artificiality of the setting. Invite participants to reflect on the experience of being in the "client" role and sharing this behavior with someone that only listened by using reflective listening or was asking open-ended questions in service of getting greater understanding of the relationship with the behavior.

How did it feel? What was it like to try to provide reflections? What did you notice about yourself and how it shaped the interaction?

Allot 90 minutes or more for this exercise depending on the size of your group.

Trainer note: Before proceeding with content, remember to take breaks and check in with participants regularly. How is this going for you? What was the morning like? How about the afternoon?

Engaging and Laying a Relational Foundation

Fundamentally, you are focused on making sure your client feels heard, genuinely understood, and respected. Most of all, you want the client to walk away with a confidence that you are a person that will support *their* wishes and goals, not just pursue your own agenda. After all, who cares about your agenda? You! This is the foundation for a good relationship and greater possibility that the client will return again and want to work with you on any myriad of issues and concerns.

Give This a Whirl!

Spot the Difference Exercise

In Motivational Interviewing, when working to communicate about the spirit of MI and the phase of engaging and laying a relational foundation, it's helpful to illustrate such concepts by comparing snippets of dialogue that a worker may have with a client. One example (**Conversation A**) demonstrates how to completely shut down a conversation while another (**Conversation B**) demonstrates the guiding style of MI and the likelihood of a different and more satisfying conversational result.

Trainer note: Have your training participants examine these on their own and then, in the group, read through each line by line, parsing out what just happened regarding whether the clinician is using active listening skills, whose agenda is being attended to, etc.

Conversation A

Client (Simone): I served in the army so many years and even though it's no longer a 'don't ask don't tell' culture, I'm still thinking I wasn't brought up to act on my feelings. My husband and I divorced when I came home from Iraq and my daughter is grown and out of the house. I just still can't muster up the courage to date women and I notice I've been drinking more lately to handle my loneliness.

Worker: How much are you drinking? Alcohol can really interfere with anti-depressant medications.

Client: I don't consider myself an alcoholic; I'm just struggling with what to do next. I think I'd drink less if I could be more myself.

Worker: What's the number of drinks you drink each week, even if it's just a guess?

Client: I'm not really sure – maybe three or four a night; I know that may seem like a lot but it helps me go to sleep.

Worker: That's probably at least around 20-30 drinks a week. The NIAAA would classify your drinking as heavy drinking. Does that concern you?

Client: I'm just so lonely ~ really for companionship and drinking helps me pass the time in the evening when it gets so quiet.

Worker: Do you care that you are considered a heavy drinker?

Client: Well, again, I think I'd be able to cut back – I'm just feeling so stuck and bored and since I've gained some weight ~ I worry I wouldn't be able to attract the kind of woman I'd be interested in dating. I feel like I'll always be alone and never know what it's really like to love someone and be loved.

Worker: Have you considered attending an AA meeting?

Client: Not really since I don't think of myself as an alcoholic.

Conversation B

Client (Simone): I served in the army so many years and even though it's no longer a 'don't ask don't tell' culture, I'm still thinking I wasn't brought up to act on my feelings. My husband and I divorced when I came home from Iraq and my daughter is grown and out of the house. I just still can't muster up the courage to date women and I notice I've been drinking more lately to handle my loneliness.

Worker: Being true to *you* has been hard.

Client: Yeah, when I was a kid, we had a neighbor who was a lesbian and my dad used to always storm around the house and talk about the "bull dyke" next door and her string of girlfriends. It really got to me. My face would go red and I would run out of the room when he went on his rants. I don't even think I realized I was gay then.

Worker: You can still feel that stinging shame.

Client: I guess so.

Worker: What's exciting is that somewhere inside, you've come to a point where you want to honor your authentic life.

Client: Yes, I think I'm finished trying to please everyone else. Not quite clear on what next steps to take since this is so new to me.

Worker: No more living as someone you're not.

Client: Damn right. (Smiles) I guess I just don't know what to do. It was easier to date men.

Worker: I have some ideas and resources if you are interested. First, what thoughts or plans have you mulled over?

Client: Well, I know from the VA that there are LGBT resources. I just feel sort of nervous to reach out to the group or even pick up the pamphlet when I go back to see my doctor. It would interest me to meet a woman who has a military background like me.

Worker: You'd certainly have some common experiences and history.

Client: Yes.

✎ Trainer note: Debrief. Elicit responses from participants throughout this line by line exercise. What global differences can be gleaned from these two examples of conversation? Invite participants to identify places in the conversation where they would have used different reflections. What would the merit of those reflections be? This may be a good opportunity to review the medical model versus a recovery orientation as philosophically different approaches to the work.

⏱ Allot 30 to 40 minutes for this exercise depending on the size of your group.

Focusing and Finding Strategic Direction

Focusing work with persons in the context of conversations about sexuality and intimacy involves gauging desire, ability, reasons, and needs for making a change. It can also involve uncovering deeply held values that may intersect with these topics. This next section gets at focusing and beginning to find strategic direction using exercises to illustrate strategies for assessing interest and exploring values.

Importantly, clinicians using MI and interested in having these conversations must learn to do the work of reflecting the "preparatory change talk." Here are a few examples of preparatory change talk that clients may make when thinking about making a change related to intimacy or sexuality:

Desire: I *wish* I had a partner.

Ability: I think I *could* create a profile for that dating site.

Reasons: I don't want to live alone anymore.

Need: I've got to talk to my psychiatrist about sexual side effects of my medication.

In Motivational Interviewing as with many other evidence-based practices, it can be very helpful to use rulers or scales to distinguish and elicit the highly unique relationship a client may have to a change behavior.

Give This a Whirl!

Gauging Interest Using Rulers Exercise

This activity can assure that the clinician does not get ahead or behind a client as they move toward making a change. We know from experience that if you rush someone to enact a behavior that they are not truly ready to enact, it may shut them down, harm your relationship, or, at worst, you may never see them again.

Trainer note: Place a large scale on the wall using a whiteboard, blackboard, or pieces of paper taped to the wall with the numbers 1-10. Ask for 3 volunteers to come to the front of the room. Get each of their names and ask them on a scale from 1-10 how comfortable they feel when contemplating talking to clients about sexuality and intimacy, with **1** being not comfortable at all to **10** being completely comfortable.

Have the participants stand in front of the number that most closely corresponds to their comfort level. Because the person with the highest number will probably be most comfortable answering questions for this exercise, begin with them and ask the following questions:

What makes you a (insert number)?

In what settings do you feel more comfortable talking about sexuality?

What makes you a (their number) as opposed to a (slightly lower number)?

What would it take to (move up 1 or 2 numbers from your original number)?

In between questions, you only use reflective listening and open-ended questions to obtain more information about why the person may or may not be comfortable discussing this topic.

Repeat the process with the other two volunteers.

✂ Trainer note: Debrief. When you are finished the exercise, ask the volunteers what the experience was like for them. Once the volunteers have returned to their seats, ask the rest of the group what they observed.

Finish by asking the group how participants could envision using rulers or scales in their discussions with clients about sexuality.

⏱ Allot 30 to 40 minutes for this exercise depending on the size of your group.

Another meaningful way of engaging clients in conversation about sexuality and intimacy is in eliciting their life values and exploring the intersection of those values and changes they may be contemplating. When you understand what people value, you've got a key to what can be motivating them.

Give This a Whirl! ✍

Values Exercise

✂ Trainer note: Print out 'values' cards from the internet. There are many versions available, some with up to 100 values! We have found this to be a bit overwhelming and use this link to print out a packet containing 40 values cards. These are value cards that do not have definitions printed on them since we are most interested in the way in which our participants define their values.

In advance of your workshop, you'll need to use a scissors and have stacks of these values cards for each workshop participant. Distribute the values and instruct participants to clear their desks to lay the cards out in front of them in order to observe the full range of values (love, faith, humor, loyalty, etc.). Some of the cards are "blank." If participants do not observe a closely held value, invite them to write one in.

Participants should study the cards for a few minutes to identify a meaning unique to them. Next, instruct participants to identify five "Core Values" and leave cards face up on the table in front of them while putting remaining cards in a stack face down. This may also take a few minutes. Patiently allow the time for people to conclude this part of the activity.

Next, check in to see if it would be okay if participants allow others to view their cards. Ask that people quietly stand and walk around the room to view their colleagues' 5 Core

Values. Debrief and discuss any surprises and probe about particular values and allow people to express reasons for choosing a particular value. Next, have them choose the value they most cherish and invite them to imagine how this value intersects with sexuality and intimacy in their lives (if it does in any way). Without divulging something too personal, invite participants to share this reflection if they wish. How could this activity be used in the service of working with persons with mental health conditions?

⏱ Allot 40 minutes for this exercise depending on the size of your group.

Evoking and Preparing for a Change

There is no substitute for experience and practice. At the start of your workshop, you are emphatically communicating that role playing and real playing is central to this learning experience. Indeed, experiential work is what can make your workshop transformative!

In this next phase of evoking and preparing for change, you have an established relationship with the individual that you work with and a particular focus has emerged. Now it's time to practice asking open ended questions and using some reflecting listening skills to ascertain what unique barriers and facilitators (things that make is difficult and things that make it easier) in the pursuit of goals related to sexuality and intimacy.

What's important is that your workshop participants practice with the client population that matters to them (adolescent youth/older adults) OR with client situations that feel challenging. This next exercise invites them to generate the detail to "Make a role play."

Give This a Whirl!

Make a Role Play Exercise

✎ Trainer note: Be prepared with "Make a Role Play" outlines to distribute to your participants before giving them instructions for the exercise.

This role play will be based on a fictitious mixture of a behavior, description of person being served, verbatim statements that the client may make, life circumstances, and

social determinants of health experienced by a client. The details of the client and client behavior are to be developed by a group of 3 persons for a phased role play and debrief later in the day. Each of the 3 participants will have an opportunity to enact the role of observer, MI interventionist, and client. No need to be perfect but there should be enough detail for improvisation.

Trainer note: Participants will need at least 20 minutes to work together to create this detail. As the trainer, you should talk through an imaginary scenario as an example and make room for lots of questions. We have found that it is helpful to do this just before a lunch break and have the "teams" turn their fictitious role plays in for review in case what's identified is not a behavior and to determine how sound a foundation there is for a role play.

Perhaps a client wants to learn to ask a person out to see a movie or to sit in the park and have a sandwich as an entrée into a new relationship. However, this client may feel fearful or uncertain based on a lack of experience.

The behavior would be asking someone out. The person may be a 27 year-old female who identifies as black, straight, and living with bipolar disorder. Perhaps she lives with roommates in a supported living apartment and works at a part time job in a corner grocery story. Verbatim statements could be, "No one ever asks me out so I need to turn some tables here if I want a date." Maybe another is, "I want to get married someday." The sky is the limit but your participants will *most definitely* have ideas for this. Social determinants could include that the client has very little income and lives in a neighborhood where there is not much in the way of inexpensive activities for a "date."

1. Behavior (contemplation stage)
2. Description of person served
3. Verbatim statements
4. Life circumstances/Social determinants of health

Return the role play creations to your work shop participants and allow them to each take a turn as observer, client, and MI clinician, affording at least 5 minutes per person and instructing them to stay in the role no matter how awkward it may feel to use reflective listening for the first time. Encourage participants to provide affirmations where possible and to steer clear of giving advice or admonishment.

Debrief! How did it feel to try reflective listening? Did you notice any urge to give advice without permission? How about observers? What MI skills did you see/observe? What went well? How might you have reflected something different?

Allot 90 minutes for this exercise but be flexible if you need a bit more or less time.

Give This a Whirl!

Agenda Mapping Exercise

As Miller and Rollnick describe in their text, sometimes the work is clear, yet there are often other multiple and complex issues that your client presents with on any given day. Having a conversation about intimacy and sexuality may not be at the top of the list or even on the list. Exploration is certainly required and **agenda maps** can be useful, are visual representations of potential areas for work, and can even be tailored to the context.
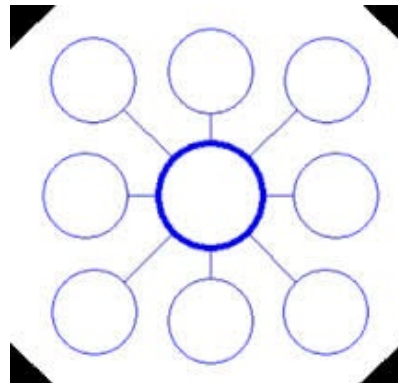
Trainer note: Have a page with bubbles to distribute – some filled with common challenges as well as the topics of intimacy and sexuality. Be prepared with a preamble to describe that people are often thinking about a variety of things in life that they would want to work or focus on.

Fill the map with items your client would like to work on in the short and long term and ask for the client to identify one for today. This is offering a menu of possibilities. You can adapt this to participants in your workshop as a means of preparing them for 'real plays.'

Have participants identify some innocuous types of behaviors (waiting too long to do laundry, improving communication with friends) that they would generally like to work on and populate the agenda map. With partners, have participants take turns asking about the items on the map and which item seems most important, that they have most confidence they could address etc. Instruct members to do this MI style, asking only open-ended questions, providing affirmations where relevant, using reflective listening, and providing summaries of understanding. Remember, no advice giving or providing of resources unless permission has been obtained. We want to give a full listen!

Debrief!

Allot 40 minutes for this exercise.

Give This a Whirl!

Role Play Demonstration

We said it to start with and it bears repeating. Great Motivational Interviewing is not a natural skill in possession of practitioners. It takes a great deal of practice to begin to develop. Excellent MI is a beautiful thing to behold!

Trainer note: The role demonstration can be done with the trainer/clinician who is skilled in MI and a volunteer participant from the workshop. It is often helpful to have participants identify change behaviors related to intimacy and sexuality that they would appreciate seeing role played before them. *Warning* this activity can, on the rare occasion, be an opportunity for a "gotcha" situation for trainers.

Your hard working workshop participants may want to prove to you how impossible it may be to do MI with their clients. Your ability to exude empathy about the very difficult work that is done is of utmost importance here. That posture of humility is requisite. Participants may say that our clients are too difficult, too symptomatic, involuntarily in treatment and so on. Thus, to engage in this exercise, it is important to have solid MI chops and be prepared for and know what to look for regarding the "gotcha" agenda. Make sure that your volunteer will enact a scenario in which the client is ambivalent about or at least contemplating a change in behavior. It is often better to do this with another trainer who has experience and proficiency in MI practice.

~One final note~

We are not trying to scare you away from including this exercise. This can be *the most powerful capstone* to your workshop as you invite participants to observe and later reflect on what they may have said, and what reflexes they noticed inside themselves as certain things were said and observed.

Debrief!

Allot 30 minutes for this exercise.

Give This a Whirl!

Just Right, Pretty Good, Cold Exercise

Trainer note: For this role play, a volunteer or the trainer can play the role of the client, Jonovan, and workshop participants will be in the role of mental health provider. Place 3 chairs at the front of the room and on the back of each chair, hang a folded paper with the words, *cold*, *warm*, and *hot*. Make sure that the signs are visible to all work shop participants.

Jonovan is living with bi-polar disorder and recovering from an episode of mania. One of Jonovan's main problems when he becomes manic is that he becomes hypersexual. He and his boyfriend, Omar, are not on speaking terms because of Jonovan's behavior when he was manic. Jonovan maxed out his credit card and then used Omar's credit card to buy large amounts of pornography. Omar also discovered that Jonovan had visited a sex worker several times while he was in this manic state. Jonovan assured his boyfriend that he used condoms, but he also shared that he was using lots of drugs at the time and so can't be sure. Jonovan says he probably should get tested, but he's concerned that if his boyfriend finds out he got tested, he will suspect that Jonovan wasn't using protection. Jonovan is worried about his health, his safety, his financial situation and his relationship.

Have an object of some sort (glasses case, mood ring, worry stone) and begin with the person playing Jonovan telling a bit of this story to the group. The first person in the audience with the object responds with a reflection when Jonovan is done speaking and passes the object to the next workshop participant. Goals for the participants should be to elicit priorities from Jonovan, discover Jonovan's relationship to his dilemma and, using **OARS**, evoke and prepare for change. Based on the participant's reflection and whether it seems accurate and empathic, the person playing Jonovan will move into the *cold*, *warm*, or *hot* chair. Continue this until all participants have had a chance to try a reflection. If someone chooses not to play, they can say, "pass" and give the object to the next person.

Debrief! Have the person playing Jonovan reflect on the experience. Invite participants to appreciate reflections heard from their colleagues. What reflections captured Jonovan's feeling state?

Allot 30 minutes for this exercise.

Planning and Bridging to Change

Let's say that your client is truly read to take steps toward dating after being single for 10 years. You have listened closely to her reasons for not approaching this part of life and understand the precise trepidation based on her experiences, ways that she has balanced her recovery as a person living with a mental health condition and so forth. She even has a greater understanding of how dating and a potential relationship could enhance recovery for her. She's ready to move ahead. Now what?

Miller and Rollnick (2012) urge us to remember that developing a plan is a beginning step. Clarify again, what steps the person is ready, willing, and able to take and validate reluctance and other reactions as she may change her mind or want to slow down. Support persistence and be willing to go back through the phases of MI again (engaging, focusing, evoking, and planning).

Give This a Whirl!

Three Phase Role Play

Trainer note: You are ready to wrap up your workshop and you've got 1 hour left. Return to the "Make a role play" exercise and revive the vignettes that your participants have developed based on clients they do work with and want to envision what it might be like to use the various MI skills that can bring about client directed conversations related to making changes in life related to intimacy and sexuality.

This Three Phase Role Play is based on the work of Martino, Haeseler, Belitsky, Pantalon, & Fortin (2007), and involves 1) Beginning a discussion about change, 2) Eliciting change with rulers, and 3) Summarizing change talk and supporting autonomy in making a plan.

Trainer note: Pre-determine who will play the client, who will play the worker, and who will be an observer. You will rotate around the room as groups of 3 work through these phases one at a time. Allow for 5-10 minutes for each phase.

Phase 1: Begin a Discussion about Change

Ask Permission to Discuss Topic / Support Autonomy – Examples:

"We have about 10 minutes left, and it's up to you, but would it be okay to talk a little about your feelings about dating?"

Sexuality and Intimacy Toolkit

"I'd like to know your thoughts about dating and where you are in thinking about change. It's something that's completely up to you. Is it ok to spend our last few minutes on that?"

Ask Open Questions – Examples

"How is dating part of your life right now?"

"What are some things that bother you about the prospect of dating?"

"When you tried to date before, what was that like?"

"Where are you today in thinking about making any changes?"

Reflect Responses to Convey Understanding – Examples

"From what you're saying, it sounds like…"

"Let me see if I understand where you are with…"

Avoid Confrontation and Coercive Tone

Phase 2: Elicit Change Talk with Rulers

Importance and Confidence Rulers – Examples

"On a scale of 1 to 10, how important is it to you today to make plans to pursue a relationship with 1 being not very important in 10 being extremely important?"

"What makes you a 5 in importance today, and not lower? What makes it as important as a 5 for you today?"

"What would have to happen to increase in importance to make it a couple points higher, say a 7?"

Reflect Patient Statements That Support Change – Examples

"You're saying it's important as a 5 because of _____"

"You can see some benefits of dating to your recovery. From your point of view, it could…"

"As you see it, it would be more important if…"

Phase 2.1: Elicit Change Talk through Information Exchange

Ask Permission – Examples

"Would it be ok if I shared with you some strategies that persons have used to meet and date someone they are interested in and what to expect?"

"Would you be interested in hearing about some of the social events and dating websites where it may be possible to meet a potential partner?"

Ask About Interest, Desired Knowledge, or Priorities – Examples

"What are you most curious about when it comes to dating?"

"What do you already know about how people get into relationships?"

Provide Information in Small Chunks – Example

"Match making websites can be great ways to find a partner and can also be very frustrating if you do not get responses right away. It involves creating a profile about yourself and putting thought into the kind of person you would like to meet…"

Check Reaction – Examples

"What do you make of that?" "How does that fit with what you're thinking about in terms of dating?"

Phase 3: Summarize Change Talk and Support Autonomy in Making a Plan

Summarize – Example

"So let me see if I have it all. Though you have decided that you are not ready to create a profile for a dating website, you would consider joining a social group at your church and exploring whether there are single persons in that community that you may find interesting. Though you are skeptical of that as a possibility, you want to try that first. Revisiting this with me in a few months sounds like a reasonable plan to you. You don't have the money to join that website and feel a little nervous to make such a "bold" move. However, you want me to know that this is a priority for you. Is that right?"

Ask a Key Question – Examples

"What are the next steps for you?"

"Where do you want to go with this? It's up to you."

Affirm Strengths, Values and/or Participation Review Plan, Arrange Follow-up – Examples

"I can see you are ready and determined to pursue a romantic relationship and to try to meet people. You are going to talk to your friend at church about this a little more to see if she will help you in your "special project." You have developed a strong recovery plan and realize that being in a relationship and finding someone to love

who loves you are one of your values and that you are worth pursuing this dream. "Is that right?"

"I'm looking forward to hearing how this goes for you the next time we meet. If it works or doesn't, we can always just take a look at what you learn."

Trainer note: Debrief each of the phases and stay flexible. You may have to stop the groups after each phase to debrief depending on level of skill and need for coaching. After you've concluded- (whether it's a one or two day training) make sure that your participants evaluate the impact of the training and are given the opportunity to provide feedback. We attach a simple evaluation form in the appendix.

Allot 60 minutes for this exercise.

Fidelity to MI

"People cannot benefit from a treatment to which they are not exposed."
~ Dean Fixen

Lastly, all important things bear repeating again and again. We know that one-day or two-day workshops are *not* effective in passing on skill of Motivational Interviewing in the service of developing proficiency in delivering this practice with fidelity. As reviewed in our monograph to program administrators, in order to create true and sustainable capabilities for workers in any environment, a good faith effort at ensuring those resources exist going forward is warranted.

This good faith effort will involve identifying and further training leaders within your organization to carry the MI torch. This may come about in a train-the trainer fashion toward improving capacity across your organization to have conversations about sexuality and intimacy. Don't forget that there are lots of other "behaviors" that MI can be helpful with so it may be well worth any investment! Coaching and supervision using audiotaped work samples to develop skills should include the use of a fidelity measure. A simple measure is the Motivational Interviewing Treatment Integrity (MITI) fidelity measure (Moyers et al., 2010). It will also mean that attending to the processes of implementation are addressed.

Appendix

Sample One and/or Two Day Workshop

(Day 1) 9:00 – 9:30 Intros (what do you want from this workshop)

9:30 – 9:45 Musical questions

9:45 – 10:15 Overview of Workshop/Sexuality & Intimacy/MI Spirit and Evidence Base

10:15 – 10:45 Imagery exercise

10:45 – 11:00 Break

11:00 - 11:20 Principles, processes and micro skills of MI

11:20 – 11:45 What is MI? (Spot the difference exercise)

11:45 – 12:30 Stages of Change & Stages of Change exercise

12:30 -1:30 Lunch

1:30 – 2:00 Eliciting Change with Rulers

2:00– 3:00 Reflective listening and role play demonstration

3:00 – 3:30 Real plays

3:30 – 3:45 (Trainer note:: optional ~ create a quiz) & wrap up

3:45 – 4 Tomorrow

Checklist

☐ Musical questions

☐ Copies of stages of change vignettes

☐ Spot the difference scripts

☐ Quizzes

(Day 2) 9:00 – 9:30 Check-in and review of yesterday

9:30 – 10:00 Starting Reflective Listening (Exercise) 45 (Trainer note: listen to a morning story in pairs) Have participants take turns sharing their morning journey: listeners can only use "reflective listening."

Sexuality and Intimacy Toolkit

10:00 – 10:30 Make a role play for this afternoon {Groups of <u>three</u> identify a 1) Behavior (contemplation stage), 2) Description of person served, 3) Verbatim statements 4) Some life circumstances}

10:30 -10:40 Break

10:40- 11:15 Values exercise

11:15- 11:45 Agenda Mapping Exercise

11:45 – 12:00 Review of righting reflex and traps we fall into (Trainer note: consider pulling from the Miller and Rollnick (2012) text for the creation of Power Point slides for some didactic review of these common interferences to good MI)

12:00 – 12:30 Demonstration of group identified behaviors

12:30 – 1:30 Lunch

1:30 – 1:45 Change and Sustain talk and finding direction in sessions

- Preparatory change talk
- Mobilizing change talk into (Trainer note: consider pulling from the Miller and Rollnick (2012) text for the creation of Power Point slides to review)

1:45 – 2:15 Just right, pretty good, cold exercise

2:15 – 2:40 (Trainer note: Choose a YouTube example of evoking and consolidating change that may resonate with your group!)

2:40 – 2:50 Break

2:50 – 3:40 3-Phase Role Play and Debrief

3:40 – 3:50 wrap up

Checklist

- ☐ Values cards and instructions
- ☐ Observer sheets
- ☐ Phase 1,2,3 instructions
- ☐ Just right, pretty good, cold labels
- ☐ Agenda mapping instructions
- ☐ Bubble maps
- ☐ Make a role play forms

Evaluation

Names of trainers:

Date:

Overall, how would you rate this workshop?
1 = Poor, 2 = Fair, 3 = Average, 4 = Good, 5 = Excellent

1. How would you rate the usefulness of the content?

 1 2 3 4 5

2. How would you rate the hands-on activities?

 1 2 3 4 5

3. How would you rate the presenter's knowledge in the subject?

 1 2 3 4 5

4. How would you rate the presenter's style of teaching?

 1 2 3 4 5

5. How would you rate the pace of the presentation?

 Too fast Too slow Just right

6. Was the workshop above or below your current skill level?

 Above Just right Below

7. What did you like best or find most useful about the presentation?

8. What skills did you learn that may improve your preparation to work with clients?

9. Were your personal learning goals for the workshop met? If "No," please describe the expectations that were not met.

10. Any other comments?

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