Talking to Change: An MI Podcast
Glenn Hinds and Sebastian Kaplan

Episode 32: MI in South Africa, with Goodman Sibeko, MD, PhD

Glenn Hinds:

Hello, again, everybody, and welcome to Talking to Change, a Motivational Interviewing podcast. My name is Glenn Hinds, and I'm based in Derry in Northern Ireland. As always I'm joined by my very good friend, Sebastian Kaplan in Winston-Salem, North Carolina. Good day, Seb.

Sebastian Kaplan:

Hello Glenn. How's it going over there?

Glenn Hinds:

Yeah, it's going good. It is Tuesday, the 23rd of June. These days are just merging into one. There's still some lockdown here. I get out of the house now and again, but my days merge into one. So Tuesday, the 23rd of June, 2020, and all is good. I'm really looking forward to today's conversation, where we begin to expand even further into the exploration of Motivational Interviewing and culture and the impact of culture on MI and the influence of MI and the expiration of culture in treatment and wider field. What about yourself, how's things?

Sebastian Kaplan:

Things are going fairly well here, as far as the shutdown or the lack of shutdown, as it's increasingly happening here in the US. An interesting experience where there's increasing concern about more cases and increased positive tests rates and hospitalizations, and at the same time people are really just sick of being at home and are going out in the world and many people are going out in the world in ways that are counter to what our public health officials are recommending. Fortunately it's taken on like most everything else in the US a very political one side versus the other framework, and we shall see how this is all going to play out.

Sebastian Kaplan:

But the situation is, I think precarious would be a good word for it, at this point, just trying to do as much as we can do as individuals really. But yeah, today's episode is one that we have been looking forward to for some time. We reached out to our friend and colleague Steve Rollnick, who many of the listeners will remember from a previous episode and may be familiar with just based on Steve being one of the cofounders of MI and ask for any ideas or recommendations for guests from South Africa, where Steve is from originally and continues to do a lot of work in the MI world. So we are very excited to have our guest today that Steve recommended to us. But before we introduce our guest

and get to our discussion, Glenn might you introduce our social media platforms and how people can contact us.

Glenn Hinds:

So, on Twitter, it's @ChangeTalking, on Facebook, it's Talking To Change, on Instagram, it's Talking To Change Podcasts or emails, either with ideas for future episodes or questions, either for myself or Seb, it's podcast@glennhinds.com.

Sebastian Kaplan:

We do invite all kinds of questions, comments, and ideas for episodes.

Glenn Hinds:

If you are listening off the streaming services it would be great when you find this is, is just to go on and leave us a star rating or a comment that would be fantastic. But, on with the show, today we're delighted to be joined by Dr. Goodman Sibeko. Did I get that right?

Sebastian Kaplan:

It's close enough.

Glenn Hinds:

Close enough. Yes. Before we went on, Goodman was explaining that even people local to him find it difficult to pronounce his name properly, and they were saying that in Irish, the spelling of a name and the pronunciation of the name aren't necessarily the same thing. That sounds like it's the same here, but we're delighted that you've made yourself available today, Goodman. As with all episodes, can we just start by, just tell us a bit about yourself and your journey and to Motivate Interview.

Dr. Goodman Sibeko:

Sure. Just to start by saying, I also have no idea what day of the week it is until I check my calendar anymore. So we are all in the same boat, and navigating all these COVID restrictions and know what comes of our lives after this. So thank you for having me. My own background, I'm a medical doctor, trained in a province about 2000 kilometers North of here, KwaZulu-Natal. After I did my initial medical degree I specialized in psychiatry where one was exposed to various different styles of psychotherapy. The ones that resonated the most with me were psychodynamic and later on schema therapy, because it really is about exploring the person's perspective, the person's origin, where they come from, and how that impacts on where they're going. I think that links to MI in many ways.

Dr. Goodman Sibeko:

After that, I then came and did my PhD at University of Cape Town, which really focuses on providing training for various levels of KADRA particularly focused on areas where there's a high burden of HIV and targeting behavior change related to either harmful substance use or behaviors around health seeking for mental health, and health access for mental health. In as far as those linked to outcomes for HIV. Following my PhD,

subsequently I've come to become co-director of the South Africa HIV Addiction Technology Transfer Center. I think in the US you might be aware of the ATTC network.

Dr. Goodman Sibeko:

So, there's I think about 11 or 12 ATTC's in the US which have now expanded into additional networks. The network's focus really is around reducing harms of substance use and providing access to care and access to best evidence for management and training for substance use disorders. As a result, the ATTC's work they leverage that expertise and that pool of resources to tackling substance use disorders in South Africa. A huge chunk of our offerings is centered around MI. As a result, I've come to interact a lot with MI and we've had the privilege of being able to start working with Steve Rollnick as well.

Sebastian Kaplan:

Wonderful. Yes. Thank you Goodman. One thing I was curious about is you've mentioned some of your past training in psychotherapy and talked about the importance in particular of understanding a person's own perspective on their health and their life choices and those sorts of things. Maybe you could say a little bit more about what you mean with that and how you understand the importance of the person's perspective to be with regards to health behavior, because I imagine there's some natural links to what Motivational Interviewing offers.

Dr. Goodman Sibeko:

I think one analogy I like to refer back to time and time again is the whole Apple rationale, or why you buy an Apple device. I use largely Apple devices because I'm sold on the idea that my life is very busy. So in order to create sync and flow, if I'm using the Apple, there's connectivity between all the activities I have to be engaged in and it's seamless and it's easy. So there's a motivation to continue to remain a subscriber of the Apple product, because I understand how it will benefit my life, because I understand how my life is busy enough or requires that kind of flow and order. The same applies to somebody who is engaged in a behavior which might either be harmful or requires a level of commitment from them if they don't have the buy-in which is originating from understanding how it is that their circumstances are impacting on the trajectory of their life in a way that could benefit from change, then there's no way that you can convince them to take that part on.

Dr. Goodman Sibeko:

So, I was saying to you, I was on another webinar before this. I haven't really done that much planning, but I did think about our conversation today. Part of my thinking was the fact that in our context, paternalism, the idea that somebody who is trained and has all the knowledge is going to come and tell you what to do, is associated with safety and containment and knowledge, and the fact that just because of how historically things have been done. But what we do know for a fact is that when it comes to harmful substances, when it comes to behavior change, that there's no way that you can achieve that if the person doesn't have the motivation to really navigate all the difficult steps that are required to get to that point or get to that next step.

Dr. Goodman Sibeko:

When we're managing people, who have depression or psychosis, as long as they address that when they go home and they don't have the nurse giving them the medication in the ward, that they will step away from the routine that's required for them to remain adherent and become stabilized. But if they understand why there's a routine, if they understand why there's a need to take the medication at a certain frequency, certain times of the day, the likelihood of them doing that without that supervision is increased. So that's greatly when I'm talking about motivation from.

Glenn Hinds:

That's fantastic and we would appreciate that. One of the things that was interesting about what you're saying is that that idea of us wanting to give instructions to point out, "Look, Apple product is much more productive than Android and your life will be much better if you just unify all of what you're doing," that the instinct that is driving that from the practitioner is a desire to be caring and to be supportive of the patient or the client. But what you're identifying is, is that the desire to be helpful in itself does not make us helpful. It's about the client's decision and what you're describing too is that in your research you have identified that there are certain things that the client needs to experience in the relationship with the helper for them to be able to transfer the information and the knowledge that has been shared during the treatment experience and that rationale of way it will be better for me to behave like this.

Glenn Hinds:

It's really important that that makes sense to the patient or the client, I suppose the responsibility and the challenge for the practitioners to ensure that the just giving information and itself isn't enough, it's about clarifying the patient's understanding of the information and does the information align with their circumstances outside of the treatment environment. I'm wondering how have you learned or what have you noticed about how to help that shift take place? So it's not just that the specialist or the expert or the practitioner has the information, it's about how to ensure that that information exchange is done in such a way that it improves the client to understand and therefore the likelihood to implement these changes.

Dr. Goodman Sibeko:

It's very much a two-way street. South Africa is beautiful for many reasons. One of the reasons that's beautiful is because of the mix we have here of cultures. My father was a mix of Sutu and Posa. My mother is Zulu, so I'm a mix of three different clans and three fairly different cultures with some similarities. South Africa has 11 official languages. So there's various ways to interact and to communicate. As a clinician, it's not feasible to have a plan of management of treatment that does not provide room to be receptive to the patient's own understanding and concept of health seeking and the practices required for health attainment.

Dr. Goodman Sibeko:

I was recently part of a study which looked at the genetics of Posa people, of people with schizophrenia who are Posa in South Africa. As part of that project, we did a few social responsibility things. As part of a study that I was leading, looking at cultural formulations of mental illness, we went into the wards and spoke to patients who were stable and about to be discharged with mental health, and without fail in that ward, this was now a ward which was located in a rural hospital in the Eastern Cape. Folks were very happy to have less voices to be less delusional and to take their treatment.

Dr. Goodman Sibeko:

But what they said is that they still know that no matter how much treatment they take, they still have to go and do the traditional practices. So they still have to go and slaughter the goat or slaughter the cow, or slaughter the chicken and call the family together. So what that means is that as a clinician working in South Africa, one has to be ready to receive the conceptualizations of health driving behavior or of the completeness of the pursuit for health. So the clinician has to be willing to listen to the patient's background, their story, their beliefs, their concept of what needs to happen for them to be well. So this really feeds into the whole idea of, am I saying, where are you at? Because if you tell somebody, "You need to take risperidone one milligram twice a day, and that's all you need and you tell them that's the only way to get better.

Dr. Goodman Sibeko:

The chances of getting them to buy into the treatment plan, is less like than if you say, "I understand, or even before you get to that point, tell me what your health seeking practices have been? And tell me everything, and don't worry about me judging, I want to learn from you." So then if the clinician then receives the information around those cultural practices, it's a question of how then does that clinician interact? We start talking about non judgmentalism or all of the practices which are espoused in MI. In my clinical experience and in our research experience, and as we provided training, it's become clear and reinforced just how key it is that that patient's perspective is represented in the dialogue, in the conversation, in the treatment plan.

Sebastian Kaplan:

Yeah. Really wonderful example of both the mindset that a practitioner really needs to have, assuming they're going to use a method Motivational Interviewing of course, which we're all obviously biased towards. The mindset of being open to what the patient's perspective is in the first place, but then a great example of a specific way of, or a specific question that taps into that. What are some of your own health seeking practices and how might they fit with the recommendations that we have? It really makes me think of examples that we come across here in the States or at least where I'm based in North Carolina, where...

Sebastian Kaplan:

I don't know that it's differentiated so much by culture or where people are from necessarily, but there's certainly a portion of the population that might be more likely to seek, I guess we would call them alternative kinds of treatment. Alternative is a broad

term of course and I'll use my quotation fingers for those, but they might use more naturalistic remedies for instance, that a trained doctor might have concerns about or might bristle against because of the lack of efficacy or the difficulty in really controlling how much of a particular substance is in a natural remedy.

Sebastian Kaplan:

You can see these conversations that really get derailed early on when providers dismiss what a person is already doing or what they believe might be useful for them and how, I'll say a simple shift, but certainly it's not simple to do this, to just be open to what someone is already doing and maybe being curious about what their experience has been in seeking their own strategies or in their own strategies guided by another provider from before or maybe it's something that's been passed down through generations within their family, or I guess another thing that people bristle against is the internet and finding information on the internet, which yes of course there's some information that's reasonable and helpful and others that might be more concerning. But it's having that mindset at the start and then having some specific ways of asking questions on how to match up the things that you know as a provider can be helpful with what another person feels like is helpful to them.

Dr. Goodman Sibeko:

I think it's that balance between information sharing for safety, we don't know what's in the material that you're consuming, versus wanting to remain in that collaborative space with the patient.

Glenn Hinds:

Yeah. But balancing from what you're describing, to better understand, what's the client's goal, part of what the practitioner's exploring is, what is your goal from coming here looking for treatment and what are you currently doing and how close to where you're trying to get to is that getting you, and there's the opportunity to then go, what is it you hope I can do to add to what's already working for you and work from that perspective? It's not saying, "Okay, we're going to go back to year zero and start from scratch." It's you're going to work with what's in front of you and recognizing what prayer or meditation or some drops here and there may in itself be working for the client, and it's really important that we don't dismiss that experience for them. In fact we augment their recovery with what it is we can offer them.

Dr. Goodman Sibeko:

That speaks to that whole idea of having to negotiate what the end point is, or what the desired outcome or what your intermediate outcomes will be. Obviously there's a clinician if somebody comes to you and their desire might be completely different. Their desire might be that I just want to be able to have a relationship. I just want to have time with my wife and my kids. So that negotiation of as clinicians navigating the balance of desired outcomes from the systemic side, from the individual patient side, from the clinician side, from the facility side, because also we'll all be competing.

Sebastian Kaplan:

Right. The negotiating of what is important to both individuals in the discussion.

Dr. Goodman Sibeko:

That's what I was looking for by the way, but I couldn't pick a language.

Sebastian Kaplan:

Okay, well I only have one to choose from. So I guess it's pretty easy for me. Another thing that we're curious about from a cultural standpoint, and so often these conversations can get really over simplified and obviously there's going to be variation within cultures, right? Of individual preferences and how people respond to styles and approaches. Obviously within MI we're trying to establish a partnership that one way that's often described is as two experts, if the conversation involves one provider and one client, both are experts, the provider is the expert in their field and the research and whatever that might be and the client is an expert on their own experience, their life history, their own lived experience with whatever the ailment might be or whether it's schizophrenia or depression or HIV, their own experience with past efforts at treatment and how that's gone for them and that's the collaborative nature of what MI strives for.

Sebastian Kaplan:

One of the things that certainly in my training or in efforts to learn about culturally competent practices is an awareness that there may be some cultures or maybe more accurately put some individuals within certain cultures that might prefer a more hierarchically driven modality. I don't know that much about South Africa or the world of healthcare provision they are Goodman, but I wonder if you could speak to maybe that in particular, maybe some other things that would come to mind as we're talking about these issues.

Dr. Goodman Sibeko:

Yeah, I think when you come to a patient and you suddenly give them space to view themselves as an expert in what has been negotiated, it's foreign to them. For very much the same reasons that you're saying, is that historically the professional has been the one to tell you what's best and what needs to be done. I think in our context that's reinforced by a few things. When I think about my Posa culture, I have a great deal of respect for my mother. She's achieved great things with very little, and she's a Zulu woman. She acquires a lot of respect in her own family. When she comes home to my closest side of the family, which is my father's side of the family, she's expected to be entirely submissive. So there's an expectation that she knows her place and that she will step back.

Dr. Goodman Sibeko:

So, in that space, the woman's voice is not expected to be heard loudly in a public forum for instance, or in forums where decisions are being made. But I know very well that my mother is the head of my household now because my father is late, for example. So, there's been an inherited position of submissiveness, which makes the shift to becoming somebody whose voice matters in an interaction like this challenging. So when you come

to somebody and you're providing an MI intervention and you're saying, "Tell me where you want to go." It's something that can be difficult to navigate because no one's ever given me the room to do that. So that's one challenge, is people who now have to reorientate themselves to being in a position of power. Now, what makes that even more challenging is that in reality, they don't have power.

Dr. Goodman Sibeko:

One of the things we're realizing now, with COVID, is how the disparity in privilege and in access to resources, results in the impact of the restrictions having a disproportionate impact on folks who have less and don't have access to resources and [19.40] industry frankly. So they are less likely to be militant in seeking, militant to the wrong word especially in the context of what's happening now. But perhaps so are more driven to actively seek appropriate access to resources. I think that's a better way of putting it. So you're telling me that yes, historically, that now in order to make my life better I have a voice, fantastic. But when I leave here, I don't have anything. I don't have any money, I don't have a voice in my home. I don't have the industry or the resources to make some of the changes that I might say I want to make. That imbalance in power is for me a very important consideration when we talk about providing MI based interventions in our context.

Dr. Goodman Sibeko:

So, it's not just having to shift somebody from being a receptive individual, but to being somebody who is a policymaker in their own life and a decisive decider of what comes next and playing that off against the actual reality of what it is they're actually having to, the context that they're having to make these decisions. So for me, that's the challenge. So now I'm a medical doctor and I'm also the youngest in my family. So that's a really weird paradox for my family. That I'm the last born so in theory I shouldn't be the one being told what to do. But because I'm the doctor who is very senior at a division in University of Cape town, my currency changes. So I have a lot of voice because of that.

Glenn Hinds:

What you're identifying is that when we're working with people we have to appreciate that the place that the individuals act varies from individual to individual, and that the empowering experience of Motivational Interviewing may be very broad for some people and very tight for others because of the experiences they have outside of the therapeutic realm, and that the opportunity is, "Yes, it's lovely that you're asking me what to do, but I'm not sure there's really any mileage in me doing that because when I leave here, I'm not really going to be able to do anything about it because of my environment."

Glenn Hinds:

Yet you are offering an example where culturally it's expected, because you're the youngest you should have the quietest voice. But because your circumstances have changed, you have your position in the family and the roles and responsibilities and the volume of your voice has been changed within that culture. It's recognizing that while it may be like this, the practitioner maintains and holds hope for change, however big or

small it may be. It's about working with the client wherever they're at to explore, and I imagine even to begin with that idea that even just exploring with them what's it like for you to have your voice in this room?

Dr. Goodman Sibeko:

It's a question about hierarchy and about the value in the voice of a professional. I think around the world, the voice of a medical doctor is fairly well respected. So there is that expectation that receiving advice from somebody with a medical qualification holds more weight. So again, in this MI interaction, you are recognized in my culture, in my country, internationally as somebody who has the knowledge to tell me how to fix this thing. But here you are telling me, so it's navigating that. So it's adding another layer. So first of all I'm not used to being listened to, you're telling me I must speak. But when I leave, what difference is it going to make because there's no way for me to exercise this power. Now also you're supposed to tell me what to do, and now you're telling me now you want to listen to me.

Dr. Goodman Sibeko:

So, it's a complex shift and I think what makes it more complex is that what we sell in our context is brief interventions. We're selling interventions where somebody comes in, which are MI based. Somebody comes in and you screen them and they identify as high risk, moderate, and they need a brief intervention. So you're saying that in this 15, 20 minutes, you're going to create this therapeutic alliance and help somebody to start realizing that they have what it takes to make the decisions to change. But you're trying to do something that actually in reality, ideally should take a few sessions, because you walk somebody into their power, and help them understand, "How does my personal internal power and my personal power in how I decide to tackle my challenge interface with the fact that I technically have little power outside of here?" So these are difficult things to negotiate. So that's just something to think about.

Sebastian Kaplan:

You used a phrase there, walking someone into their power, which I think struck Glenn and I both as a wonderful image, perhaps there's even a subtle place for ambivalence to arise in a way that providers don't often think about, regardless of where they're practicing around the world, that there may be... We talked about ambivalence a lot in terms of the specific behavior change, whether they want to reduce their drinking or wear masks in public as the case might be now with COVID. But what you're suggesting it seems is that there may be a level of ambivalence on the person.

Sebastian Kaplan:

I guess as I'm talking about it, I'm not sure that it's maybe the right word for it, but it feels like there's some similarities there that there may be some ambivalence on the part of the person to embrace or accept the power that the provider is offering. Given that the medical doctors are just so often seen as this person with power and with knowledge that one must abide by or abide with, maybe it's just such a foreign conversation to have for a

person, to have that power offered to them. I wonder what your thoughts are about the concept of ambivalence in this context and how it fits with your experience.

Dr. Goodman Sibeko:

As you were talking, what came to mind for me was that Apple analogy again. The reason I'm bought into this is because I understand how the seamlessness and the interconnectedness of my devices makes my life simpler. I think one wants to use that ambivalence as a starting point too, and explore what are the factors that are resulting in it? Again now this links back to psychodynamic ideas, that, so if somebody understands why it is that they struggle to accept the power that they have over the outcome of their management, and over the planning of their management, this might be a reach, I'm not citing any literature, but if you're able to start walking someone into realizing how the ambivalence is playing out in that circumstance, it could very well be a light bulb that makes them think about, "How does this apply to my harmful substances?"

Dr. Goodman Sibeko:

Realizing that I actually do have a voice and that I do have the ability to make decisions that change the course of where I'm headed, could the same be said for my inability to control when I drink, how I drink, where I am when I drink. So it's linked. I think you're right. I think the term is the right term. So I agree with you on it, but I think it's a vehicle that can be used in the therapeutic plan. I think in the context of how we are currently training providers, and that we're training them to provide these interventions in a very limited time in circumstances which might not always provide the privacy that you require for the particular assessment and intervention.

Dr. Goodman Sibeko:

So, it's a question of how do you explore that ambivalence and how do you maximize the learning from the exploration of that ambivalence in the short time we're asking providers to do it and I think if you're doing a much longer therapy, my therapist has been with me for seven years. I think she knows me better than anybody can possibly know me. So if we decide to walk down a path of using MI principles to explore how my ambivalence is ready to certain things, there's time to do that. So I think in a more longer term, therapeutic interaction there's time to do that. But what about the short term?

Glenn Hinds:

I wonder what you're saying that it sounds like the efforts in South Africa are about endeavoring to make large populations of practitioners make some changes in their interventions. That that's a journey, and that what it's about small changes by a lot of people and the interventions, and over years that that can be developed. But also part of that shift is about supporting practitioners to recognize that they need to see and believe in the client's power and choicefulness for them to be blue walking towards it. You can't walk someone towards somewhere you don't think exists. So there's a shift in the practitioner's attitude, a shift in the practitioner's understanding of who they are and their relationship and their willingness maybe to give up their traditional belief. Having grown

up in that world where doctors were one thing, and now there've been told, "Well, we're inviting you to see doctors as slightly different."

Glenn Hinds:

Yes, you're going to be helpful. But what the research shows is you're going to be much more helpful if you approach it from a slightly different perspective where you invite clients to talk. Then when they go in that conversation, they go into that complex state that you're describing, which is some people who are coming to them have had very little power for a very long time, and they've only got 15 minutes to change it, quite a radical shift taking place across South Africa. I'm just wondering what are you seeing in relation to the efforts across South Africa about practitioners' willingness to change and the impact that's having on patient and plan engagement and outcomes?

Dr. Goodman Sibeko:

I think that's so key about practitioners needing to be in a position to begin to make that shift to actually extend that message of the patient's own power in the interaction. I do think it's a shift that needs to happen. Again I don't think that's unique to South Africa. I think that's probably across the board. That really speaks to the need for practitioners to be mindful. But again, you can only be mindful once you become aware. That's why there's exposure to evidence. What we've seen when we've trained providers, we've stratified our training offerings and in a couple of ways. Our mental health and self-care trainings are geared towards non specialists at the moment, and that will evolve. In our self-care we use a very much more simplified version of MI, which we call being a guide on the side. We talk about what are the things that somebody who has always been there for you and always listened to you. What are the features that they possess that really made you feel.

Dr. Goodman Sibeko:

Then we talk about how you extend that to a patient. Whereas with more professionalized coaches we train specifically in MI, and in screening brief intervention and referral to treatment. What we've seen there is the resistance can be quite profound because the practice has been so ingrained, that patients take on an almost childlike quality in that they shouldn't be doing this, it's bad. In Afrikaans we say stot, and I'm going to tell you how to do it right. So you're not taking your ARVs every day, bad, bad, bad, you're going to die. As opposed to, can we talk about what you think you might achieve by taking treatment and how does that align with what you want for your health outcomes kind of communication. So we experienced a lot of resistance which has played out in different ways.

Dr. Goodman Sibeko:

So, there's people who've been aggressively vocal about, "Are you trying to tell me that I don't know what I'm doing?" Or, "Are you telling me that I must listen to this person who has no academic medical background and make them part of this conversation?" So those are the interesting responses we've had from some providers. So my team uses as is required, role play, in providing the training to these providers. So when they experience

the role as the patient, often the penny drops, because then they experience the language of inclusion and of participating and of having a voice. Then the penny drops, oh, is that what it feels like? Because the end goal is the same. The end goal is improved health outcomes. It's improved quality of life, and it's improved industry. But the pathway to getting there is the shift that needs to happen. Some of the things we've heard is, "I'm happy to realize that I don't have to contain this."

Dr. Goodman Sibeko:

Because I think some of the anxiety of having to get a patient better or how to get them taking their treatment is historically paternalistic and it's a very hard line. So learning how to make that shift to a collaborative side-by-side is not always easy. Part of that is, so if somebody comes to a Motivational Interviewing and training, understanding what MI is about. So, first I came in and trained with you and that meant I get MI, I get what we're trying to achieve, how I receive and how I onboard the techniques will be different to somebody who comes in defensive. Who comes in saying, "I use problem solving therapy. I use this, I use that, and I don't know how this is going to fit." So when we walk in there's often that resistance of, "I know what I'm doing." And of this person cannot be necessarily expected to know what to do. How can they have a voice in this process? I know better, I'm trained, I'm supported, et cetera. That's the challenge. But you're very right that the shift has to be with practitioners and that has to stem from mindful change.

Sebastian Kaplan:

So something that you structure in trainings or in learning environments is to have the practitioner adopt the role of what it would be, what it is like for a patient, and in particular a patient treated with an approach or engage in a conversation where that traditional hierarchy exists, where they are told or confronted or perhaps even threatened into behavior change. Then experientially they see, potentially, not everyone I'm sure. That light bulb moment occurs and they can understand from their own lived experience in this role-play.

Sebastian Kaplan:

Now I understand what happens when someone pushes back, when someone who's encouraged with all the right references to literature and perhaps factual evidence, how that in and of itself isn't what will guide someone to behavior change. That there needs to be other ways to provide this information for people to use it. Use it in the way that we all want to use it. Goodman you mentioned something, another interesting phrase of the guide on the side or that was a way that you've described part of your training methodology or mindset. I guess just wanted to hear more about what that was, because I lost the thread on that.

Dr. Goodman Sibeko:

Yeah. So we necessarily would need to adopt styles of teaching which reach the demographic we're targeting. When we train registered counselors or professional nurses or clinical psychologists or doctors, we can easily walk in and start the ambivalence and start saying open-ended and start talking about all this. But when you're talking to non-

specialist workers who have varying levels of education, many of them have 9th or 10th grade level of education and haven't had any education beyond that. Some of them are older and may not have the capacity necessarily to grasp concepts which are very Anglican in origin, very Western. When we reach that circumstance, the necessity is that you have to find the language that will transmit the information. I'm purposely not saying simplify, because I don't want to say that because it's not what it is. It's about finding the appropriate language. How we have done that is by distilling what the experience of being a partner in the conversation for change for the patient into how do you vocalize the experience of being empowered as a patient.

Dr. Goodman Sibeko:

Then we've taken that and use that as the core features of what it is to experience having a guide on the side. By asking the providers, these are usually community health workers or peer providers who are in the community doing tracking and tracing HIV. Saying to them, "What are the things about your experiences of a supportive relationship? Whether it's a partner, a friend, a family member, anybody. What are the experiences that have made you feel that you were in a trustworthy circumstance where you felt listened to, where you felt like you had a say in what happens next. Ultimately as I'm shown, be surprising to any of us, the features are the same. So somebody who lets me speak my mind, somebody who doesn't necessarily hold an opinion about what I'm saying. So somebody who lets me be unsure. And these things all link directly with the principles all around.

Dr. Goodman Sibeko:

Almost without fail, these are exactly the same things that have come out each time. Then you talk about, "So, what is it about when your sister listens to you in this way that makes you feel?" In that way you actually create a practical and relatable experience of what it is to have a non-judgmental interaction. So, somebody might say, "Whenever I tell them my problem, they are able to tell it back to me in a way that I may not have thought about." So you are summarizing, but obviously what you don't come back and say it's summarizing you say, so when somebody tells you the story in that way, you feel you've been heard and so modeling and reinforcing those, and then saying to them, "Well, if you go into the community now and you find somebody who is not taking their treatment, do you think that if you had to listen to their story and tell it back to them that they would feel valued and there could be..." So it's working from the back end. So that's what we've put together is that concept of being a guide on the side.

Glenn Hinds:

What strikes me Goodman is that everything that you've said is consistent with an approach which is, that you are going to work with practitioners, to work with patients, to work with the community, work within the culture, where you are looking towards them and exploring where they're at and what is it, they're doing and how to assist them. You're invading lots of evoke cases. You've done a lot of evoking. You're drawing off the people that you're worth, what it is and what it is they think. What is it they can learn from their own experiences. What you're changing is the language and making the language appropriate to where the individuals act, to make them feel valued in the conversation

they're having with you. Then being curious, what did you learn from that that you could then translate when it's your turn to be the lead in the conversation?

Glenn Hinds:

That almost when you mentioned earlier on that the professionals experience some reluctance, it's almost like they go through a conversion experience when they realize, "Uh, someone treating me like this actually made me feel warm," and the light bulb is now I know I can do this with another person, and they will find it helpful because that's what they were always interested in. That no one wants to take on an approach because it's lovely and fluffy. It needs to be, will this work? With this help me do what I do? Once that experience is manifest for them, they introduce it and they do things differently. Again just that shift away from what you're describing that paternalism towards collaboration, and that's consistent with everything that you're doing and your whole approach a sensitive culture shift in the treatment across South Africa. I suppose what are your hopes, what are your expectations or what would you like to be seen change over time now that this is beginning, in South Africa. Where do you see MI's place in that?

Dr. Goodman Sibeko:

I have to say, so you were talking about how does a practitioner learn or navigate that part of creating that shift for providers? I think for me, in training, I think for me I am part of that demographic that technically doesn't have a voice. I grew up in a township. I grew up knowing the experience of exclusion, and I'm 40 now. I was awake during the transition when democracy arrived in South Africa and I saw the change and I see the areas where we haven't changed. So, I'm very much aware of my own, the parts of me that haven't evolved to power yet. So there's parts of me which are clearly evolved in power and there's parts of me which are somatically not there yet. I'm still not good enough. So there's many things that we deal with. But I think that as a clinician, if you have an awareness of those parts of yourself, it's easier to be empathetic in how you engage with somebody that needs to make a similar a part on a smaller journey.

Dr. Goodman Sibeko:

So that smaller journeys is changing the motivation to change harmful alcohol. So you're not trying to change immediately in any case, their whole outlook on life, but trying to certainly help them find the motivation for these smaller changes that will lead to better outcomes for themselves. So I think that's part of it is the clinician's ability to empathize and be sensitive and to step back from themselves and allow the patient the space. So I think that's part of it, and that comes again from that mindfulness and being receptive to that experience for the patient. I think that... and there's other elements that would come into play there, the clinician's own disposition, how willing are they to be consultative?

Dr. Goodman Sibeko:

I've trained under many fantastic folks who some of them are more democratic and consultative than others. There's some who, it's my way or the highway or there's others who, "Let's to talk together." I have certainly hope my team experiences me as the latter. I don't know. Not privy to those conversations when I'm not around. So I think that in terms

of, for South Africa, I think that the place for MI is in the shift that has to happen in our country as a whole, from a larger cultural perspective in terms of recognizing people's voice and enabling the space for them to have industry in decisions that impact on their health and economic outcomes. Then also in terms of clinical service, ensuring that patients are partners and collaborators in designing health care and in designing their own interventions, is not only, and this is one of the selling points I often share with collaborators, that what we're trying to do here is to take the pressure off the practitioner.

Dr. Goodman Sibeko:

We're trying to say, you don't have to have all the answers. The patient has the answers. Your role is to walk with the patient, to identifying those answers. So if we have a system that is enabling of the changes that allow that voice to be nurtured, for me that's the change that MI is going to bring. I think the most important thing is when we talk about MI, we don't come in and say, "Throw all your toys out." We're saying, "No keep your toys. This is something that you can use to contain some of your toys." So it is something that can be cross-cutting and it's not exclusive of anything. I think that again is an idea that is required, not just in South Africa, but across the world.

Dr. Goodman Sibeko:

There's this idea that things are always external and when they come, they are proposing something completely new that must either be seen as superior to what has been there before or inferior and kicked out. That's what we're seeing with MI. That's not what we're saying. We're saying here's a style of communication that you can apply to use the tools you're really good at. You're really good at problem solving. You're really good at CBT. You're really super at schema therapy. How about trying out this language that allows you to take a lot of little bit and allow the patient to be a partner, and in so doing actually empower them to drive some of how this... So it's about capacitating patients. It's about changing the culture to a more socially inclusive and listening culture. For me that's the vision.

Sebastian Kaplan:

Well Goodman, you've really guided us through an exploration on both sides of the conversation around healthcare interventions from a patient's perspective, really helped us better understand some of these challenging points in conversations. For instance when a patient has their own views or their own strategies for health, and how a provider can be respectful in approaching those differing perspectives and how they might engage in conversation with a patient to include the provider's own recommendations. Also inviting us to really be aware and mindful of the power differential and a patient's lack of power in their day-to-day life and how MI can be a really sharp shift for them when the provider is inviting them to engage in this more collaborative discussion. Then conversely from a provider standpoint, the importance of the provider being really in touch with their own experience and how that can influence their healthcare delivery in any number of ways.

Sebastian Kaplan:

Then just a moment ago you used this phrase, again, a lot of the phrases that you're using Goodman are striking a really nice chord for me. Like you said, "You can keep your toys," and the point isn't for providers to give up the things that they spent so many years and energy and money to learn and they really have adopted and they really believe in, that adopting MI isn't about giving up your toys but it's about finding a way, I suppose, to help the provider share their toys with the person that it's intended to be effective with, it's a way to facilitate that. I wonder if you could spend just a few moments here.

Sebastian Kaplan:

I know we're getting close to the end of our conversation today, but maybe if we take the context of the HIV work that you're doing, and in particular you mentioned some of the community health workers and peer support persons that you help train, how are all of these concepts and these important lessons that you're sharing with us, how does it play out on the ground, so to speak, out in the communities, working with people from a provider standpoint, we're asking to make lots of really significant behavioral changes to help manage their HIV illness?

Dr. Goodman Sibeko:

Yeah. I think that one of the limitations of the trainings that we do is that we don't always have the scope to go back and reinforce, and that's always been something that I've been unhappy about. Hopefully in future we can find ways to be more consistently in touch with folks we've trained to continue to provide that top part and that reinforcement of the principle. Certainly what have done is gone back to these providers and ask them, "Since you've received this training, how has your behavior been in terms of communicating with patients in terms of eliciting harmful behaviors and in facilitating conversation to adopt behaviors that will lead to change?" So what we've gotten from feedback that we received from providers is things... Specifically I'm actually looking at all the quotes in my mind because we've done a couple of surveys. Where people say they felt stronger in the ability to engage with patients because they realized it wasn't all up to them.

Dr. Goodman Sibeko:

I think anything that I would provide as for the detail, well that might be a little bit presumptuous, because we haven't done a specific scientific investigation. But those are some of the qualitative feedbacks that we've had. So it appears that there has been a level of capacitation to providers, that allows them to step back from being the hero, and allows them to be a collaborator. So that's been the sense across the field and hopefully we'll be continuing to monitor them, we are starting some monitoring and evaluation programs in the coming months over the next couple of years, on the colleges that we've trained and the new ones that we're training. So hopefully soon we'll be able to more quantitatively actually provide evidence for what that change in perspective results in for the client experience.

Glenn Hinds:

To get us back to that realization that if I as a health practitioner want to help people that I come into contact with to change, then I must be changing myself to help them achieve

that. Because whatever I'm doing if I keep doing that I'll keep getting the same results. You're creating an environment where existing practitioners and new practitioners in South Africa are being offered opportunities to think about, what would you find helpful for you to be willing to think a little differently? What do you really bring into this party that's working and understand why it's working. And as you explore that, to help them understand, well what is it you're doing that's maybe not working? And why is that not working? And just to be curious about both an then to invite them to decide, what do you want to do with this awareness when you go back out into practice and your desire to be helpful to other people?

Glenn Hinds:

It's just that sharing of experience, and almost recognizing the paradox of collaboration, you don't lose power in collaboration. In fact you enhance the power. It's almost exponential. The more you share the power, the more power you experience, and the outcomes that you set out to achieve. So really exciting stuff and what you're describing and unfortunate given the time that we have, I'm just going to shift gears slightly and shift direction and at this point normally what we ask our guests, Goodman is, what's happening, what's going on for you at the moment that's catching your attention? So it doesn't necessarily have to be MI oriented, but just something that's catching your attention that we could have a quick chat about.

Dr. Goodman Sibeko:

Goodness me. I think I left Facebook maybe five, six years ago. The reason that I left Facebook is because there was an incident locally where a woman called a bunch of swimmers at a beach, she referred to them as monkeys. The interaction that followed made me realize how toxic that space had become, because what was missing was the real engagement about what is it about this that's offensive? Why is it offending some people? Can we engage on that? Why is it that you don't think it's offensive? I think so these are the conversations that are really important to take us forward.

Dr. Goodman Sibeko:

I think for me that's on my mind about what's happening now with COVID-19, and it's not just in the US, not just in the West, it's also happening locally in South Africa. Where so much of the engagement is just toxic and nasty. It's splitting across racial and cultural lines in ways which I think we may not have experienced should we not have a world as connected as it is now through social media? So it plays on my mind a lot, the amount of information and engagements which aren't necessarily healthy that we're exposed to as a result of the way the world is organized now. And that hat's on my mind a lot, and very mindful of how I engage with information and with news and with social media.

Sebastian Kaplan:

I suppose not surprising that your description of toxic communication that easily is sparked from a social media post is something that... Here we are speaking literally from three different continents, and I'm sure we can all relate quite easily to the notion of toxic communication, and again in three different continents all impacted by this global

pandemic where one might think that we have a common enemy, unfortunate to use that term maybe in that warring sense but we have this common challenge that we all share where there's some really basic things that we're all striving for. To stay healthy, to stay alive in many respects.

Sebastian Kaplan:

Even in that context, the communication can be so fractured and toxic and blaming and us versus them and yeah, well certainly something that's on a lot of people's minds and a challenge for society, likely for forever, I imagine at some point. Goodman, another thing we ask our guests here at the end of our conversations is if people in the audience are interested in contacting you to ask questions or to share some of their experiences, would you be willing for them to do so and if so how might they reach you?

Dr. Goodman Sibeko:

Yes. Please do. They're welcome to, they can tweet me @DrGSibeko I think Sebastian you follow me already. So people can access me on Twitter. They can also email me at goodman.Sibeko@uct.ac.za. I'm also easy to find on the University of Cape town website under faculty of health sciences. Also if you search for me on the Addiction Technology Transfer Center Network, you will find me there as well. I would just say don't send me a direct message. I'm horrible with those. But communicate with me in any other way and I'll-

Glenn Hinds:

Fantastic, and just to clarify, the spelling of your surname is S-I-B-E-K-O. Well, Goodman, thank you very much for your time here. So just before we finish, perhaps you could include our social media links for people how they can contact us and leave reviews.

Sebastian Kaplan:

Absolutely. So, on Twitter it's at Change Talking, on Facebook, Goodman you won't be seeing this of course, but on Facebook, it is Talking To Change, and on Instagram it is Talking To Change Podcast, and any emails to us you can reach us at podcast@glennhinds.com.

Glenn Hinds:

Thank you very much Goodman for your time and for sharing your wisdom and offering us an insight into some of the fantastic work that's already taking place in South Africa and the efforts to make people's experiences across the whole country much more collaborative and it sounds like the universal experiences is that there are changes being offered, and we're all experiencing some ambivalence towards what it is we're doing, whether we're practitioners or whether we're patients, and part of what you're endeavoring to do is create a culture of acceptance and curiosity, and to work with people on that journey as we all move forward together. So thank you very much for your time and your contribution.