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

Episode 47: MI and Diabetes with Judith Carpenter

Sebastian Kaplan:

Hello everyone. Welcome to Talking To Change: A Motivational Interviewing Podcast. My name is Sebastian Kaplan and I'm based in Winston-Salem North Carolina U.S.A. And as always, I'm joined by my good friend Glenn Hinds from Derry, Northern Ireland. Hello Glenn.

Glenn Hinds:

Hello Seb. Hi everybody.

Sebastian Kaplan:

So first we'll start off by sharing the various ways to reach us. You can contact us on Twitter. It's @ChangeTalking. On Facebook, we're at Talking To Change and on Instagram, we're @TalkingToChangePodcast and you can contact us directly via email with questions or suggestions. Any questions about training, the email address is podcast@glennhinds.com. And also want to invite everyone to rate and review us if you wish, we certainly welcome the feedback. We had a really interesting conversation with our friend and colleague Judith Carpenter, talking about MI and diabetes care. And Glenn, what struck you? What stands out as something that our listeners can look forward to?

Glenn Hinds:

I suppose, one of the first things that really struck me about what Judith was telling us was just how prevalent diabetes is, just how many people are experiencing this worldwide and how complex a condition diabetes really is for the individual. And as a consequence of that, the challenges that presents for a practitioner, who's trying to support someone with either type one or type two diabetes on a day-to-day basis. And then the wonderful way that Judith describes how Motivational Interviewing can offer opportunities to be supportive in those conditions. So, it was a really rich conversation with so much to take away.

Sebastian Kaplan:

Yeah. It was really helpful as someone who doesn't work in that diabetes world day in day out is really quite informative and helpful to hear about some of the differences, you know what is diabetes and differences between type one and type two? And as you said, these prevalence numbers which are quite striking. One of the things that was really, I think informative specific around MI and the application of MI was the use of direction or directiveness, which many of our listeners will be aware that MI is not often something that people do in a directive way.

Sebastian Kaplan:

And maybe that can be a bit of a misconception that we never give advice or give advice only in rare instances and certainly will withhold concern that we might have and actually that's not true. And Judith gave us some really great examples and it was a great discussion about how we express concern and how we offer some direction as needed in an MI style or with the warm heart as you put it. So that's something that really stood out to me as far as MI application.

Glenn Hinds:

Well, we hope everybody enjoys the episode. Let's have a listen.

Sebastian Kaplan:

Yeah, Judith. Tell us a bit about your background, your early MI story and how you got into this work.

Judith Carpenter:

Sure. Thank you for inviting me. I am a registered dietician. I have held that title for some 30 plus years. And when I came out of university back in the 1980s, Google wasn't a verb, and I was the fountain of all knowledge. And I distinctly recall just struggling to help people change behavior and I guess that was my starting point of wanting to be a different type of practitioner.

Judith Carpenter:

I'll go back and tell you a little bit more about my story but to roll forward. I currently work both as an MI trainer which I do alongside working in a clinical pace here in the UK, in the Midlands where I work as a specialist diabetes dietician. That's a busy job and that's, I guess one of the reasons why we're going to be chatting today. I got into MI I guess, as a way of wanting to be a better professional.

Judith Carpenter:

I was a really, I guess, paternalistic practitioner who really wanted to change the world, one person at a time from a dietetic perspective back in the late '80s and it really didn't work. I found more often than not patients didn't come back or if they did come back, change hadn't happened. And I didn't know enough then really from a psychological perspective, but I knew that I didn't really have the skills to do the job. I had the knowledge base in spades, but the skill was really lacking in terms of trying to help people change eating behavior, which is what dietetics actually is largely.

Judith Carpenter:

I set myself in a bit of a quest to be a better professional. And I started with some counseling skills training which I found really helpful, some Rogerian stuff, but it didn't quite fit the bit in terms of being able to integrate that into medical consultations that I was running then and still, and then I literally stumbled on some training by Steve Rollnick called Motivational Interviewing. And to be honest, I didn't really know what it was. I read a little bit about, it sounded interesting.

Judith Carpenter:

I think like a lot of your other speakers who have graced this stage when I met it, it just fit. It was just right. What I'd also like to say was I couldn't do it. That was something that I was really aware of. It took a while for me to really work in a better way, but I was to learn, I was keen to continue my learning and I became a member of MINT back in 2000. And ever since then, my passion for Motivational Interviewing within healthcare has really grown. And I'm very privileged to be able to train people both on this country and previously before pandemics internationally, in this wonderful, wonderful way of working with people and I continue to use it today.

Judith Carpenter:

I think I went back into clinical practice from having just a training role. About six years ago, I took a sabbatical out and was training for about eight years, but I went back into clinical practice. I used Motivational Interviewing with every patient that I work with. If I wasn't using MI, I don't quite know how I'd be practicing because the only other real skill base I have was based on that knowledge base that happened for me when I came back out university all those many years ago. So that's a bit of my story.

Glenn Hinds:

Yeah. And as you mentioned, some of what you're saying relates to a lot of what other guests have mentioned in their own journey that their desire to be helpful is what brought them into the game that they're in. But there was something seemed to be missing because their efforts to change people wasn't bringing about the results that their input was offering, and that changed when they were introduced to Motivational Interviewing. And I guess I wonder what it was that you noticed for yourself then Judith, what was it about Motivational Interviewing that changed things for you so much that encouraged you to put the effort necessary to become proficient at it?

Judith Carpenter:

I think early on, even in a crude way when I was practicing MI and desperately trying to learn it, just being able to already start to see different results in real time with the people that I was working with, it made a huge difference. I think that anyone listening to this episode who is a healthcare professional, it will resonate that we are so trained in the what to do and how to fix. And you really believe that is your job. That's your role.

Judith Carpenter:

So, to be able to really engage well with people and be curious about them as human beings and build that relationship is so fundamental. So, changing the focus, I think and making the focus not on the fixing but on the person, where the person's at. And then as we all know, the change can happen quite spontaneously when we change what we do, we change what we get. And that's certainly been my experience.

Sebastian Kaplan:

Yeah. It's a nice way to frame it. If we change what we do, we change what we get. And yeah, like you mentioned, so many others have said that just adding the knowledge base

that hopefully most people are blessed with out of whatever training that they've been in. And then MI provides this wonderful structure and guidance on how to communicate around things.

Sebastian Kaplan:

Judith, I wonder if you might set the stage for us a bit in our discussion about MI in relation to diabetes care. And most people have probably heard of diabetes have a somewhat of a sense of some of the challenges but maybe you could even just start us off briefly an overview, what is diabetes? And you know this is type one and type two, maybe just help us understand that.

Judith Carpenter:

I think it's important to point out from the off that lots of people manage their diabetes incredibly well. And outside of going to regular routine appointments really don't need an awful lot of support. The majority of people with diabetes, 90% of all the people with diabetes have type two, which is quite a different condition to type one, which is obviously there for only 10% of the diabetes population. It's a huge, huge percentage of the population. So over 400 million people worldwide have diabetes. So, 10% of those will have type one and the rest will have type two.

Judith Carpenter:

Type two is the most common and type of diabetes. It's often linked to lifestyle. And we now see children with type two diabetes and when I first started working in diabetes that wasn't the case. It was mainly a type of a condition that happened with people as they got older. It's largely related often to people's weight. There's a real link between weight and development of type two diabetes but it's more complicated than that because there is a genetic predisposition. So, type two diabetes and type one diabetes, I suppose you describe as a disorder of glucose metabolism.

Judith Carpenter:

In type two diabetes people often making insulin, which is known that is produced in the pancreas but it's just not getting to the right places. It doesn't work in the way that it's supposed to. And in type one diabetes, which is an autoimmune disorder, there's an absence of insulin so the pancreas stops making I insulin. So, they have two very different developments really but both of them have similarities. What's really shocking, I think is that you are much more likely to have a stroke or a heart attack, particularly if you've got type two diabetes. You can go into heart failure. So, type two diabetes is often described as a cardiovascular disease.

Judith Carpenter:

Type one diabetes can also cause cardiovascular problems and both types, but particularly type one can cause problems related to other things that people may be familiar with, like kidney disease and circulatory problems causing things like below knee amputations. It's serious, it's really serious. And it's difficult. I think it's difficult for people to cope with and I think it's difficult for healthcare professionals at times to manage.

Glenn Hinds:

I think people will be structured by how prevalent it is and from what you're describing, the seriousness of it is that it's quite complicated in that it affects so many other aspects of an individual's physical wellbeing. I guess then one of the things to be curious about is when someone with type one or type two diabetes comes to a dietician like yourself, what is it your role is, what is it you're trying to do and where does MI fit into that?

Judith Carpenter:

My role is interesting really. In fact, I hold a role now that I held back in the late 1980s and it's the same title, but the jobs are really different. I actually now work largely with people aged 18 to 25, who predominantly have type one diabetes and who often are not taking insulin, which insulin is lifesaving. So, an absence of insulin is life threatening. So, if you are a young person who needs to take insulin and you're choosing not to take it for a whole number of reasons, then without insulin within 48 hours, you'd be dead. So, it's a serious condition.

Judith Carpenter:

And so, people have to do a lot for diabetes. And specialist care, we look after people that are really at times who often have type one diabetes and often struggling or need extra support. So, I would say work with a young adult population, other populations that we might look after people in women in antenatal care, people that have foot problems and so there's lots of the workers around prep.

Judith Carpenter:

So, someone like me now works in a much more holistic way with helping support people to manage their diabetes, of which managing their food intake is one part of that, but it's not the only part of it. And so, a lot of the time that I spend is actually trying to support people to consider whether or not they're going to start taking insulin or whether they're going to take insulin for food, because they may be developing something like diabulimia which is an eating disorder associated with type one diabetes.

Judith Carpenter:

I also see people with type two diabetes and sometimes they're very young people who are really struggling. I think where my Motivational Interviewing comes in is around supporting the person to understand what it is around their condition that they want to do. Because the other thing about diabetes, it's not just a question of taking medication whether it's oral medication or whether it's injectable medication, there's knowing how to adapt what you're doing.

Judith Carpenter:

So, are you taking enough insulin or are you taking enough medication? What's your blood glucose levels and how are they affected? What are you're going to do? So, it's a constant risk assessment and I think as a result people struggle because other things affect diabetes control that you have no control over. So, you can control what medications you take, what you may or may not choose to eat and how active you are,

but you can't control the weather for example, or illness or stress or hormones. So, there's lots of other things that affect diabetes, so people get burn out really quickly.

Judith Carpenter:

I think diabetes, all types of diabetes but particularly type one diabetes has a huge amount of emotional distress attached to it. We know that almost half of the people with diabetes will have some emotional psychological problem. So, we have high prevalence of people with depression and anxiety and other levels of emotional distress because of having diabetes.

Judith Carpenter:

I guess when you say, what do I do with my MI? I sort of do all of that really. It's really navigating a path through what makes most sense for the person, whether that's starting to take insulin again because they haven't been taking it whether that's trying to eat differently, whether that's choosing to monitor their blood glucose levels, whatever they're going to do with their condition. And the other part of this, I think that's really important is to say, people do this day in, day out. There's no breaks, there's no holidays, there's no time out, it's never ending.

Judith Carpenter:

I actually don't know of many other medical conditions where people have to do so much all the time. Lots of people have to cope with different medical conditions, they may pop a tablet or may have to do one or two things. People with diabetes have a whole number of things they have to juggle in order to get good control because that's what they may be trying to get or to aim to whatever they're aiming for. And even when they do it well in the same things day in, day out, the results are different.

Sebastian Kaplan:

The thing that struck me the most I think was the concept of no holidays, that no matter what day it is, no matter what's going on, no matter where the person is, that there's just no let up with this. And even just what you emphasize before too, particularly for type one, there's a kind of urgency about type one diabetes that with other really significant medical conditions may not exist. And so, I don't know.

Sebastian Kaplan:

I guess I'm still sitting with that and just imagining what the day-to-day experience is, particularly for a young person who is going through so many changes and transitions and their own kinds of search for meaning and all that. I don't know. I guess I don't really have a question as much as I'm just struck by what you've shared and just trying to imagine life is like for someone in this position.

Judith Carpenter:

Yeah. I think from my experience of talking with people, particularly the population that I work with, it's tough. It's really tough. And it's not that people are not aware of what they need to do, it's just doing it becomes overwhelming at times, it's too much. I think what

Motivational Interviewing does, it offers a way of working with people. It offers a difference to that paternalistic fingering wagging. You've got to take your insulin type of an approach because my experience has been that nowhere is it more and more important than coming alongside someone who is going to decide whether or not to take insulin and keep themselves well and healthy and alive.

Judith Carpenter:

It's tough. It can be really tough. I think particularly young people as they are navigating life at that particular stage, it can be really difficult. I also work with all other adults, but I'm particularly struck by how difficult it is for young people with both type one and type two diabetes to focus it and manage it, at a time of life when I guess people are taking risks and having fun and not having to think about those types of things. I have young people, my own young people, my own children are the age that I look after, and I know the difference in their lives without having to contend with a long-term condition. So yeah, it's not easy.

Glenn Hinds:

What was interesting as you were describing that idea of coming alongside of someone, I just imagined very choppy water and as a lifeboat coming alongside someone and just the tide lifting and falling on both sides and how difficult it can be just to step into that world. It sounds like that's what you're describing the challenge for you as a practitioner, is to be able to go into all of these different people's lives recognizing the one thing that they have in common is that their presentation of diabetes, everything else is uniquely different.

Glenn Hinds:

And you're paying attention to all of that at the same time and trying to explore with that person rather than saying, "Look, you have to change this, you have to change this." You've shifted your approach to going, let's be interested in what's going on here and then begin to explore their own resourcefulness.

Glenn Hinds:

I guess one of the challenges must be knowing that this is a life-threatening condition. And that as we call in Motivational Interviewing that righting reflex that instinct that wants to say, look, you need to do this to keep yourself safe. I suppose one of the things to be curious about is how then do you hold that for yourself knowing that you're in these choppy waters and how do you maintain that ability to come alongside without trying to fix?

Judith Carpenter:

I think it's such an interesting and an important point. And for me the right to reflex has never gone away. I think of it as a whisper in my ear that is constantly there. And I'm mindful of it and it's so interesting because when I very first started learning Motivational Interviewing, I remember distinctly using my OARS, my open questions and reflecting and trying back to find out what was going on for people. And then when I got it, I remember

then just saying, "Right, okay. Now I know." And I just, my righting reflex would come right in.

Judith Carpenter:

Then I remember learning to stop myself almost having a meta conversation with myself, "Stop." And I would stop, and I would actually say, and I talk about this on training all the time when I'm training people. I would say to people, "I seem to be telling you what to do and I don't mean to do that so let me just backtrack." And then I would ask an evoking question. I would distinctly remember doing that.

Judith Carpenter:

Now I guess the whispers in my ear, but I suppose I've got to the point because I've been using MI within a clinical setting for a long time that I'm just curious about what that is. And I just know that it just doesn't work. And I think one of the things that I find a lot of the people that I work with find refreshing is they hear something different when they come and speak to someone like me.

Judith Carpenter:

Because people come in with their defenses because they're ready to fight the fight as necessary and when then it's not met and they're actually able to have, hopefully a genuinely curious conversation about where they're at and what it would take. And there's times when you do have to act. We've had young people come into our clinic who have actually been in that life threatening situation. And that's what I love about that in that whole directing following guiding.

Judith Carpenter:

There are times when it is appropriate to say you are not well. And what we really have to do here is to get you that medical attention that you need, and that has happened. But the conversation that then happens a few weeks later in the clinical setting is not the same type of conversation. I think that there's a way of shifting in. I feel it shifts Glenn. I think it shifts from the righting reflex, that desire to fix, I guess one of the things I like to think about is it's a good thing because it shows you care. It's a good thing, it shows your concerned.

Judith Carpenter:

If you didn't care and you weren't concerned, you wouldn't be doing the job you're doing so that's a good thing but actually it's how you use it. And then the other way that I do use it and I have done, and I did this recently with a young person who I'm quite concerned about, and she has really poorly controlled diabetes over a number of years. And she's has like a lot of people when you start talking to them, their backstory is immense. So, she's coping with diabetes on top of a difficult upbringing childhood and has some PTSD.

Judith Carpenter:

And she's not been managing her diabetes very well and I've worked with her for a long time. And on and off, I felt she's somebody and I'm sure we all have people where you

take one step forward and one step back and then one step back, and then you might get another couple of steps forward. And slowly over time, you inch your way somewhere but it's not a fast-paced thing. I was really concerned about her.

Judith Carpenter:

She's got something called diabetic neuropathy, which is when you get damage to your nerves and it happens normally in your limbs and you're eating in your hands and it can cause horrible, horrible symptoms where you have pain, a lot of pain, particularly you can't sleep at night because you're in pain. She's young and she works in the legal profession, and she's got a high-powered job, she needs her sleep. She's not sleeping.

Judith Carpenter:

And I remember my righting reflex was screaming at me, "This is not going to get better until you control your diabetes better." And I took a bit of a chance with her. Everything we've been doing hadn't been working and I just said, "Look, I just want to just talk with you, and I really want to share my concerns about what I see is going on here." And I was really genuine and honest with her, but I felt myself getting slightly out on a limb really.

Judith Carpenter:

As much as, she might have been really affronted. She wasn't. And I did it with a kind heart, but it was certainly driven by my care and concern for her. And she took it on board, and we've taken a couple of steps forward, but it is a slow process. Because people will do what they choose to do. And like many of your guests have talked about, we have to support their right to make that choice, even when it's not a choice we want them to make, or we would make for them.

Sebastian Kaplan:

Judith, you shared two. I guess in my head, I have it as two different examples of how you've were worked with somebody that I think would be really interesting for people, especially people that are new to MI just to reinforce. So, the idea of that meta process and just naming something in the moment saying something like, I'm realizing I'm giving you too much information or I'm telling you what to do.

Sebastian Kaplan:

I imagine for somebody who's just trying this out and shifting how they do things; I think it would be helpful to invite them to consider just saying that. Just not having to feel like they've got it all down or that they're perfect at this, but if they catch themselves going too much into the information giving mode that maybe they were trained in and they're wanting to try out MI and which is much more of evoking strategy obviously or method. That they could just call time out in the middle of the session or a conversation and just say, "You know what? I realize I'm just telling you way too much here. Let's try to shift this around." That was one thing that I think I would invite people to consider.

Sebastian Kaplan:

Then the idea of directing. I think we spend so much time in MI rightfully so on evoking and drawing out and acceptance. But it is okay. It's not a violation of MI law to express concern, significant concern, even to say, this is what we need to do for you, depending on the situation of course. But it strikes me that the context matters greatly when you do that, and I think you were alluding to that there too. Doing it with a warm heart, I think you said. Maybe if you could say more a bit about that directing piece and how you can shift in these three different conversational styles that you referenced.

Judith Carpenter:

Yeah. I guess. For me the directing has got two aspects. We recently had a young man come in to see us who was unwell. He was going into this condition called diabetic ketoacidosis, which is just life-threatening state, that if someone didn't then receive insulin, he hadn't taken insulin for a couple of days, two or three days. And we literally got him emergency medical treatment. That was very directive, but it was the right thing to do. That was absolutely, it was the best decision to make for him at that moment in time.

Judith Carpenter:

And he wasn't against us doing that. So, it's not as if we were violating his right to decide, he knew he was unwell. So, there's that type of directing where you're- I'm always minded of that stopping the child running out into the road type of directing. So, there's that. The other one I think is about asking permission to raise your concerns about something. I think there's something really genuine about doing that.

Judith Carpenter:

And I think that listening to Bill and Terry's recent podcast about that genuineness, being myself. I consciously made a decision to do this with this young woman and I've done it a number of times with people over the years, but being very genuine, I'll often ask permission. So, I'll often say, look, as I'm sitting here, I've got some real concerns about something I can see that's going on with this, whatever it might be. And if it's okay, I really would like to share my concerns with you.

Judith Carpenter:

I also feel that if I don't share my concerns with you, I'm not being a very good diabetes practitioner for you. And then sharing my concerns, I think that's what that the strategy of elicit provide elicit allows us to do beautifully. Sharing my concerns in a way that is gentle but factual and offering them back to the person. So, what do you make of that? What do you make of my concerns? I can't make you do anything you don't want to do. And I have found systematically in healthcare consultations, people are very willing to listen and often in agreement.

Judith Carpenter:

I think sometimes it's a little bit like if doctors tell patients to stop smoking 3% of people do, but there's something about someone actually taking that responsibility and saying, actually, "I'm really, really worried about this here." And then I counter that. And I guess Sebastian, I have that sort of like a slightly itchy feeling inside when I do it because I

counter it with what the alternative would be. The alternative is a really paternalistic expert driven way of coming down on someone which goes and violates completely the way that we work in Motivational Interviewing or in any helping helpful way.

Judith Carpenter:

There may be some people sitting listening to this who think that maybe we should or shouldn't do that. But I think it's very difficult when you work in some difficult circumstances at times and you have time limited consultations, to be able to have a framework to manage that I think is really important. Because it's not as if we don't care whether or not you choose to do this, I don't care is not really an attitude of mine that's helpful.

Glenn Hinds:

I guess you're probably in the wrong job if that's the attitude that you have, that I don't care. And even your reference to the righting reflects its recognizing that arises from a place of compassion. It's because you care for somebody that you want to say, "Just do this and everything will be okay." But what we know from the research and from our experiences is that people generally don't like being told what to do, even if it's the right answer.

Glenn Hinds:

So, what you're describing there in what's called information exchange protocol EPE, elicit provide elicit, what's wonderful but that is just that again, you're describing that the directive approach has its origin in compassion. And the way you manifest that compassion is that you ask permission to share what are your concerns that the concerns belong to you and you're saying, this is what I'm worried about. And then invite the person to continue the conversation by exploring what it is that you have concerns about and where they fit in for them.

Glenn Hinds:

And it sounds like that's the dance that's the staying alongside of them. Even you mentioned that on one step forward, one step back. One step further back and then two steps forward. Again, you could see the black and white footprints of a particular type of dance. It sounds like that's where the skillfulness of the practitioner comes in is being able to adjust the conversation to the dance that the individual is needing to move through.

Glenn Hinds:

But your idea, your concern and your purpose is to invite them to get to a particular place where their health and wellbeing is more fruitfully maintained, I guess. I suppose where that takes me then is just, if we're thinking about the audience, what else can people take from your experience, I wonder Judith? But what you've learned on this journey through this really challenging work that might be helpful for people as they listen. What has helped you adapt to be this profession and what you're doing?

Judith Carpenter:

It's a continuous work in practice. I think I'm always learning, which I think is really great. And I'm always learning from the people I work with, which even better. There's a couple things, really. There's something about being really curious about another person and evoking, I find evoking is just such a lovely thing to be able to do with everyone asking evoking questions, as opposed to telling people what you think they should do. When I talk about sharing my, I concerns that would've been after a whole sequence of evoking that hasn't really generated a conversation to flow really.

Judith Carpenter:

There's something about evoking. I think the other thing is I think as a healthcare professional, we also have to give people information. I spend a fair amount of my time talking about stuff. Whether I'm teaching people around counting carbohydrate in terms of being able to match insulin to it, whether I'm helping people to consider ways to consider reducing their weight, if that's something they're interested in or getting more active, I'm also giving information.

Judith Carpenter:

I think my sense of me, if I was to take a bird's eye view of myself in a clinic setting, the MI is the pulse of what I do, but I change, the dance changes and so I feel I wear different hats. Sometimes I'll be... and this could all happen in half an hour called consultation. It feels like a very active process. I think that was one of the reasons when I first met Motivational Interviewing between that I liked it so much. Was it gave me a real clarity about my role. That it wasn't just about sitting back and following and listening, which is an integral part of what we do when we're using MI and we all know that. But there's a really active participation, I think, of a clinician or a therapist with the dance or with someone at the pace that that person's at.

Judith Carpenter:

I can do a clinic that has, maybe six, seven or eight people, one after the other. There'll be some similarities, but there'll be real variations if I was watching myself doing that, depending on what was in front of me. There's something about reacting to what's in front of me. There was something that I was listening to Bill saying recently about, the feedback that you get is instantaneous if you look for it. If you have the attention, not only within yourself but to the person that you are with, you will find out how well you are doing.

Judith Carpenter:

Like I say on training, if it's working well, keep doing it. It's when it doesn't work well and when it doesn't work well in healthcare consultations is when you have this imbalance of power and someone who is being expert-driven onto someone else, trying to get them to do the things that they think, or they can see that are really important to do. I think that there's a whole number of things going on. And you've got a mental checklist in your head because where you are going with this. So, it's quite curious really, to think about it.

Sebastian Kaplan:

Yeah, I can really hear the real, genuine interest and even excitement maybe at times, or maybe that's, I don't know if that's quite the right word. But certainly, your job is a challenging one, but you've found a way to bring creativity to it, I guess. You're talking about this busy clinic day with six or seven people, but each person requires its own dance to really connect and bring out some good outcomes.

Sebastian Kaplan:

I was curious, Judith, as someone who has a lot of information about diet, about exercise, about medications and things like that, how do you decide how much to say or how much information to give someone? And then I guess the follow up to that would be, you're talking about this power imbalance as a way to gauge whether what you're doing is having impact. How can you tell if you need to shift course or change direction in the context of a brief consultation?

Judith Carpenter:

To your first point, people always know much more than we give them credit for. That's what I would say off the bat. People know themselves very well, so being curious and evoking and ask what they know already, what they've done, what they'd like to try, what they've tried before and would like not to do again, people know themselves pretty well. That's my voice, my starting point in whenever giving people any information.

Judith Carpenter:

That creates an energy in of itself, when people start talking to themselves about what they know and what they would like to do and why they would like to do it. I think that though I do give information, or I might discuss a topic with someone, often people do know. Sometimes they don't and you're teaching someone something right off the bat. Then I think it's really important not to overwhelm people.

Judith Carpenter:

I always remember back in; my first job was doing this job in the late 1980s. There was a really nice young guy who'd been diagnosed with type 1 diabetes, and I went in, I suppose, like an excited puppy. He was a smart guy, and he was taking everything on board, and we talked about everything, and it was completely, he was asking lots of questions and I just got completely caught up about a long time with this chap.

Judith Carpenter:

At the time, it was when people had stopped going into hospital when they were first diagnosed with type 1 diabetes, and they were seen in diabetes centers over here in the UK. I remember one of my colleagues about, he was coming in on a regular basis. Maybe every couple of days to get his insulin titrated. About two or three times he'd been in and on the second or third time, one of my colleagues, one of the specialist nurses came to me and said, "His blood sugars are all over the place. Could you just maybe have another word and just see. Don't know what's going on." So, we went back and had another conversation.

Judith Carpenter:

In my haste to give so much information and make sure he knew everything, he just missed, he'd missed, and I'd missed the really important points. Often when someone's diagnosed with type 1 diabetes, they have no energy, so they're drinking lots of sugary drinks to give them energy. And we mentioned this and amongst the myriad of things. I talked to him for probably 40 minutes about. But because it was amongst everything else, he was still doing that. It was a solidary lesson really to learn to slow it down and just give what's important at the time. People let you know; I think what they need to know.

Judith Carpenter:

The other thing, I think that's really important being that I'm no longer, the fountain of all knowledge, is that most people get their knowledge from other sources, so we are but an influence. It can be helpful to give people-evidence medical information. Sometimes when there's maybe some contradictory information that they've heard. But outside of that, a lot of people already know a lot of stuff and so a lot of the time you are helping people to make sense of what they've already learnt and heard and what it would mean for them. I've completely forgotten the second part of your question.

Sebastian Kaplan:

Well, it was about the, and thank you for the clinical example there, it really brought that to life. But about sensing that power imbalance and when things are going in a direction that may not be where you're wanting them to go and how to notice that, how to bring it back.

Judith Carpenter:

I hope my power imbalance is pretty steady, I'm hoping. I see it a lot with some colleagues at times. Patients often will come and tell me, this person says I have to, and I don't really want to, and I didn't really listen. I try to, I think just completely, always again, watching the person and getting their feedback, asking permission. If it's okay, I've got some information that might be helpful. Rather than telling people. The thing I really steer away is from telling people what to do. That doesn't mean I don't guide people with what the information is about. It's literally telling them - because I think that sets up the biggest power imbalance.

Judith Carpenter:

The other thing I think is I try and ground where they're at in their life. Diabetes is something that's going on in life generally. It's about making the person feel seen as a human being that has to manage diabetes. I think you said it nicely earlier Seb when you said, I see lots of different people. Or maybe it was you Glenn, I'm sorry. I can't recall, but I see lots of different people, the one thing they have in common is they've got diabetes, but everything else is not in common.

Judith Carpenter:

Making a person, I think we all want that if we go and we're working with anyone to feel seen and heard. And it's just able to get a sense of how their condition fits in with this. I

think that creates a really good balance that I'm curious enough, I hope to be led by them. I'm a beginner in their world. I might have some knowledge and expertise in this diabetes thing, but I'm a beginner in their world and I really do try and make sure that for me, I create that.

Judith Carpenter:

I think that's about for people that are maybe listening and trying to come on board with their mind. That value of engaging with people as the first thing we do, so important. I spend actively really consciously engaged with somebody that I've never met before. And continue to do so, but in that first meeting with somebody, because it pays off dividends. And particularly, I would say to people listening, when you've got limited time with people you can't afford not to.

Glenn Hinds:

By mentioning the engagement, which is one of the four processes that we talk about in Motivational Interviewing and maybe you could go under bit more detail then, but when you're describing engagement, what does that mean for you and how do you know when that has been achieved?

Judith Carpenter:

I think it's an ongoing process engagement. But from the off, it's there's something about just for me, about getting to know the person that I'm talking to. Getting to understand their world and getting a sense of that. Then like others who practice Motivational Interviewing being able to use always my engaging skills to be able to convey that. People let you know if it's right or not. The value of using good reflective listening is so important. And yet as healthcare professionals, that is not in our repertoire. It's not something we're taught to do. It's a big challenge, as we know, and certainly continues to be a challenge for people when I'm training them. Just getting people to listen in a more reflective way, for you to have the time to do that can be really difficult. It can be a stumbling block for a lot of people, but it's so important. So, people let you know.

Judith Carpenter:

I can see myself doing it and I think a lot of us, when we are training Motivational Interviewing and we're saying to people ask a good question to open up and reflect back what someone says and maybe make another reflection and see if you can put an affirmation in now summarize it, that sort of process I think really does work and I think it really works in healthcare. I think particularly it's important because it can be done in a relatively short space of time.

Judith Carpenter:

I think there's something about engaging at the front end that pays off dividends further down. That's certainly been my experience. Certainly, something I train people to do. For somebody who is maybe a therapist or psychologist think, well, that's just obvious - it isn't if you're not trained in it.

Sebastian Kaplan:

That's a great lesson about engagement, which if we're not careful can sometimes seem like, well, that's just the how is the weather? Did you find good parking? Just the chit chat. And really, it's something much deeper than that. You may not have much time, but it is an opportunity to begin to learn about a person, to listen for a strength and have an opportunity to affirm it. To summarize a person's brief story, which communicates so much in it.

Sebastian Kaplan:

It communicates that you're attending, that you're listening, that you're curious, that you're not judging them. I guess ultimately the message being, maybe especially if you have a really short period of time, engagement maybe more critical. And that's not just something nice to do to be friendly or something.

Judith Carpenter:

It reminds me of something recently, and I had a lovely young, barely 18-year-old who was diagnosed with type 2 diabetes and strong family history. She came to see me as the dietician, and she carries fair amount of weight around her. She was terrified. She came into the clinic room with her mother, and she sat down, and you could just see the fear in her eyes. And would it be such the wrong thing to do would be to do what I was trained to do when I first did my, came out of university. I spent long time engaging with her actually. So, it's just to find out a little bit about her, how she felt about being there, given that she looked so nervous and what does she not want to happen?

Judith Carpenter:

Then I promised her that wouldn't happen. She had a huge fear, and she was fear of being judged because she was carrying this weight. She'd already been to see other people who told her that she was carrying too much weight and she would get type 2 diabetes like her mom and lo and behold. You can just get a sense of this. It was interesting because we started working together and we talked about, I do use a bit of Cognitive Behavior Therapy stuff, particularly with people that have got eating issues.

Judith Carpenter:

We talked with her, and I've been doing a little bit of blending some Motivational Interviewing with some CBT to help her get a better understanding and do things differently with her eating, which is pretty deep rooted and has gone on for a long time. And in my experience, you can't ever help someone to get where they want to be, which for her is losing some weight until some of those other issues are addressed.

Judith Carpenter:

I think I've seen her maybe three or four times now and the third time she came in to see me, she was a different person. She was smiling. She said, "Mom, you can wait out there. I'm going to go in and see Judith myself." And just a difference. We chatted at the end of the clinic appointment and she's doing really well, and I asked her how it was going. And she said it's the best it's ever been for her. Because she's been talking to people about

her weight for probably the last 10 years. Bearing in mind, she's just 18. And she said, "I was just so afraid when I first came that you were just going to tell me off and you were going to..." And that holding that fear.

Judith Carpenter:

I think that's something really important about engaging and helping to do what's right. But it's completely different to how people like myself were trained, and dare I say at times are still being trained. Because it's so easy to train medical professionals to just have medical knowledge. The art of how we do something, the thing that I think we've all been talking about, it's not just what we do, it's about how we do it. Both of those things really matter. I think it's paramount. I think there's something about Motivational Interviewing is such a wonderful way of working with people that allows us to think about the how we do something when we already know the what.

Glenn Hinds:

I think what word stuck out for me in that last sentence was working with people not working on them and how easy it would be to miss the presentation of this young woman. And what was beautiful by the way you described it was you saw her fear and you met that. And for me, that's almost like the second part of the four processes, which is the focus. And in that moment, her weight wasn't the issue. It was that she was frightened, and you met her there and you responded to that with kindness and compassion and understanding.

Glenn Hinds:

It was only when she stopped to feel frightened that you could move on to the next thing and that your efforts are being reinforced by results. The third session she had changed, I guess she was still carrying the same amount of weight, but her presentation had changed, her engagement had changed, her engagement with her own relationship with her own condition in the context of her whole life had changed because of her experience of being with you. It sounds like what changed that for her was just how you were with her and that changed everything.

Judith Carpenter:

That's what I think you were alluding to earlier, when you were talking about the creative excitement. That actually, it could be really dull doing this job day in day out. I don't do it full time. It's tiring, it's tiring work, but it could be really dull when you're just trying to do the same thing. But it's never the same because people are always different and that's the biggest gift that you have, is the people that you work with are always different and receptive.

Judith Carpenter:

Truly, meeting Motivational Interviewing changed the way that I practice, and it changed the results that I get with the people that I work with. That's not to say that it's not about people always making significant changes, but sometimes they do really significant changes because they're being held and observed and seen to be as who they are. But

it's not just about a nice way of being with people. These are skills that are really helpful to be able to learn to integrate into what you do. That's been my sense of MI and I guess that's my sense as both a practitioner of it and as a trainer of it.

Sebastian Kaplan:

As nice and kind and warm and gentle as we might seem, this is serious stuff. This is a serious intervention that brings out some serious positive outcomes in many instances, which is great. Judith, I had some more type 1 versus type 2 questions if that's all right for you.

Judith Carpenter:

Sure.

Sebastian Kaplan:

Maybe there's an MI thread to follow with this. This is just maybe based on how I've heard other people talk about the distinction. One is the idea of whether they're reversible or not. My understanding is type 1 is permanent and type 2 is reversible, so I guess just to check with you about that kind of distinction. Then I guess somewhat similarly, I suppose, is the onset of type 1 versus type 2. The term pre-diabetic is something that we use here in the states. I don't know if that's something that's widely used.

Sebastian Kaplan:

It has the idea that this is something that you might catch early and can again reverse it maybe. And maybe that's not the case in type one, which at least in my crude understanding comes out of nowhere and just this sudden shock to the person and their family. Am I on the right track there? Help me out if I'm not.

Judith Carpenter:

Very good, Sebastian, you're perfectly well on the right track. Type 2 diabetes tends to have more of a gradual onset. There is a state at which you can be pre-diabetic, impaired fasting glucose can happen. So, you're not metabolizing the glucose in quite in the right way, but it doesn't quite hit the threshold for type 2 diabetes. There's been some very interesting research and programs, certainly running over here in the UK and I wonder from what you are describing, if they also running over there in the U.S. Of actually helping people not develop type 2 diabetes.

Judith Carpenter:

Because if you have pre-diabetes, you have a 50% chance of going on to develop diabetes, but you have a 50% chance of not developing it. There's been a big push over here in diabetes prevention programs. There's a National Diabetes Prevention Strategy where the focus is on helping people to make lifestyle changes. Which invariably mean making changes to eating, making changes to activity in order to prevent type 2 diabetes.

Judith Carpenter:

There's also been some other interesting studies. There's been a big study that actually talks about weight loss to reverse type 2 diabetes, which has been... So, there's some programs also trying to help people to reverse their type 2 diabetes and that can be very successful. Invariably they are based on losing a fairly significant amount of weight, which is easier for some and less easier for others.

Judith Carpenter:

But you can also make some significant dietary changes without losing weight to actually really reduce down medication need in type 2 diabetes. All of that can be reversible, but people with type two diabetes get a really raw ride, really. Because there is a genetic component. It's not fully understood. It's a cardiovascular disease. It can happen for a number of reasons. Often people talk about it because it's do with lifestyle, so there's associations with people ‘Well, if you've gained weight, that's why you've got type 2 diabetes.’ But not everyone who carries weight develops diabetes. So, it's more complicated.

Judith Carpenter:

But it a slower onset and it can be initially I think within the first, maybe six years, I think you can reverse it and you can stop people getting it. That's good news, but people have to work really hard, and change is a part of that process. Type 1 diabetes is an autoimmune disease, so you can't stop you’re getting it. And it happens. We don't really know why. It can be bought about by a significant event. Could be a bereavement, an illness. It used to happen, and it still does, but we used to see type 1 diabetes, you see a peak. And children when they first started school and when they would first go to secondary school and when teenagers will go to university, but now you can get type 1 diabetes happening at any age.

Judith Carpenter:

But autoimmune basically means the body's attacking itself, so it falls into a range of conditions like thyroid disease and rheumatoid arthritis and some of the inflammatory bowel diseases. It just happens, so you can't stop yourself getting it. But both of them are around managing glucose and the treatments are different. Type 1 diabetes, someone needs insulin. That's the treatment. You can't manage it on medication.

Judith Carpenter:

Type 2 diabetes, people can manage it through lifestyle measures and/or medication and/or injectable medication including in insulin. People often think if they go onto insulin with type 2 diabetes, they've developed type 1 diabetes but that's not actually the case. I think that it's helpful to clarify that. It's an incredibly increasing condition, particularly type 2 diabetes, particularly with this pandemic. There's been a lot of people who've struggled with diabetes and with COVID developed diabetes, so there's certainly a pushover in the UK to try to consider lifestyle.

Glenn Hinds:

There's things about their own health that have impact on other aspects over health, that the choices that we're making in one realm of our life tends to have an impact on another and in reverse as well. That there's things that, as a consequence of developing diabetes, type 2 diabetes, there are some things I can be doing that either can slow that process down or potentially even reverse that for myself. Why that sounds very simple, it sounds like the challenges for you in your clinic is to help people navigate what those decisions mean in the context of everything else that's going on for them.

Judith Carpenter:

Absolutely.

Glenn Hinds:

And for some people changing their diet may be quite simple and for other people it's really complex. Some people have different types of relationships with their body and body weight and presentation. And even just what you're describing there about, the expectation or the culture that we live in, the simple idea that if you've got type 2 diabetes, it's because you're eating too much and you're probably overweight. And it's almost like there's a shaming message being given out that somehow you deserve it. You deserve it. You brought it about yourself, and I imagine that's perhaps what you were experiencing as you described that young lady earlier on.

Glenn Hinds:

That came in frightened, expecting to be told off, and that's not working. And maybe again, it's a challenge for us as practitioners who are not necessarily working in that world, but also to recognize, what are the sense that of the people we are coming into contact with. And what society's message about someone who presents like that. And to recognize that's a weight that somebody potentially carry and, on their shoulders, expect us to perpetuate that self-shaming or that sense of guilt.

Glenn Hinds:

If I guilt you enough, you're going to change. What you learned earlier on the process was, guilt in some ways is not very good long-term motivator, but it's about that shift away from rather than making this person feel guilty or ashamed or frightened of this, how can we help them feel safe? It's in that place where they feel safe that they will come up with ideas and notions about what they can achieve in steps towards becoming the type of person that they want to be.

Glenn Hinds:

And your job as you describe it, is to come alongside of them and just work out what's that for you. And from time to time, you can offer them information or advice based on your knowledge of the condition and invite them to consider how that will be of use to them. I guess that's one of the takeaways then for me, is just translating that process into other clinical settings or other social care settings. What's this person presenting most, what's that like for them and what is it they need from me to begin with? Before we can start getting down to the nitty gritty of what I'm being paid to help you change.

Judith Carpenter:

Yeah. And I think the other part, as I'm listening to you, Glenn, is that I have with the other side. We have people who have lots of mental health problems, lots of social care problems, so it's never just someone's diabetes. A lot of the time in my clinical world, I'm dealing with, as we mentioned earlier, an awful amount of psychological distress, diagnosed mental health disorders and conditions, and it's how diabetes, their diabetes, you're there to support them with their diabetes, but actually you are really trying to help support them in their life of which their diabetes is part of that.

Judith Carpenter:

So, it's never just... Rarely for me, I suppose, working in a specialist service, is it just diabetes that the psychological aspects, not only of managing a condition like type 1 diabetes or type 2 diabetes, which makes you more distressed and more anxious and more depressed, just because you've got a long-term condition. That may sit alongside other things that are already going on for someone.

Judith Carpenter:

I think we paint a very poor picture when we say, it's just do this, or it's just that. And it's just eatlo better. It's just move more. Those messages that are probably far and wide, it's an unhelpful thing to consider. Eating's really interesting because everyone needs to eat. When you have other behaviors like, I don't know, smoking, drinking, substance misuse, there's choices around not having to do those behaviors that you choose to do. But everyone needs to eat.

Judith Carpenter:

So, helping people, and I think that's coming back to where I started. Helping people change their eating behavior, which is in essence, what a dietician's job is, is not easy stuff. It's never as easy as just telling people the facts of the matter of what they need to do. It's much more complex than that.

Sebastian Kaplan:

It's striking how many hats you wear in these conversations that you guide people through changes in their eating and exercise. But that story of the young person who is so frightened, and there was plenty of clinical, medical data testing stuff that you could have explored, but you responded to her what she looked like and how she appeared physically probably before she even said a word. That sounds like something a therapist would do and that's a real part of your job.

Sebastian Kaplan:

Diabetes doesn't care that you're the dietician or that young person didn't care like, "Oh, wait a minute. You're not my therapist. You're my dietician." The distinctions and the boundaries that we have professionally are just so artificial in these instances. Maybe that's one of the wonderful things about MI, that it allows us to respond to another human being in ways that are helpful, regardless of what the content is. Granted there are some professional limits to what we do.

Sebastian Kaplan:

But MI at least affords us a chance to not respond really quickly with, "I can't talk about that." I'm not a therapist or for me, I'm not a dietician. I can't talk about what you're eating. It still gives us some skill and some room to explore something and to be curious and to be empathic when someone's struggling in an area that may not be what we do.

Judith Carpenter:

Yeah. One of the reasons that people often shy away from learning something like Motivational Interviewing is they worry, people tell me all the time, they worry about opening this can of worms or Pandora's box or whatever you call it. To them, they're blinkered. They're like they have blinkers on, they can't see what's in front of them. I think being willing to learn a skillset that will actually enhance what you do, and also help you to recognize that you don't have to fix everything. You certainly don't have to fix things.

Judith Carpenter:

I can honestly say in the 30 plus years that I've worked clinically, there's not much I haven't heard actually. And I don't have the experience in skill to deal with a whole number of things. But I certainly have the experience in skill to listen and to show understanding, and to ask what the person wants to do. And to at times be able to sign post or advocate. One of the things I see myself doing more and more in more recent years is being an advocate for particularly for young people who don't have a voice. And that normally is not around in the world of dietetics. It's normally around the world of their mental health or their social circumstances or whatever. I think being blinkered means we are not able to do the job.

Judith Carpenter:

I just wish, I guess, that this skill mix, and for me, it's Motivational Interviewing and for someone else, it might be something different, but this type of skill mix was actually embedded into undergraduate learning. Because most people go into helping professions to be helpful. But it's a bit like trying to, I don't know, dig a road and you've got a fork and you've not even got a proper spade or a drill. You don't have the tools for your job if you don’t know how to do something a different way. Because the job entails working with human beings and the human beings are complex and wonderful and difficult in equal measure as we all there. So, we need a breadth of skill set really.

Judith Carpenter:

I think for me in my practice and in my training, that's what MI offers. That was, I guess, was why when we sometimes we hear colleagues and friends on your podcast talk about, I didn't know what I was looking for, but when I met MI, I found it. And that was my experience too. But at a time, when lots of people who were just therapists or psychologists going into the world at MI, there weren't that many of us at the time that were not from that arena. I was just lucky to meet it earlier than others, I guess.

Glenn Hinds:

So much of this is about the journey and in your description of a client's journey or a patient's journey through the relationship they have with this condition has just turned out for them, the diabetes. But it's also sound like what you've been describing as your journey as a practitioner and your desire at the very beginning was to be helpful and what has happened over the years is just your understanding of what being helpful means has changed or has become more informed.

Glenn Hinds:

And alongside of that, your how to be helpful has also been developed and developing and that's still an ongoing process. That's both the exciting and the challenging thing about recognizing ourselves as helpers, is that it's not that when we walk out of college that we're a done deal. We've taken a step and there's many more steps to take. I think that idea that you've been reinforcing through that curiosity, that how can we stay curious? And it sounds like that's what makes the job continue to be fulfilling.

Glenn Hinds:

Is that to be curious about each person we meet can be very fulfilling in itself for us, because we're being enriched by the people we meet and curious about where they're at and discovering these things about them as we explore with them, who are you trying to become and what is it I can do that can help you become that person that happens to have diabetes in this instance.

Glenn Hinds:

One final point then, what struck me was that idea of how often we are afraid of opening a can of worms or Pandora's box. I remember learning that Greek story of Pandora's box, where the box is opened and all the ills of the world were out to discover what's the last thing in Pandora's box is hope. And hope is one of the eight characteristics that Bill and Terry talked about in our previous episode of helping, is that the practitioner brings hope into the room.

Glenn Hinds:

If you open in that box, you've already got what responds to these ills or this individuals ills, is that you have hope for them. And I think that's one of the things that we challenge and perhaps that life journey teaches us how to become more hopeful for ourselves and for other people. I guess that that's something to invite people to think about as we're coming to the end of today's episode, is what can help you remain hopeful in these situations with these clients? Whatever the condition they're presenting within your clinic or your social care circumstances.

Glenn Hinds:

But as we are coming to the end, Judith, we always invite people to think about, what else is going on in your life at the minute that may or may not be MI-oriented and that's really capturing your attention?

Judith Carpenter:

Some hope for myself really, I recently have a few months ago, have some surgery, some orthopedic surgery. One of the things that I've been doing, well before that happened actually, but really ramping up now is just, I'm embarking on a year of health. I'm doing that because I'm coming up to a particular soonish in the next couple of years, a significant birthday. I'm embarking on a year of health because one of the things that this last year has taught me is to be really grateful for what I have and to be the best version of myself I can be. So, I'm getting myself better and I'm taking more care of myself and putting myself a little bit in my own spotlight, which I haven't done for a while.

Judith Carpenter:

It's very easy when you work a lot, as I'm sure you gentlemen both know to be caught up in the work and take the attention away from other important things. I'm embarking on that and I'm growing some vegetables for the first time in my garden. As I look out here now, it looks like there's triffids growing. I'm just embarking on a number of things about myself, really, which I think has been really interesting in the last year or so. I was certainly over in the pandemic and before then, taking up yoga. That's been a really good practice and I've just started that back again. And I'm just enjoying that whole process for the moment and just going to see where it leads me.

Sebastian Kaplan:

Well, as someone who also has a significant birthday coming in a matter of months, appreciate the reminder of the importance of these sorts of shifts and inspiring to hear about a whole year of health. That's quite wonderful. And Judith, if people are curious to hear more about am MI and diabetes care, or perhaps some gardening tips, if you're willing to share them, would you be willing for people to contact you? And if so, how can they reach you?

Judith Carpenter:

Sure. Probably email is the best. I'm a good responder to email. My email is optimalchangemi, that's optimalchangemi, one word, @gmail.com. And you can get me on Twitter at @optimalchangeMI. So, O-P-T-I-M-A-L, the word change and good MI added in at the end there.

Glenn Hinds:

Fantastic. Just a reminder of people, how people can contact us on Twitter, it's @changetalk, and on Facebook, it's Talking to Change and on Instagram, it's Talking to Change Podcast. And by email it's podcast@Glennhinds.com. Judith, thank you very much for sharing those wonderful insights and your caring spirit. And thank you for coming.

Judith Carpenter:

Thank you.

Sebastian Kaplan:

Thanks so much, Judith.

Glenn Hinds:

Bye everybody.

Sebastian Kaplan:

Bye-bye.