Motivational Interviewing Newsletter: Updates, Education and Training

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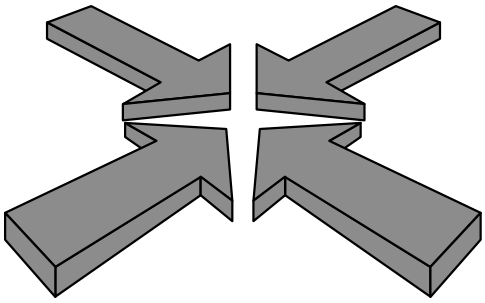

New Perspectives

FROM THE DESERT

A Moratorium on the MISC

We have learned quite a bit about how MI practice, training, and quality assurance work since the Motivational Interviewing Skill Code (MISC) was developed five years ago. We have reliability data on the MISC scales, showing us where we have problems of definition in coding. We have been rethinking versions and passes of the MISC. Paul Amrhein's psycholinguistic findings have substantially changed how we think about change talk.

With all of that, it is time to redesign the MISC. We are continuing to use the original version in ongoing studies, but if you are planning to implement new studies, do a translation, or otherwise make use of the MISC, I recommend that you wait until we have completed the MISC 2.0. Our target date for doing so is March 1st. As a preview, here are some of the changes you can expect:

(1) In the first (global) pass, we will be sharpening up definitions where coders seem to have struggled, and eliminating categories that are redundant.

(2) In the second (behavioral) pass, the largest revision will be in how we record change talk. Here we will be incorporating Paul Amrhein's categories and findings to code both the occurrence and the strength of language reflecting Desire, Ability, Reasons, Need, and Commitment. We will also be retaining sequential codes, rather than relying solely on total counts. In the Reflection codes, we will be eliminating the subdistinction of with/without affect, because coding proved utterly unreliable. Other code definitions will be sharpened up, and we may cut a few codes.

(3) The third pass (talk times) will be emphasized as optional, to be used only if there is a particular reason why this is of interest. Two examples where we have found it useful is in giving individual feedback on practice, and in cross-cultural comparisons. For many applications of the MISC, however, the talk timing pass is not needed.

Meanwhile, Terri Moyers is developing a single-pass coding system for Motivational Interviewing Treatment Integrity (MITI). Different from but informed by the MISC, the MITI (officially pronounced like "mighty") is meant particularly for applications where the central concern is documenting the fidelity of MI practice (e.g., for clinical trials).

When might you still want to use MISC 2.0 rather than the MITI? Some provisional examples are:

for process coding of MI, to link therapist responses to outcomes
when therapist and client *behaviors* are of interest (rather than global ratings)
when you want to provide specific feedback to people who are learning MI

MI, Spiritual Direction, Agenda Setting, and Health

Over the past few decades, the concept of "spiritual direction" has emerged into popular use to describe a facilitative relationship between a seeker and a spiritual mentor. The tradition itself is quite old, and can be found in most world religions. As with psychotherapy, there is a broad range of styles. Because of its connotations, some discard the term *director* in favor of concepts such as spiritual *friend*, *guide*, *companion* or *facilitator*. Nevertheless, *spiritual direction* remains the generic name for this vocation.

I have been fascinated by some parallels among client-centered counseling, motivational interviewing, and spiritual direction. The more I read about spiritual direction, the more it sounds fundamentally like what we do in MI, at least within certain styles. This in turn has interested me in the possibility of applying MI in the service of facilitating spiritual as well as psychological and physical health. This is not a new idea, of course. Many who work as spiritual directors already describe their practice in ways that would sound very familiar to an MI practitioner.

The word "direction" seems to suggest a directive, *docere* approach. When I first heard the term "spiritual director," it evoked for me an image of someone with a whistle around the neck, a coach calling in plays. There are indeed highly directive and prescriptive spiritual directors, who take on an expert role, as with a seeker studying at the feet of a master. Of this style, the Benedictine monk Thomas Merton (1960) wrote critically:

> The "director" is thought to be one endowed with special, almost miraculous, authority and has the power to give the "right formula" when it is asked for. He is treated as a machine for producing answers that will work, that will clear up difficulties and make us perfect. He has a "system" or rather, he has become an expert in the working of somebody else's system… Some directors… are tyrannical and arbitrary. They allow themselves to ignore or overlook the individual needs and weaknesses of their penitents. They have standard answers which are "hard sayings" that admit of no exception and no mitigation… Thus they take satisfaction in secretly indulging their aggressive instincts… It assumes as a basic axiom of the spiritual life that every soul needs to be humiliated, frustrated and beaten down… Obviously, no direction at all is preferable to such direction as this (pp. 18-20).

At the other end of the spectrum is a companionable *ducare* style. Here spiritual wisdom is regarded as residing within or coming through the seeker, and the "director" has a role akin to that of a midwife. Like Carl Rogers, those who work in this way tend to trust an inherent direction within the person, a "God within" seeking to be realized. Of this approach, Merton wrote:

> The whole purpose of spiritual direction is to penetrate beneath the surface of a man's life, to get behind the façade of conventional gestures and attitudes which he presents to the world, and to bring out his inner spiritual freedom, his inmost truth… A spiritual director is, then, one who helps another to recognize and follow the inspiration of grace in his life, in order to arrive at the end to which God is leading him (p. 17).

Sounds familiar? Take away the Christian concepts of God and grace, and these sound much like the premises of client-centered counseling. These parallels were evident to Rogers himself, and are expressed in part in his published dialogues with theologians Martin Buber and Paul Tillich.

The MI paradox of a client-centered yet directive approach is evident in spiritual direction. The ultimate direction is understood as coming from God as manifest is the particular seeker. The director merely facilitates the process… and yet, the director is also an active partner in this dance of spirit. The process of inspiration comes through both seeker and director, and through their unique relationship.

Merton was also clear that the spiritual director is concerned with the *whole* person. While some Christians do hold a notion of a detachable spirit that is separate from the body, such dualism is alien in Jewish conceptions of soul.

> There is a temptation to think that spiritual direction is the guidance of one's spiritual activities, considered as a small part or department of one's life. You go to a spiritual director to have him take care of your spirit, the way you go to a dentist to have him take care of your teeth, or to a barber to get a haircut. This is completely false… The spiritual life is not just the life of the mind, or of the affections, or of the "summit of the soul" – it is the life of the whole person (p. 14).

Apart from mystical conceptions, how might MI be helpful in the process of spiritual formation, of developing the whole person? Reflective listening has a long history in spiritual direction, but what of the directive component that focuses, keeps the person moving along an emerging path?

Although America is perceived (not without reason) to be a religious nation, there is much in U.S. culture that discourages people from exploring their spiritual, existential side. We are a culture of constant stimulation, of materialism and busyness and distraction. If indeed there is a "still small voice" in us to offer direction, it is nearly inaudible in our noisy lives. Spiritual directors help one to focus, and stay focused, on deeper issues of meaning and relationship and existence.

A secular parallel is found in the process of values clarification, which is being explored by some as an aid to or extension of MI. A counselor might first help a client to clarify the central, guiding values in her or his life, those that are held most dear and that define the person's essential identity. Reflective listening is helpful here, as are tools like the values card sort. Once these values are declared, the directive component of MI becomes relevant, and could be used to help people move toward value-behavior consistency.

We started out doing this in addictions treatment, oscillating the person's ongoing substance abuse against what she or he defined as central values. Few of the deeper human aspirations are advanced by overdrinking or using cocaine. The intended outcome there was reduction or cessation of substance use, in the service of promoting fulfillment of the person's core values. Values were incorporated in MI in order to promote specific behavior change – in this case, substance use. That is not a long leap from how we ordinarily think about MI, as directed toward a particular behavior change goal. In order to code change talk, in fact, it is necessary to define the target behavior.

What happens, though, when the intention is more diffuse – something like "health promotion"? What then is the target behavior? One can imagine a large range of behavioral changes that could promote physical, mental, and/or spiritual health. This quandary led to discussion of agenda-setting in MI; negotiating with the client which behaviors are to be focused upon and changed. It creates a challenge for coding change talk, in that one must decide whether a particular behavior change to which the person is expressing commitment does, in fact, promote health.

If it's a problem for coders, it's also a problem for MI practitioners. If the method of MI does indeed center on client change talk, then it is vital that the counselor recognize, elicit, and reinforce change talk. As we monitor tapes of people who are learning MI, that is a substantial challenge. The active listening piece is hard enough, but once that is in place, the next step is to learn to steer, to use the tools of MI to elicit and reinforce change talk. A small minority of practitioners can do that after workshop training. That was, in fact, what we focused on in developing an advanced clinical training workshop on MI, because it is the piece most often missing.

And so we come to the anxiety that as one begins to lose focus on specific behavior change, MI becomes murky, and at some point may not be MI at all. This legitimate concern needs to be reconciled with the reality that most clients do not come with one single behavior change goal, even in settings (like addiction treatment) where you might expect that they would. They have many concerns, and also in an area like health promotion, there are many possible behavior changes that a practitioner could encourage. Hence the process of agenda setting.

One way in which we have pursued this recognition is to encourage a client to choose topics from a finite menu. Steve does this with health behaviors, and also leaves the door open for clients to introduce concerns that are not on the pre-set menu. In the interest of direction, the practitioner may focus on one behavior change at a time, but it is common in ongoing counseling or

consultation to be tracking several change dimensions simultaneously. Our compromise on this for a cognitive-behavioral intervention being used in a current multisite study was to begin with motivational interviewing, and then develop a change plan from a finite menu of modules, with the proviso that in any given session the therapist should not be pursuing more than two modules.

This comes still closer to general psychotherapy and, interestingly, to spiritual direction. In the latter case, within the context of a generally reflective and supportive relationship, the director encourages practice of a finite menu of spiritual disciplines such as prayer, meditation, fasting, and contemplative study. The "spiritual formation" goal tends to be broad, somewhat vague, and concerned with the whole person. Yet there are particular behaviors to facilitate in pursuit of the broader goal, much as one may encourage exercise and dietary change to promote "health." The directive aspect of MI could therefore be a tool for facilitating the intermediate behaviors that serve fulfillment of ultimate goals and values. The choice of which behaviors to pursue is a matter of agenda setting, familiar in health behavior change counseling and in psychotherapy.

What seems to be emerging here is MI as a comprehensive clinical method, a platform that involves more than the critical conditions described in client-centered counseling. In psychotherapy or health care, the person is actively involved in determining goals and in choosing behavior change means to those ends. The style of MI does not at all exclude using other methods (such as cognitive-behavior therapies) for pursuing the client's goals. The tricky skill is in weaving together the generally empathic style, the eliciting of intrinsic motivation, and the pursuit of means to ends.

How do I finish this piece? I guess I find myself at a frontier, a use of MI that moves past focal behavior change, and yet retains integrity with the basic spirit and methods of MI. Hobart Mowrer came to a similar place after a long and distinguished career in clinical and experimental psychology, writing of "integrity therapy" in *The New Group Therapy*. It's a balance of focal clarity and openness to look beyond the presenting problem to the client's larger existential context, the broader view of health. The further I move into MI, the more it is perfused with tensions and paradoxes.

References

Merton, T. (1960). *Spiritual Direction and Meditation.* Collegeville, MN: Liturgical Press.

FROM ONE SIDE OF THE POND

What Goes on Inside?

I heard from a number of people that Bill Miller's piece in the last newsletter was useful and interesting. There seems little doubt that many researchers and trainers in the motivational interviewing field will not sit back and simply regard MI as a dose of technical expertise. It will be essential to get inside the consultation, and work from there. Here in Wales we are working on a number of projects geared towards unpacking the key elements of effective conversations about behaviour change. One is to develop a brief checklist of key skills described in Chapter 18 of the second edition of the Miller and Rollnick text on MI. It's a trainers' checklist which might also be useful to researchers. My colleague Claire Lane is working on reliability and validity. Another, in its very early stages, involves a series of experiments designed to tease out key processes, like whether it's the confrontational behaviour of the practitioner that elicits resistance, or the other way around! MINTie Jim McCambridge from the National Addiction Centre in London is helping us sort out a host of conceptual and methodological matters.

What's in a Conversation?

We have had a wicked thought: what would a conversational analyst make of an MI session, if he knew little about the subject? Professor Clive Seale, from the Department of Sociology at Goldsmiths College in London, has made an offer we can't refuse. We'll publish his impressions and analysis as *soon as it is available.*

MI and Behaviour Change Counselling

This distinction made between two overlapping counselling styles (see Chapter 18 of the MI text) was made in order to protect MI from oversimplification and diffusion. My personal view is that we can't have it both ways: nuture MI as a skilled activity and encourage its widespread application among practitioners of all kinds, in any setting where behaviour change is an issue. We need to draw a line somewhere. It seemed a pity to produce yet another name for a method, behaviour change counselling, yet there was sufficient evidence in my healthcare environment to get a little alarmed: practitioners and researchers were (and are) calling an activity MI when it seems very far from my understanding of its essence (the skilful invitation to a different perspective about how behaviour change might sit more comfortably with the client's values).

In the UK healthcare environment, the term counselling is often used to describe what a generalist practitioner does when they sit down and have a quiet conversation with a patient, hence the common use of a phrase like "counselling about a poor prognosis". This fits in well with the way behaviour change counselling is described in Chapter 18 of our book. But in the US, I understand, the term behaviour change counselling might not be so useful, for a range of reasons. I have no idea how to resolve this issue, other than to return to a call for a clear account of the content of whatever method is being used, whatever name is being given to it.

The "Three-in-a-Row" Exercise[1]

Aims

To develop a platform for constructive learning of MI in a workshop, based on participants' *feelings* about their clients. To start a workshop well, and to elicit as much as possible about MI from the participants themselves, before filling in some new pieces. To provide something concrete to return to at the end of the workshop.

Background

It's often hard to engage trainees when they think that a trainer is about to immerse them in some foreign method. The idea here is to start a workshop (or lecture) with their experiences and feelings about their clients, and to build from there. One can take any of a number of directions having done the basic exercise. I have usually started the workshop with this exercise. It has even worked in very large lectures.

The Basic Exercise

Locate a typical client…
where motivation is an issue
Elicit this from the group, before or during the workshop, or give them a case if you know their world well enough. Elicit their agreement that this is a typical case. Avoid the "client from hell", because it's too extreme. If possible, write up and display the key characteristics of this client before you start.

The feelings of practitioners
Solo: Ask them to write down in just two minutes their answers to this question: "You are about to see three clients like this in a row. With all of them, you are going to raise the subject of (the behaviour change in question). *How does this make you feel and why?*"

Pairs: Ask them to interview each other about their answers to this question. The goal should be to listen and elicit from your partner, then switch roles.

The feelings of clients/patients
Ask three or four people to imagine that they were this client, and the subject of (behaviour change in question) was going to be raised. *How do they feel, and why?* Ask them to answer this question on their own, as above, and to interview each other in pairs.

Large group
Elicit and list on two flip chart sheets the feelings that emerge from practitioners and clients.

The outcome
I display three sheets: the client description is in the middle, and the feelings of practitioners and clients are on either side.

Where Next?

You can now ask a number of questions, for example:

(1) What goes on in these sessions, to make people feel like this?
(2) In what way are they different, for example, to a bereavement counselling session?
(3) What do you usually do in this kind of situation?
(4) How could you make things worse?
(5) What are the general guidelines for responding constructively to this kind of client?
(6) What skills are needed?

I usually focus on No. 5, at a general level first. Often, the principles of MI pop out! Then if you turn to No. 6, you might even get further, with skills like empathic listening popping out as well! The goal here is to elicit from them the principles and skills of MI, before you have uttered a word about the subject. In this exercise, your main task is to listen and elicit, genuinely, not fearful of hearing confusing or irrational voices (just like in an MI session!). Having done this exercise, I often state that the aim of the workshop is to see how MI might help them feel better and more skilled at working with this kind of client.

At the End of the Workshop

I usually return to this exercise, and the associated three sheets, at the end of the workshop. You can repeat the exercise, asking how their feelings have changed, and why.

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[1] developed by Stephen Rollnick: feel free to copy, adapt and develop this exercise, as you please

MINTIE Career Posting

Established, 22-year-old mental health provider in Powell River, BC, Canada, seeks qualified applicants for 19-bed addictions recovery center for adults opening May 2003:

Program Manager
Intake Counselor
Group Therapist
Case Manager
Continuing Care Counselor

Treatment will include MI, cognitive-behavioral skills training, and the transtheoretical model (stages of change) as vital components of its substance abuse and dual disorder program.

Counselors will make extensive use of telephone and videoconferencing; relocation may not be necessary. For further details, interested applicants are asked to contact Daniel Jordan, General Manager at theorcas1@yahoo.com or 604-789-0371.

Motivational Interviewing and Behavior Change

Peter Prescott

My first introduction to MI was in 1991. The workshop didn't have that much impact on me. I was used to a more "active advice" and "finding solutions behavioral" type of treatment, which focused on the **good** intervention. In watching demonstrations of MI, I found it difficult to see and hear what the counselor was doing and of course why he was doing it. The counselor was so laidback that he was almost invisible.

However, a while after the workshop, I tried some of the MI-techniques and, to my surprise, they seemed to work. So my view on MI changed. One episode I especially remember was an exploration of pros and cons of substance use that resulted in changes in one of my clients.

Another important ear-opening experience was self-observation of my own communication habits, especially the use of closed questions. I actually began to hear myself asking closed questions and was able to start asking open ones. Change wasn't easy. For a while I had to write down appropriate open questions before treatment sessions.

The shift from closed to open questions had a positive and reinforcing effect: It was easier to avoid, and prevent, counseling sessions turning into unpleasant, energy-draining and unsatisfactory wrestling matches. I found myself in fewer and fewer difficult situations, and the difficult situations that arose seemed to be a bit easier to handle. I fell less frequently in the expert trap, and the "find the right solution for the client" trap. So, I became, for period, a happier therapist. This is a good thing about MI, it reduces the wear and tear of working clinically in the addictions field.

However, I think I became too non-directive for a while. Learning how to integrate being client-centered and directive has been the part of MI I've had most problems with: When should I limit myself to exploration of the client's experience, and when should I try to "stretch", push or pull the client a little in the direction of change?

Motivational Interviewing

As the subtitle to both editions of Motivational Interviewing emphasize, MI is about preparing people to change. In some ways I find this to be a useful definition, in other ways I feel that this delimitation is confusing, since many aspects of MI clearly have potential to help people with more than just preparation for change. However, if MI is to move beyond this, I feel that it would be profitable to incorporate action strategies from other traditions into its own particular approach to treatment. It's this broad view on MI that I wish to explore.

MI is about counseling (or treatment?), and it's about behavior change: (1) Counseling: MI, describes in a very concrete manner, how to talk with people about their own behavior in a productive manner. (2) Behavior change: MI has underlying assumptions about how, and why, people change problem behavior. MI can trigger behavior change and increase the likelihood that person will attempt to change. MI increases the chances of succeeding with a given change attempt.

Tasks in Self-Initiated Behavior Change

Self-initiated behavior change consists of different tasks that a person must attend to in order to succeed. MI focuses mainly on the initial tasks of change. In the beginning of change, motivation is the main task, and MI assists the client in preparing for change by exploring reasons for change, ambivalence, and leading the client towards the step of making a "big" decision.

MI's preparation to change has two characteristics: (1) A *cognitive* dimension: The awareness of negative consequences (eliciting change talk, information exchange, assessment with feedback). (2) A *motivational* dimension: The meaning and importance of the negative consequences for the client, which can lead to value conflict, discrepancy and self-reappraisal, are important aspects of motivation building. In some ways, MI is clearly confrontational, in that the person confronts himself. The counselor's empathy and acceptance are important, and enable the client to face, with less distortion than usual, the unpleasantness of candid self-evaluation.

MI is influenced by the SoC (Stages of Change) view that the client should attend to different tasks at different phases of change. The SoC-model simplifies change, and tempts the counselor to fall into several misconceptions, one of them being that when the task corresponding to a stage is "solved", the client leaves it behind and moves on to new tasks. This describes uncomplicated change, and is probably an exception to the rule. Changing addictive behavior isn't usually so straightforward. Although certain tasks are in focus at different times, the number of tasks increases as one goes through change. Early tasks continue to be issues later on in the change process. New ones are added to the old ones. Old tasks are not necessarily solved once and for all. They do, however, become more familiar, but have to be "re-solved" over and over again, though this often takes less and less time.

Motivation is a recurring topic from the beginning to the "end" of change. It continues to be essential throughout the change process, and is an issue the person deals with when making decisions, implementing change, maintaining change, and overcoming, preventing, or avoiding relapse.

Overcoming motivational obstacles (for example rationalization, reluctance, rebellion, preference, decisional delay) is a challenge throughout change. These obstacles can be re-activated late in the change process. A confrontational counselor, or the stress of everyday living, can activate them again.

Like motivation, action is usually seen as having its own time and place in the process of change. "The action phase" is thought of as being of short duration, and coming late in the change process. Again, I feel that this is to simplify things too much. *Thinking* about change (planning, ways to do it, self-efficacy), and behavioral experiments, are often present long before the client has come to terms with ambivalence. Action roadblocks (thoughts about low self-efficacy, feelings of hopelessness and helplessness) are also present in the early stages of change, often long before a decision is made.

Questions, Themes, Dilemmas and Counseling Strategies

Questions to be asked & answered	Themes	Dilemmas	Counseling strategies	
			Elicit (& explore)	**Provide (& explore)**
Why?	Motivation	Ambivalence "I want to and I don't want to."	Motivational change talk Ambivalence	Information Feedback from assessment
When?	Readiness Decision-making	Postponing decision Procrastination "Now or a little later?"	Commitment and readiness change talk Decision postponement	Negotiation *Empathic persuasion?* Expert opinion
How?	Action Competence Self-efficacy	Hopelessness Helplessness Mismatch between expected difficulty of change and perception of self-efficacy "Am I able or am I unable?"	Solutions and competence change talk Perceived difficulty	Give a menu of advice about solutions Give support/help Remove barriers Instill hope

Challenges for the Counselor

In order to become skilled in MI you have to unite contradictory counseling demands, and that's not always easy.

Both directive and client-centered. MI is a directive client-centered approach to counseling. Eliciting change talk with appropriate open questions, and the selective use of reflection, is both directive and client-centered. MI's techniques for providing information (assessment and information exchange) are also directive and client-centered.

Being directive means both leading and following. The counselor is directive by politely steering the consultation into relevant areas; by selectively following the client with follow-up questions or reflections and summaries when he or she says something that is change-relevant. The counselor steers away from unproductive topics and "resistance".

Providing, eliciting and exploring. The counselor alternates between providing information, expert advice and solutions, and eliciting the client's motivation, decision-making, solutions and self-efficacy. MI focuses mostly on eliciting, brief MI, MET seem to rely more on providing strategies.

However, the terms "eliciting" and "providing" are a bit deceptive, and only the beginning of the both strategies. Often before, and always after, eliciting or providing, the counselor is active in **exploring** the client's thoughts.

It's not what the counselor says and does that's the most important; it's what the client says and does. One of the basic tenets of MI is that behavior change is the client's responsibility. I prefer to formulate this in a slightly different way: It's the client's own activity that is of vital importance. Self-initiated behavior change poses quite a few challenges for the client, and in order to change the client must ask herself the "right" questions, and find her own acceptable answers to these questions.

Since changing behavior necessitates client activity, it follows that what the client says and does in counseling sessions is very important. The counselor can increase the likelihood of change if he allows the client to say, and do, the "right" things. Even though MI focuses on counselor behavior, it's actually not what the counselor does and says that's most important for change. It's the effect of the counselor's interventions, statements, questions that are significant, not the interventions themselves. Even when providing information, an expert opinion about a sensible goal, or advice about how to change, the client's activity is important. Asking permission, reflecting responses and asking for patients viewpoint on the material provided are attempts to keep focus on client activity.

The client's responses, behavior and utterances are in the limelight, and they guide the continually ongoing choices made by the counselor.

Areas for Further Clarification

Integration with other approaches. How can aspects of MI and approaches like solution focused therapy or CT/CBT be integrated?

Acknowledge complexity. On the surface MI appears to be easy to do, however it's hard work to become adept in its use. The expert MI-counselor is able to integrate seemingly opposite approaches, such as leading the consultation by following, being both client-centered and directive. Although application of some of its procedures and strategies can be lead to quick results with cooperative and compliant clients, complicated clients with difficult problems will always pose more difficult challenges that require us to grab deep into our toolbox of non-MI strategies and personal resources.

Training programs for professionals who wish to attain a high level of proficiency should be developed and offered.

More theory and conceptualizing. We need the big theoretical picture that can guide where the counselor should be going, and how to get there: Theory about addictive behavior in general; about the differences and similarities between specific addictive behaviors (smoking, alcohol, cannabis, heroin, amphetamines and gambling have different features); about change processes; and about counseling.

Microanalysis of process. While theory tells us where we want to go and the general way of getting there, the ongoing decisions made by the flexible counselor keeps him on the road and allows him to take alternative routes to reach the goal of helping an individual client. Microanalysis may help to illustrate these decisions, and how they are influenced by the client's reactions. It can also show us how the client reacts to the counselor's behavior. Microanalysis of both successful interventions, and of successful counselors, can give insights into the "how" of influencing people to change.

Both MISC, and Ken Resnicow's one-pass coding system are fruitful approaches. I would also like to see qualitative analysis of the ongoing interaction between counselor and client.

The merit of small decisions and behavioral experiments. How can small decisions and behavioral experiments help the client to move toward making the big decision?

What effect can a small change have on motivation, decision-making, commitment, self-efficacy and hope?

How does a small success change improve counseling and the relationship to the counselor?

Alternative ways to conceptualize "resistance". Perhaps problems, dilemmas, and obstacles could be words help us to understand why people don't change:

- Problems with motivation (reluctance, reactance, rationalization and preference)
- Problems with identifying solutions and self-efficacy (resignation, hopelessness and helplessness)
- Problems with decision-making (decision postponement)
- Problems with the circumstances around counseling and being in counseling (coercion)
- Experiences of personal unpleasantness connected to counseling (shame, shyness, ambivalence)
- Disagreement about the focus for counseling (goal formulations, acceptable solutions)
- Problems in the relationship (dysfunctional emotions and cognitions, both client and counselor)

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MINT Forum 2003, Crete

Currently 39 Minties have registered for the 2003 MINT Forum in Crete and the preparation team – Peter Prescott, Anette Søgaard Nielsen, Robert Kenyon and Jackie Hecht – is busy developing ideas and proposals for the programme of the Forum.

The early-bird registration fee (€ 415,-) applies until March 1st. For information and registration, please visit www.motivationalinterview.nl or contact the Centre for Motivation and Change at the following address:

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FROM OLD EUROPE

Motivational Interviewing and the Chinese Art of Warfare

Last year I read a popular book about the Chinese art of warfare (von Senger, 2001): A colleague had mentioned the book – written by a Swiss professor – during a lecture. In his opinion MI and the clever Chinese art of warfare are very much alike. This started me thinking… I am interested in MI, Chinese philosophy and military history (yes, it is true… one of my strange interests…) and so I decided to read the book. The text turned out to be quite boring and "geschwätzig" (German term for chatty) but reading it helped me to understand a frequent misinterpretation of MI: Some trainees assume that MI is a smart method to manipulate "unmotivated" patients. Obviously, many people are fascinated by cunning therapists using a variety of tricks to make their patient drink less, stop smoking…

Transparency: Be honest

Sometimes I ask my trainees and myself: Could you always interrupt a session to explain to your client what you are doing right now without embarrassing yourself or annoying your client? For example, what would the reaction of your client be if you had to explain that you were just using a trick called therapeutic paradox? Following this sort of questioning I often discuss a number of ethical issues with my trainees. During the discussion I tend to interpret the answers to my question as an index of transparency in the relationship. My personal ratio of "yes" and "no" answers to the "transparency question" changed considerably since I read *Motivational Interviewing*. Should the answer always be "yes"?

The False Hope Syndrome

Carl Åke Farbring (Sollentuna, Sweden) and David B. Rosengren (Seattle, Washington) made some very helpful comments on the issue of inflated self-efficacy ratings (Carl, I cited your comment in a German-language paper on relapse prevention; Demmel, 2002). Preparing a manuscript about our own research (David, I will send you a first draft of the – English-language – paper as soon as possible) I discovered two interesting articles: one about the relationship between self-esteem, neuroticism and locus of control on the one hand and self-efficacy on the other hand (Judge, Erez, Bono & Thoresen, 2002) and a second paper on the "false hope syndrom" (Polivy & Herman, 2002). The authors raise a series of questions relevant to behavior change in general (Why do self-change attempts fail? How do people (mis)interpret their failures? Why do people try again? etc.) and review the literature on inflated self-efficacy: "… confidence that is earned (i.e., confidence that is based on a record of success and competence) is more likely to be associated with future success than is confidence that has not been earned and that may, in fact, be totally unwarranted…" (Polivy & Herman, 2002, p. 686). Where does this leave us?

Need Some Confidence…

A German University of Applied Science announced a training workshop in MI. Here is a short summary of the ad: Two British family systems therapists – Bill and Steve – developed a new method – based primarily on the transtheoretical model – to stop smoking, drink less and solve almost every problem you can imagine. Could you resist to comment on this ad? I couldn't… I wrote a letter and offered to have a conversation about MI. The reply was rather cold and indicated a spirit different to that of MI. Despite a growing number of credentialed trainers the MI field continues to be the Wild West of psychotherapy in Germany…

All the best,
Ralf

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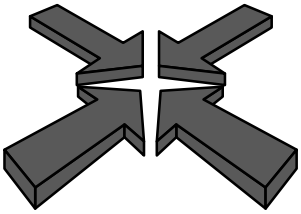

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