From The Desert

Bill Miller

E-I, E-I, Oh!

Extraverts, Introverts, and Motivational Interviewing

Within Carl Jung's typology of personality, introverts by nature prefer to ponder before speaking. Processing goes on internally, silently, and at some length. When introverts speak, if it occurs to them to do so, it is likely to be a considered product of deliberation. Extraverts, in contrast, often think aloud. Their speech reflects the process itself, more than the outcome of deliberation. Whereas introverts are less likely to "show their work" in overt verbalization, information processing is more transparent in the speech of extraverts. This personality style difference contains the seeds of misunderstanding in communication. For example, introverts, failing to appreciate the process of "trying out" ideas in conversation, are likely to overestimate the finality of what an extravert says.

It seems to me that this natural style continuum may have some interesting implications for MI. It could be, for example, that MI is a better fit for extraverts, who naturally process things and reach conclusions via interpersonal dialogue. Introverts may be more inclined to go away and think about it. Introverts' in-session speech may be less predictive of outcome, at least in an initial session. On the other hand, one might predict that commitment language coming from an introvert would more confidently predict subsequent behavior. An extravert may just be trying out commitment language.

Falling at the monastic end of the E-I continuum, I am inclined to think things through rather thoroughly before I write something. Even more than speech, writing holds a daunting kind of finality for me. Before I put it in print, I want to consider the possible flaws and biases, how those who disagree could perceive it and reply. This makes scientific peer review an appealing, albeit annoying process. Peer review is one more chance to get it right before it is said.

Writing for the MINUET is a less accustomed process for me. Like the MINT listserv, MINUET is an extraverted, sociable publication, a safe place to try out ideas that are partially formed or informed. By nature I worry that what I write "from the desert" will be taken with too much finality and authority, or that those with different views may feel publicly denounced or disenfranchised. I do not mean to speak *ex cathedra* here or elsewhere, and particularly here in MINUET I am expressing work in progress, hypotheses, possibilities. Many of you, particularly the extraverts, may already take this for granted (Well, duh, of course!), and for this I am grateful.

I believe that the MINUET should be a dance of possibilities, of half-baked ideas and whimsical, wistful commentary. It should be a safe haven for loving dialogue without diatribe, for critique without competition. Whereas fiction is to be read with a willing suspension of disbelief, please read what I (and others) write here with willing suspension of belief. And if you're not naturally introverted, don't fret about any of this; just carry on reading and enjoying the MINUET as usual.

With that said, we introduce a new symposium feature for the MINUET. The basic structure envisioned by editor Allan Zuckoff, and one that has been quite successful in scientific journals, is a stimulus essay that is distributed in advance to several colleagues who are invited to comment on it from their varied perspectives. The essay and commentary are then published together. I am pleased to provide the essay to begin this process. ◼

Editor's Choice
An Actual Bounty

Allan Zuckoff

Regular readers of the MINUET will be struck by the length of this issue, as well as the variety of articles and contributors it contains. A large portion of its length and variety is accounted for by the first MINUET *Virtual Symposium*, on the topic of *Values and Motivational Interviewing*. Inspired by a series of MINT listserv discussions, this symposium features an original essay by **Bill Miller**, followed by 23 commentaries by MINT members who participated in those earlier discussions, and Bill's final, thought-provoking response to the commentaries. For me, the presence of this extraordinary gathering of minds to address such seemingly abstract questions as, What role should the values of the interviewer play in the conduct of MI? What role do they, in fact, play? What does it mean to say that MI is a "directive" counseling style, and what are the ethical implications of such a stance? How should we think about our responsibilities as trainers as well as practitioners? — provides a heartening contrast to the relentless focus on the bottom line that seems increasingly to plague our field. So long as counselors, trainers, and researchers are asking such questions, and treating them as important enough to warrant thoughtful and well-considered answers, I will not despair for the future of our professions.

In This Issue

In his "whimsical, wistful commentary" *From the Desert*, **Bill Miller** considers the implications of differences in personality style for how one reads the MINUET, and offers his own view of its place in our ongoing dialogue on MI, in *E-I, E-I, Oh! Extraverts, Introverts, and Motivational Interviewing*. We then feature an original contribution by **Gary Rose, Stephen Rollnick, & Claire Lane**, who offer a new framework for conceptualizing the ways in which practitioners helpfully talk with their clients and patients, *"What's Your Style?" A Model for Helping Practitioners to Learn About Communication and Motivational Interviewing*. **Carolina Yahne** then answers Steve Rollnick's plaintive call in MINUET 11.2 by taking on *The Role of Hope in Motivational Interviewing*. **Jackie Hecht** provides us with a *MINT Forum 2004 Description and Preliminary Agenda* to whet our appetites for what will undoubtedly be intriguing (and fun!) goings-on in Portland, Maine, USA, and **Tom Barth** provides an inside look at the proceedings of the recent *Nordic Motivational Interviewing Trainer Meeting*. **Gary Rose** keeps us informed about the workings of our executive branch in his *Steering Committee Update*. Then, **Grant Corbett** is back with another instantiation of his regular column, explaining *What the Research Says …About Change Talk*. This is followed by rich editions of two of our recurring features. In the *Training Corner*, **Kathyleen Tomlin** offers her *Reflections on Supervising and Implementing MI into Agency Life,* and **Jackie Hecht** describes the lessons of a memorable training experience in *A New Training Experience Many Miles form Home*. The *Research Round-up* features **Lars Forsberg & Carl Åke Farbring** describing exciting developments in controlled research on MI in forensic settings in *Large Scale Research in Swedish Prisons and Probation*, and **Carol DeFrancesco & Rosemary Breger** giving us an insider's account of life with the MITI in *Reflections on Coding*. And the issue ends with our *Virtual Symposium*. Readers will find a table of contents and contributors on page 18 to help them find their way through this forest of deep thoughts and original insights, which I hope in turn will plant the seeds of further listserv discussions and MINUET articles (or letters to the editor; see below) in seasons to come.

Looking Forward

The annual meeting of our MINT organiza- tion, scheduled for October 28-30, 2004, will (if experience is any guide) be the site of stimulating presentations, inspiring demonstrations, and stirring discussions on various aspects and applications of MI. Plans are currently underway to ensure that these activities and the ideas that grow out of them are not lost, but will be available to readers of the MINUET through summaries and reflections to be published in our next (February, 2005) issue. We also hope to provide an account of a symposium on MI scheduled to take place on November 3, 2004, as part of the EUROPAD meeting in Paris, France, entitled *Motivation Approach to Heroin Dependent Patients*. If any reader is aware of other conferences or symposia that feature MI, I would be grateful to be notified and perhaps arrange for those to be covered in the MINUET as well.

The reference to "letters to the editor" in the previous section requires a bit of further comment. I have observed that readers may at times have reactions to articles published in the MINUET, yet may not feel that they have enough to say to merit a full-blown article. To encourage any who might feel this way to have a chance to be heard in these pages, I will be introducing a new section entitled, appropriately enough, *Feedback*. (Thanks to Grant Corbett for suggesting this title.) Brief comments, opinions, suggestions, et al on articles published in this issue will be heartily welcomed, from MINT members but also from any reader who wishes to have a say. To avoid inhibiting MINT listserv dialogue, letters (unlike other MINUET contents) may be reprinted verbatim from listserv posts, so that readers not privy to the listserv may have access to the responses of MINT members to what is published herein. And to those who find themselves trying to decide whether or not expressing their opinions really matters: rest assured that there is no more welcome knowledge for any author, than to learn that what he or she has written has stirred a reader to respond.

Finally, it is my fond hope that this issue's virtual symposium will be only the first of many. I have already begun to consider themes for future symposia, and I welcome suggestions of topics as well as volunteers for participation. As always, my goal is to make the MINUET as inclusive as possible across cultures, interests, and specialties — with (if you'll forgive my unreconstructed humanism) the spirit of MI as the thread that unites us all. **M**

What's Your Style?

A model for helping practitioners to learn about communication and motivational interviewing

Gary S. Rose, Stephen Rollnick, & Claire Lane

Scepticism About Methods And Models

Training in communication and motivational interviewing can be tough on a number of fronts, and disengagement among learners is not uncommon. One of the most uncomfortable experiences is when one senses a clash of values and models. The scenario is well known to trainers: guided by seemingly unshakeable wisdom about the value of listening to or sharing decisions with patients, one adjusts the exercises, the design, the location or even the context of training, and yet resistance from learners prevails. One can be left feeling that the principles of a client-centred approach to heath care are under threat, not just from a work environment that discourages listening, but from a pool of sceptical practitioners who know better than to adopt unrealistic work practices. Candidates for rejection in training can include the techniques of listening or even a well-worked model like motivational interviewing or the shared-decision-making approach. "My patients like to be told what to do" or "I don't have the time to listen" or, with buoyant indignation, "How would you deal with this patient?" (describing the patient from Hell). In short, these techniques, models and methods can be viewed as idealistic or inappropriate, despite the undoubted momentum they have built up in the research and educational arenas. In training, we try to defend them from oversimplification, and sometimes we diffuse cynicism and encourage learning. Our coffee room and debriefing discussions are never short of anecdotes about how difficult it is to change the attitudes and behaviour of practitioners. From our vantage point, we can produce a colourful account of the resistant practitioner from Hell.

Do We Make Practitioners Feel Bad?

One possibility is that if one promotes a model, method or technique that is at odds with the learner's perceived everyday reality, they might feel bad or disengage from learning. The un-stated message is that what they do is not good enough, and a defence of their everyday practice is a perfectly understandable reaction. It was a background in motivational interviewing that led us to view resistance among learners as a signal not to label them as resistant, or to bypass their concerns with some clever observation or training exercise, but as an opportunity to understand their value systems, aspirations and everyday challenges. One product of this approach to learner resistance was the development of a group training method called *context-bound learning*, in which everyday challenges formed the basis of learning, and in which commu-

nication skills were only brought into the foreground when they seemed relevant to solving problems. We developed this method by asking practitioners how we might best be of assistance to them. But what model and skills were we bringing into these situations? Put simply, it was a set of values, techniques (like listening), and methods (like motivational interviewing), and sooner or later we would come up against the impression that we were wanting practitioners to do less instructing, and more listening.

A Dubious Dichotomy: Tell Them Or Listen

It is one thing to note that practitioners often instruct patients when they might have done better to listen, another to allow this to form the basis of our approach to training. We believe that we have made this mistake at times. The problem here is that listening is viewed as patient-centred and egalitarian, while in contrast, instructing can be viewed as paternalistic, practitioner-centred and not conducive to good communication. A simple example illustrates the troubled nature of this dichotomy: you are lost in your car, flustered and anxious, and you ask a passer-by for help. After briefly establishing where you want to go, the stranger gives you very clear instruction, stopping to check that you are following, and you drive away thinking, "What a nice helpful person". We all know of equivalent scenarios in health care consultations, and it is difficult to view these as practitioner-centred or somehow characteristic of poor communication. We also know that instruction can be given in more or less skilful ways, and that it is probably more suited to some problems than others.

In our efforts to clarify the boundaries of instruction and listening, we discussed the problem with groups of learners, including a team of cardiac

rehabilitation nurses and psychologists, a large group of health visitors, and a number of groups of general practitioners. Our question to them was: *what is it that you do that works?* What styles do you use, and in what situations?

Natural Communication Styles

The most common call from practitioners was that informing or instructing patients about what you feel they might do was acceptable and useful in some situations. The next question was more complex to deal with: *what else do you find useful?* What emerged when we sifted through the reactions were three approaches to communication, based upon the concepts of instructing (or informing), guiding, and listening. We then presented these three approaches to learners, and got the impression that it had face validity, captured by the reaction, "Yes, this is what I do".

The three approaches were defined as follows:

1. **Instruct:** *Give information or advice.* Other activities associated with this style include directing, informing, leading, educating, telling and using one's expertise. It is used when there is information that one wants to provide, hopefully which the person wants to receive.

2. **Listen:** *Understand the person's experience.* Other activities used include gathering information, following, eliciting, attending and empathising. It is used when one wishes to understand how the person feels or what has happened to them.

3. **Guide:** *Encourage the person to set his/her own goals and find ways of achieving them.* Other activities associated with this style include coaching, negotiating, mobilising and motivating. It is used when the person is facing change, having to make decisions and to act upon them.

Standing back from the healthcare environment, we were struck by the

relevance of these approaches in everyday situations *where one is placed in a role of helping others*, and took the step of calling them "communication styles." For example, as a parent, one's job is not just to provide food and love, but to help children learn to cope with challenges like crossing a road, riding a bicycle or overcoming fear.

Scenario 1: Child runs across a road
Scenario 2: Child learns to ride a bicycle
Scenario 3: Child seems very frightened

Most people would say that in **Scenario 1** they would *instruct* the child, very quickly, so as to avoid an accident. In **Scenario 2** most parents know that the best approach is to *guide* the child (try instructing and the child often gets upset!). In **Scenario 3** one would tend to *listen* first, so as to understand what's going on. Similarly, in helping a junior colleague at work, for example, one would tend to use an instructional style in explaining some new procedure, a guiding style in talking about learning a new set of skills, and a listening style if this person was upset or angry.

Guide
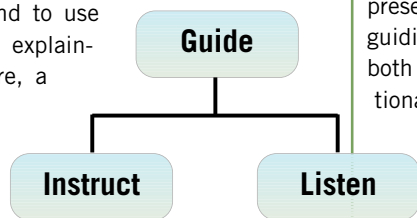
Instruct   **Listen**

Figure 1: The Three Styles

Figure 1 provides one way of illustrating the interrelationship of these styles. Guiding can be understood as a higher order style which integrates the best of instruction and listening, generating a product distinctly different from the other two styles.

Good Practice: Some Tentative Principles

Reflection about our own approaches to helping others, as parents and professionals, revealed that some problems are much more difficult to solve than those presented above. For example, a child refuses to get off a bicycle, or to get out of the bath; a patient storms into the consulting room demanding action about an experience of apparently negligent care by a colleague. Sometimes it is not that clearly evident which style is the best to use, and when. The following principles seemed relevant:

1. The model is merely a heuristic device, a simplification of the complex world of communication when helping others.

2. The three styles are sometimes used in a clearly distinct way, at other times it's a matter of relative emphasis, more like the mixing of three primary colours.

3. No one style is better, or more patient-centred or more useful than another. Which one to use depends on the circumstances.

4. Each style can be used with more or less *skill*. For example, a few, carefully-chosen, well-matched words of instruction can sometimes make all the difference, while its opposite is not difficult to imagine. So it is with both listening and guiding.

5. A *mismatch* between the style and problem at hand is conceivable, for example, if we were to instruct a child who has burst into tears. The "righting reflex" (Miller & Rollnick, 2002) might be an example of a mismatch in which an instructional style is used where guiding or listening would be more appropriate.

6. *Over-reliance* on one style might prove unfruitful. For example, it might be of value to listen to a child who refuses to get out of the bath, but perhaps not for hours while the child and the water get cold!

7. *Flexible shifting* between styles is probably the norm in most helpful consultations.

8. *Motivational interviewing* can be presented as a refined form of the guiding style, which makes use of both listening skills and an instructional style, geared towards supporting the person's way out of uncertainty about change.

9. Having a clear set of *prioritized or strategic goals* in mind when responding to a complex challenge is often a good idea. For example, when faced with the angry patient described above, most practitioners would say that the first task is to listen, before shifting priorities and considering some other approach to the problem. "Tell me exactly what happened…," followed by some listening will often calm things down and give you time to think. A prison officer told us that while listening to a demanding inmate might not immediately bear fruit, in the long run it would in most cases, because a platform of mutual respect could be built up.

In summary, the three styles provide a conceptual guide to helping communications. It is not a method as such. We are not sure whether it would be fruitful to develop measures of the styles. How and when to use the styles successfully will involve bearing in mind these principles while taking into account the person one is talking to, one's own feelings and preferences, and the context and culture within which the conversation is taking place.

Some Examples Of Style Mismatching

We have encountered a number of striking examples of *mismatching* that might be useful to describe. They illustrate the potential utility of the model.

Blind instructing

The *righting reflex* has been used in the motivational interviewing field to describe the almost reflex-like tendency to use an instructional style to solve problems that are probably best dealt with using one of the other styles. The problem is not with the *righting reflex* or with instruction per se, but with its inappropriate use.

Guiding to a fault

We have met many doctors and patients who report difficulty and irritation when the doctor asks the patient questions like, "What do you think is wrong?" or "What would you like to do about this?" Some patients answer (or say to themselves), "Why ask me, you're the doctor. Just tell me what to do!"

Listening going adrift

Finally, there is the phenomenon of the wonderful listener who follows the meanderings of the client's conversation here there and everywhere, missing opportunity after opportunity to transition into Phase 2 of the consultation.

Opportunities And Limitations

We have found this model to be a useful introduction to our training efforts, and have experimented from time to time with a range of exercises (e.g., formative self-assessment of competence in the styles as you go through training). Its main functions are to legitimize the validity of all styles, including instruction, and to identify motivational interviewing as a refined form of guiding. We often state that the goal of training is to encourage flexibility of communication across and within these three styles.

Like any model that is an oversimplified representation of a more complex reality, one can run into difficulty when discussing its ability to explain or predict behavior or reac-

tions. For example, it is not always possible to take a piece of dialogue and identify which of the three styles it represents. We have no idea whether it is worthwhile to develop measures of the styles. It might be of value to identify the principles and skills involved in using each of them. However, the main purpose at this stage is to resolve the "tell them or listen" dichotomy, legitimize the use of different communication styles, and to make explicit the guiding style; its use often does not come naturally to many people and practitioners, ourselves included. **M**

References

Miller, W.R. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd edition). New York: Guilford.

The Role of Hope in Motivational Interviewing

Carolina E. Yahne

Recently my husband and I watched a film about the life of Gandhi. In one scene, a distraught Hindu man spoke to Gandhi about having killed a Muslim child to avenge the death of his own child. He described himself as being in hell since those murders. Gandhi responded gently, "I know a way out of hell." That is one form of the hope we can provide our clients: that we can help them find a way out of the suffering they have experienced.

Steve Rollnick's comments in the most recent edition of the MINUET (Rollnick, 2004) also reminded me of the collaborative role we play as motivational interviewers. We can join as a team with our patients, using their expertise and ours to "get to the bottom of this" to cooperate and change. Communicating that we offer a *partnership* with clients in exploring and resolving ambivalence can reinforce hope. We jointly share expertise with our clients: we are experts about behavior change and they are experts about their own lives.

The hope of working in a partnership is important. We often reinforce clients' autonomy and responsibility in a motivational interview, but in doing so, do we appear to reinforce their isolation as well? If we say "Only you can decide if you'll make a change," it may sound as if we are abandoning them to their own devices and hence, undermining their hope. We can reinforce their autonomy while offering our support as well.

In a volume Bill Miller edited on integrating spirituality into mental health treatment, Bill and I (Yahne & Miller, 1999) co-authored the chapter *Evoking Hope*. We concluded that hope takes various forms, including hope as will, hope as way, hope as wish, hope as horizon, and hope as action. Perhaps what is most relevant to MI is inspiring hope in our clients as our first duty as clinicians. Our attempt to understand and collaborate with a client's sources of hope is a key element in successful treatment.

In our chapter we described three ways to foster a client's hope: educating, eliciting, and lending. Educating may involve reframing attributions and offering a menu of options. Eliciting involves evoking the client's strengths and affirming past successes that built on those strengths. Lending our hope to clients who feel hopeless has been important. As a good-bye gift at our last session, a client gave me a colorful hand-stitched quilt sampler. She framed it, and on the back of the frame she wrote: "Thank you for believing in me until I could believe in myself." She felt that I had loaned her hope.

There may be cultural differences with regard to hope. Jeremy Rifkin, (2004) opined that Europeans are less hopeful than Americans; that Americans are flushed with hope and optimism (sometimes unexamined optimism) and that Europeans, as a people, are more pessimistic. One of my European colleagues took me aside at a Training for New Trainers many years ago to let me know that my optimistic comments were over the top. It wasn't the first time I'd been accused of being a Pollyanna. Yet my clients and trainees have often borrowed my optimism temporarily until their own hope was available to them. I look forward to more conversations with my MI colleagues about the role of hope in our work. **M**

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Rollnick, S. (2004). Let's hope. *MINUET, 11.2*, 4.
Yahne, C. E. & Miller, W. R. (1999). Evoking hope. In W. R. Miller (Ed.), *Integrating spirituality into treatment: Resources for practitioners*. Washington, DC: American Psychological Association.

MINT Forum 2004
Description and Preliminary Agenda

Jackie Hecht

The MINT Forum is an international meeting that was designed to facilitate the sharing and exchange of ideas related to all aspects of MI training. The main goal is to provide a forum whereby trainers can present their current research, clinical strategies, and training exercises in order to share their work and get feedback from their colleagues.

The agenda for this year's program is almost finalized and includes updates on research findings, demonstrations of new and refined training exercises, panel sessions, and small group discussions on topic areas of greatest interest to the attendees. Sessions span the range from theory to practice and monitoring for treatment fidelity. Unlike other professional conferences that are more formal and structured, the MINT forum is participant-driven, with a major emphasis on networking and collaboration. Trainers of all levels of experience are invited to facilitate and/or participate, and these interactions form the basis for the forum's success.

A preliminary agenda for the Forum is presented below. Also, this year we will be making a special effort to identify participants who are willing to commit beforehand to covering the Forum for the next issue of the MINUET. For more information, updates about this year's program, or to volunteer to write about a particular presentation or discussion for the MINUET, contact me at 401-793-8960 or jhecht@lifespan.org .

MINT Forum Agenda
Portland, Maine
October 28 - 30, 2004

Thursday, October 28

Getting started	09:00 - 09:45	Welcoming new MINTies; Review of Agenda Jacki Hecht and Forum organizers. Big group exercise Facilitator: Steve Berg-Smith
Morning session 1	09:45 - 10:30	Plenary Session: "A Theory of MI" Presenter: Bill Miller
Morning Break	10:30 - 10:45	
Morning session 2	10:45 - 12:00	Plenary Session: "Humble Thoughts from the Steering Committee: Past, Present and Future" Presenters: David Rosengren, Terri Moyers, Chris Wagner & Gary Rose
Lunch	12:00 - 1:30	
Afternoon session 1	1:30 - 2:30	Facilitated Training Exercises - TBN
	2:30 - 3:30	MINUET Actual Symposium: "Values and Motivational Interviewing" Discussant: Bill Miller Panel Organizer: Allan Zuckoff
Afternoon Break	3:30-4:00	
Afternoon session 2	4:00- 5:00	Breakout Topics - TBN Cathy Cole - Distance Learning

Friday, October 29

Early Risers	7:45 - 8:45	Facilitated Discussion Group "Should MINT certify trainers and practitioners? If so, how?"
Getting Started	09:00 - 09:30	Morning Welcome: Jacki, et al Facilitated Training Exercise - TBN
Morning session 1	09:30 - 10:15	Plenary Session: "Communication Styles and Culture Change" Discusion Facilitator: Steve Rollnick
Morning Break	10:15 - 10:30	
Morning session 2	10:30 - 12:00	Facilitated Training Exercises - TBN
Lunch	12:00 - 1:30	
Afternoon session 1	1:30 - 2:30	"Common Threads: Results of a Meta-Analysis of 73 MI Outcome Studies" Presenter: Bill Miller
	2:30 - 3:30	"Engagement Session: New and Improved" Presenter: Allan Zuckoff
	2:30 - 3:30	"Body & Soul: A dissemination project" Presenters: Marci Campbell & Carol Carr
Afternoon Break	3:30 - 4:00	
Afternoon session 2	4:00 - 5:00	Networking/Breakout Groups Chris Wagner, Mary Velasquez, et al.: Group MI

Saturday October 30

Getting started	09:00 - 09:30	Morning Welcome: Jacki, et al Big Group Exercise - TBN
Morning session 1	09:30 - 10:15	"Coding: Experiences from the Field" Presenters: Carol DeFrancesco & Denise Ernst
Morning Break	10:15 - 10:30	
Morning session 2	10:30 - 12:00	Panel Discussion: "What to do about the high rate of false-high-confidence in basic MI skills?" Panel Organizer: Dee-Dee Stout
Lunch	12:00 - 1:30	
Afternoon session 1	1:30 - 3:30	Informal Networking
Afternoon Break	3:30 - 4:00	
Afternoon session 2	4:00 - 5:00	Informal Networking

Steering Committee Update

Gary Rose
SC Chair

Greetings from the Steering Committee! As current chair of the SC, I am pleased to report that we have been busy working on the 2004 MINT Forum meeting and the 2005 TNT's. As you know, we'll shortly be meeting in Portland. Jacki Hecht has been spearheading the effort to organize the MINT Forum meeting and we owe her many thousands of kudos for her hard work. Among the offerings at this year's meeting will be an opportunity to meet with SC members to discuss MINT and to brainstorm regarding the future. One item on our agenda will be to report on the ideas generated by the ad hoc certification committee, a group of MINTies who have been for the past few months struggling with the ins and outs of certification. Jeff Allison has agreed to provide us with a report summarizing the committee's machinations. Thanks, Jeff!!

With respect to 2005, we can announce that the 2005 TNT's are scheduled for 28 August - 3 September in Amsterdam. The tentative plans are to run two concurrent TNT's, with Bill and Steve serving in grandfatherly consultative roles across both TNT's. We also hope to have a MINT Forum meeting scheduled alongside the TNT's.

The SC has been discussing ways to broaden the pool of MINTies with TNT trainer experience. For 2005, we have queried the TNT trainers emeriti regarding interest in functioning as lead trainers. The response has been overwhelmingly positive. Our plan is to select two lead trainers and then work together to bring on other MINTies without TNT trainer experience as cotrainers; we'll be able to discuss this plan further in Portland.

After considering input from Bill and Steve, taking into account opinions expressed by listserv members, and with the concurrence of the authors, the SC has voted to release the TNT training manual for public distribution. This was felt to be in keeping with the spirit of MINT and its emphasis on sharing our knowledge. Terri's prologue does enjoin readers from republishing the materials, and requests proper acknowledgement of the source. The manual will shortly be available on the public area of our website. Chris Wagner and Rik Bes are developing a proposal for dues collection. We hope to roll out a dues collection plan for 2005 in late Fall.

My tenure as SC chair comes to an end with the October meetings. Terri Moyers will then assume the chair for the next six months. See you in Maine! M

Nordic Motivational Interviewing Trainer Meeting

Tom Barth

This was the 4th meeting of MINTies from the Nordic countries. All of the meetings, from the first one in 2000, have been held at the same venue: Christina Näsholm's conference site, a little schoolhouse built in 1927, on the island Reso, in southwestern Sweden. (See www.resogam-laskola.com)

Our meetings begin on Tuesday evening, when we have introductions and a good meal. Wednesday and Thursday we work from 9 - 12 and 14 - 18 (2 - 6pm). Equally important: time for outdoor life, a boat trip, taking walks, and a good meal to end every day; and live Swedish folk-music in the little restaurant on the last night. Friday we work until lunch, and then start for home.

Fifteen MINTies from Norway & Sweden attended this time. Usually there are a few from Denmark as well, but none of them could come this year.

Day 1

Tore Bortveit started, presenting the EMMEE study (Miller et al, in press). This is a study of the effects of MI training in different formats (workshop alone, or with added feed-back and/or coaching). This was followed by discussions of the following topics in small groups of three:

➢ How do the EMMEE results compare with your own experience?

➢ What are the implications for the way we do MI training?

➢ What are some practical ways for us to organize feedback or coaching?

➢ This study (and MISC) has a criterion for "clinical proficiency." What level of proficiency do we think is sufficient?

➢ Since it is obvious that feedback is helpful, can trainees learn to score themselves?

Among the themes that emerged from these discussions: trainees need organised time in the places where they work to do training follow-up; learning MI may not be compatible with trainees' expectations for the learning process; in some cases, we have very limited expectations as to the level of proficiency trainees will acquire as a result of trainings we provide.

Astri Brandell Eklund & Peter Wirbing presented a Swedish project aiming to educate MI trainers in the area of high-risk alcohol use. (Teaching professionals in general medical practise to do short MI-type interventions with patients who have high alcohol consumption; see www.fammi.se.)

Questions were raised about these trainers:

➢ What should be a minimal level of MI understanding, for them to teach others?

➢ What should they teach (the actual content of the training they are going to offer)?

➢ Do they need a special teaching method for this (other than competence in MI)?

➢ How can one work to maintain trainer competence?

We discussed these questions in small groups; some of the themes of the discussions were:

➢ Can one prepare trainees before a workshop — e.g., provide materials ahead of time; demand preparation work? Remind them of what they already have learned in their own MI training?

➢ Maintenance: build a support network. It is unrealistic to expect that all the trainees will actually train others.

➢ Content: make it simple — very simple — only teach one or two strategies.

➢ When training the potential train-

ers three dimensions are important:

- substantial weight on "MI spirit."
- training in the actual content (strategies to be taught).
- motivating trainees to actually go out there and teach others (relapse prevention element in the workshop).

Lena Lindhe Soderlund presented on training personnel in pharmacies to use MI-style communication about health and life-style issues. Elements of the training process she described included:

➢ A standard 2-day MI workshop for a group working in pharmacies.

➢ A smaller group selected to develop adaptation to match work in pharmacy.

➢ Development of a training program and a "short guide" (6 steps for exploring motivation to change — including importance & confidence rulers).

➢ Development of a "report sheet" — a decision tree with little boxes where one can check off which elements had been included in a single intervention.

➢ Training pharmacy workers in a district of Sweden.

➢ Maintenance interventions to keep them engaging customers in these conversations.

Lena showed us a short educational video developed for the project, which featured customers in a pharmacy who were not ready, unsure, and ready to change health-related behaviors. She also described a qualitative evaluation procedure, exploring human and organisational resistance against implementing MI-type communication. This was followed by brain-storming and feedback to Lena from the group.

Sara Paulsson, Jaana Sandholm & Jeanette Johansson presented on "The Scales," a group-based, MI-type treatment programme for inmates with substance abuse. Background was given on the implementation of MI in Swedish criminal justice systems: several preliminary group treatment programmes have been developed into "The Scales-program" — a metaphor for moving to a stage when one considers change. Important questions: How to explore ambivalence in group format? And, can one develop discrepancy in group format?

The program utilizes 2 group leaders with 6 - 8 inmates, meeting 8 times (twice weekly). Participation is voluntary; recruitment is done through a flyer. They have a waiting list. Pre-treatment assessment is done with SOCRATES and URICA (for other behaviour problems). A treatment manual has been developed. After each group meeting, the group leaders meet and make notes on change talk from each individual. Each inmate gets feedback on personal change talk in an individual session at the end.

Day 2

This day had more of a workshop format. The focus was on measuring, scoring, and MI certification.

Tom Barth began with an introduction of MITI (The Motivational Interviewing Treatment Integrity Code). This was followed by a discussion of the question, Do these categories capture the essence of MI as we see it? The group was a little surprised that there is no special scoring category for summaries, and the definition of empathy was also debated.

The group then engaged in individual scoring of the MI video with Bill Miller and John (the man whose company urine drug screen turned up marijuana), with Tom supplying the "correct" codes as we went along. (There is a transcript with codes at the UNM website, and at the MI website as well.) We were surprised at how high our inter-rater reliability was already at this stage. Individual scoring of several sections of our Swedish/Norwegian training tapes, with new reliability checks, followed, and at this point we also discussed why we chose one code and not another. Our coding showed very good reliability, and interesting discussions about the global scores (empathy and MI-spirit) ensued.

In a discussion about possible MI certification, **Tom Barth and Astri Brandell Eklund** told about some of the ideas from the MINT Certification committee. As to the question, "Do we want certification?," the answers were "yes", "no", "ambivalent" or "it doesn't matter what we want because it will happen anyway". Some would rather have a standardised peer-review system. Many questions were raised about how practitioners of other methods prove their qualifications. We considered the problem with those who work with AMI or behaviour change counselling: would they qualify? What about people who work in systems where the "standard 45 minute consultation" is not the working method? We thought these questions were important and interesting.

Day 3

First on the agenda was "How I teach ambivalence." Several people presented their versions of teaching ambivalence — each a short, 5-10-15 minute presentation, primarily focusing on the actual "lecture" or method through which the concept is explained. Some give a little lecture, others only explore/explain the concept through a series of exercises. Small groups then discussed the material and shared their own experiences.

"From the world of MINT" followed: what is happening internationally? It was announced that several web addresses — www.motivationalinterview.no/se/dk — have been reserved by us, and we discussed the question, How can we share them and use them? We then discussed plans for a Scandinavian TNT next year and our thoughts about Nordic trainer meetings in the future. With evaluations and good-byes, our meeting ended. **M**

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... About Change Talk: Part 1

Grant Corbett

Eliciting "self-motivational statements", or "change talk"[1] from clients appears to be (or at least was) unique to the Motivational Interviewing (MI) style (W. R. Miller, personal communication, June 11, 2004). This intentional evocation of client "concern about and desire, intention, or optimism to change" (Miller, 2002) was proposed by William R. Miller in his seminal 1983 paper.

Little was said in that early article about "self-motivational statements", other than they were presumed to help clients "learn what I believe as I hear myself talk" (Miller, 1983; p. 160). Thus, I asked Dr. Miller about his reasons for including change talk in MI (W. R. Miller, personal communication, June 11, 2004):

It was related in my mind to the cognitive dissonance finding that when one publicly verbalizes, without obvious coercion, a position that is opposite to one's own, attitudes tend to shift toward the new position that was defended.

The foregoing suggests three hypotheses on the necessity for eliciting change talk. One, based on Dr. Miller's 1983 quotation, is that clients "learn" their reasons and intention to change in response to counsellor questions and reflections. This implies that the salience or accessibility of thinking affects behavior.

The second hypothesis derives from Janis and Mann's Decisional Balance Theory (Janis & Mann, 1977). That theory proposes that a shift in 'decisional balance', in particular of the pros and cons of change, is critical to movement through the stages of change (Prochaska, 1994; Prochaska et al., 1994).

Research supporting these hypotheses will be outlined in the next two sections. The third hypothesis, cognitive dissonance, and implications for clinical practice will be saved until the next issue. In that column, Change Talk: Part II, we will look in more detail at Paul Amrhein and colleagues' (2003) research. That study, perhaps the first to predict subsequent behavior change by the frequency and strength of client commitment language in therapy sessions[2], is a critical step in understanding MI effectiveness.

Salience of Reasons and Stated Intentions

In a 2001 study, Kahler had 47 excessive drinkers generate and recall reasons and information supporting and opposing reduction in alcohol use. He found that "participants who had spent more time during the last month thinking about why they would want to change their drinking were more able to generate reasons to change." (p. 115). Kahler concluded, "[A]ccess to information supporting change in drinking depends on frequent conscious retrieval..." (p. 115).

Kahler's study underlines that our clinical activity may not need to cause clients to generate reasons for change but rather to 'evoke' existing thinking. Perhaps it is not coincidental that Miller & Mount (2001) refer to the open-ended questions, affirmations, reflecting, and summarizing (OARS) used in MI as "evocative skills" (p. 458)?

Are client verbalizations of existing thinking necessary for change? Change talk is elicited by a number of proposed questions; for example, a counsellor might ask:

➢ Evocative questions: "What do you make of that?"

➢ About the pros and cons: "What is good and not so good about ...?"

➢ For elaboration: "Could you tell me why that was a concern?"

➢ For the worst-case scenario: "What is the worst that could happen if...?"

➢ Clients to look forward: "If you didn't take this medication, what ...?

➢ Clients to look backward: "Have there been other times when...?"

Research on the "generation effect" and Reasons Theory appear to suggest that expressing reasons increases the accessibility of thinking for decision making. For example, "generation effect" studies have looked at the influence on memory of asking subjects to complete or modify thinking, rather than providing them with the information to be remembered. Eliciting existing attitudes and beliefs appears to be the critical factor in the robust effect of "generation" on memory (Lutz, Briggs & Cain, 2003).

James Westaby (2002) in a series of studies in support of Reasons Theory, showed that accessible reasons "explained 55% of the variance in attitudes" (p. 1098). Thus, evoking change talk may increase accessibility of reasons to change in memory.

However, accessible attitudes without a stated intention may be insufficient for behavior change. In an analysis of an MI study, Amrhein and others (2003) showed that client statements of "perceived ability, desire or need" (p. 873) did not predict change, but intention did. The latter needed to be evoked with "commitment strength ... arising in part from therapist requests concerning information about the client's intentions" (p. 873).

"Self-prophecy effect" and intention-behavior theory research has also reached similar conclusions. For example, Spangenberg, Sprott, Grohmann & Smith (2003) found that a self-prophecy, that is an intention elicited by the question "Will you X?", predicted behavior. However, they concluded, it was not the priming of need, but rather the statement of intention, that was responsible for the effect.

Several meta-analyses have looked at studies where intentions were elicited and subsequent behaviors assessed. These reviews report correlations between intention and behavior of between .47 and .53. The implication is that stated intentions account, on average, for up to 28% in the variance in behavior (Ajzen, Brown and Carvajal, 2004).

One might conclude that only commitment talk is necessary and expression of need is not. However, the salience of reasons appears to be a necessary pre-condition to commitment. Three lines of research support this belief. Studies on the impact, or biasing effect, of questions on relevance, reasoning and decision-making comprise one line. For example, Fitzsimons & Shiv (2001) examined the impact of asking "hypothetical questions" on respondents' subsequent decision-making. They found that those who participated in question-guided cognitive elaboration, as

occurs in MI, exhibited greater behavior change compared to those who did not receive it.

The use of questions is common to MI, "Self-Prophecy Effect" and other research referenced in this column. Asking questions about thinking implies client expressions of reasons for change, and these are the basis for commitment.

Amrhein's and colleagues' research (2003) also supports the need for both types of client talk (reasons for change and commitment):

> Commitment strength is influenced by the strength of its underlying dimensions...client desire, perceived ability or self-efficacy, need and reasons. (p. 873).

As Bill Miller stated 20 years ago, "I learn what I believe as I hear myself talk." (Miller, 1983; p. 160).

The third area supporting the need for expression of reasons is research relevant to Decisional Balance Theory.

Decisional Balance: Stated Benefits of Change

Asking a person's perceptions of the costs and benefits of changing has been shown to be associated with change in prospective studies (e.g., Cunningham, Sobell, Gavin, et al. 1997; Rollnick, Morgan, & Heather, 1996). Prochaska and colleagues (1994) found that across 12 problem behaviors there was an increase in evaluation of the pros of changing prior to a person moving into the Action stage of change. Thus, they conclude:

> These results suggest a systematic approach...First, intervention should target the pros of changing, which should lead to progress from precontemplation to contemplation. Once such progress has occurred, intervention should then target decreasing the cons of changing, which should lead to further progress from contemplation to action. (p. 44)

In the Manual for the Motivational Interviewing Skill Code (MISC) 2.0 (Miller, Moyers, Ernst & Amrhein, 2003), six kinds of change talk are mentioned. These six kinds of natural speech reflect:

1. Desire to change (D+) or not to change (D-)
2. Ability (A+) or inability to change (A-)
3. Reasons to change (R+) or reasons not to change (R-)
4. Need to change (N+) versus lack of need for change, or a need not to change (N-)
5. Taking steps toward (T+) or away from change (T-)
6. Commitment to change (C+) or not to change (C-)

Positive forms of three of the first four types of change talk, captured in the acronym DARN, imply or explicitly state benefits of change (i.e., Desire, Reasons and Need). Self-efficacy (Ability) is an expression of a person's confidence that he/she can avoid or counter the costs of changing, the other side of the decisional balance. Thus, eliciting DARN statements is consistent with Prochaska and colleagues' recommendation to evoke a person's pros

and cons of changing, which are associated with motivating progress to Action.

Taking steps and commitment talk have been shown to be independent predictors of change in research by Paul Amrhein and colleagues (2003). Thus, we will look further at their study's implications in the next issue, in Change Talk: Part II. **M**

Notes

[1] The term "change talk" replaced the phrase "self-motivational statements" beginning with the second edition of the book *Motivational interviewing: Preparing people for change* (Miller, 2001; p. 1).

[2] Also published in 2003 was Jeger, Znoj & Bern's study on "action control sequences", a form of commitment language in psychotherapy.

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Reflections on Supervising & Implementing MI into Agency Life

Kathyleen Tomlin

One of the primary goals of our department in the last several years has been to increase the skills and expertise of staff in the application of MI to their work with clients. Recently, in a management meeting, an applicant for an open position was asked to step into the room and meet with our team. Prior to having the candidate come into the room, our Clinical Director had stated how excited he was about this candidate, since she seemed "very knowledgeable" about MI and the Stages of Change theory (Transtheoretical Model of Change, TTM). However, when she responded to questions about her knowledge of MI and how she saw it working with clients, her summation was, "Oh, it is basically providing a structure to keep us client-centered. Start with where the client is at and help them move to recovery." She then went on to speak of the stages of change, going through each stage and identifying the therapist's goals for that stage as it relates to the process of "recovery."

As I listened I struggled to keep my opinions to myself, to avoid creating more stress on the applicant or embarrassing my boss. The applicant had minimized and misunderstood the spirit, style, and principles of MI. Her answer lacked depth of understanding, including the idea of having recovery (in the traditional sense of lifelong commitment to abstinence) as the only goal for treatment. Additionally, her description of MI was blurred with a description of the TTM, making it clear that she did not realize that the two were not interchangeable.

I couldn't help but feel disappointment about the interview. Mind you, we have a very supportive administrative structure. Our team has spent years learning MI, using my skills as a trainer, looking at what works within other systems, etc. It struck me as odd that, after all the time we have spent, others viewed this applicant as well-versed in MI. Later on in the day, I checked out my perception with a colleague, another supervisor in the department, who has a thorough understanding of the philosophy and practice of MI. He agreed that the applicant's understanding of MI was minimal and her knowledge of the stages of change theory basic.

In the previous few months, our agency had been having some trouble with resistance from certain staff. Additionally, some staff already motivated to learn this paradigm seemed to be struggling with the strategic use of MI, as well as with the whole philosophical approach and changes in thinking that are required being effective. All of this leads to the question, What is a supervisor supposed to do?

A Little Context

Ironically, I have been contemplating what it would take to get the fidelity to MI that is important to its implementation, supervision, and practice for about five years. I have learned some things, and my recent experience with the job applicant confirmed some of my observations.

Both before and since my "MINTie" experience in Rhode Island in 1998, my focus has been on teaching, training, consulting about, and supervising the implementation of MI in a variety of organizational systems. I have been invited into systems of care that serve youth and adults; clients with co-occurring disorders; and adult and juvenile corrections populations. I have helped to train and supervise probation officers, medical staff, and managers interested in improving their practice. In the course of these experiences I have listened to hours of taped counseling sessions from practitioners attempting to use MI in their work; provided live supervision; developed training programs and curriculums for MI group work; and participated in onsite consultation to implement MI into existing agency life. All of these experiences have shaped my thinking about what leads to successful implementation and supervision.

In the course of this journey, I co-authored and published a workbook (Tomlin & Richardson, 2004) designed to address the "how to" aspects of MI with a series of activities that encourage this integration, and that also addresses the movement towards establishing evidence-based practices with client care. What follows are common themes that keep coming up as I travel through the various agencies and organizations as they ready themselves to move towards evidence-based care and becoming more client-centered. My hope is that those of us who are able to attend the MINT forum in Portland can meet and continue sharing our experiences.

Successes

➤ *Start with where they are at.* I quickly discovered, as I was teaching MI, that trainees were more familiar with TTM than they were with MI. I often start workshops with an explanation of this theory as a way to engage participants with what they already knew. My next step is to introduce how MI will help them operationalize this theory. What I discovered was that most people did not really know TTM, but had seen the spiral of change or the pie-shaped figure which names the various stages of change. Once I describe the full theory to them, their eyes start to glaze over. Many of the trainees had not engaged in thoughtful consideration of the complexities of this theory and often mixed it up with MI. I then go into how MI is a philosophy about counseling that calls on a variety of theories, as well as a way of intervening but also thinking about change and how this occurs for people. MI, I explain, is a good place to start to build and develop a set of beliefs, attitudes, skills, and strategies that can guide clinicians' work.

Another way I "start where they are at" is by talking with trainees about the 2nd edition of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, which agencies in my area are mandated to apply. Fitting MI into this structure is a way to begin where many clinicians start their work. This particular structure intends to individualize client care, and complements some of the philosophy of MI. Helping clinicians learn MI thus helps them meet other mandates, which increases MI's appeal.

➤ *Build it and they will come.* Training or workshops in themselves do not transfer to the work environment. This, of course, is beginning to be reported in

research findings, and it has certainly been my experience. Follow-up training with concrete plans for implementing services and program structures to increase MI in everyday work life is essential. There are many methods to accomplish this task that can be agency sensitive. Some agencies use existing meetings, such as clinical meetings or supervision, while others create services designed to retain clients in the early stages of change and motivate them through change.

➢ *Demonstrate*. Agencies and staff often ask for models. Though they may agree with and appreciate the principles and direction of MI, many of them wonder how to use it in existing program structures. Over the years I have created many models designed to "fit" the needs of specific agencies. For example, in some agencies, a group was requested as a starting point that would be staffed by specially trained counselors who then interface with other staff, thereby beginning the process of inviting discussion around the underlying beliefs of the agency philosophy of care. Of course, one of the challenges is to move folks from a "program" think (where all clients receive the same services, usually group and often several times per week in outpatient, or in a residential setting where the "program" is a daily structure with little room for variation) to be more client-centered, and these initial "models" are ways to engage systems towards being more client-centered over time.

➢ *Practice with structured feedback and identification of strengths.* Probably the most effective strategy, when staff were willing to participate, was offering clinical supervision with samples of counselors' work with their clients. Helping agencies and clinicians appreciate the importance of structured feedback regarding their MI skills is one of the best ways to help integrate the appropriate use of MI. Although the MITI is a nice tool for giving this feedback, often I found I had to use a series of rating sheets that also reminded people of the basic language of MI and what it translates to in practice. So, I created a series of rating sheets that accomplished this for people: starting with the basics (the OARS with definitions, then addressing Change Talk and identifying traps), and then later, as people gain knowledge and understanding, using a single-page rating sheet with global rating scores from the MISC. Currently we are looking at the MITI as a replacement to our single page-rating sheet, but we have not yet gone in that direction. Balancing feedback with improvement ratings, along with noting of counselor strengths that already put them in the ballpark of MI, is important as well. Many counselors will say they already know the OARS; however, few really know the strategic use of these skills, let alone recognize change talk when it occurs or know what to do once they hear it.

➢ *Ask for change.* One thing that is important for implementation is to ask for change from the identified agency and/or staff group. Counselors are generally compliant people. We like to please others and avoid conflicts. Most often our communication skills are very good. I have found that generally, we like to learn and perfect our skills. Thus, asking for change encourages discussion about the correlation between our clients and us. We continue to benefit from these rich clinical discussions as a result of the request for change from our systems. Having time to talk and contemplate how people change is important while learning MI skills and strategies.

Challenges

➢ *Staff resistance.* Of course resistance to change often arises in systems. This is to be expected. However, what I did learn is that counselors resist for primarily two reasons: one is unspoken or open concerns around competency; the other is that they hold competing beliefs, attitudes and approaches that are counter to MI. Validating competency concerns is easier for me than tackling beliefs that are counter to MI. When confronted with the latter in systems, often I am asked to "fix" this problem. Usually this means, "Can you take care of the staff who do not want to change so that we do not have to?" This is a consultant trap to avoid, the "kill the messenger or you can save us" trap. The "dancing and wrestling" image takes on a whole new perspective when working with organizational change.

➢ *Complex system issues.* The greater the complexity of the organization, the more challenge to making changes. Each change within a system often results in ripple effects elsewhere in the system. A thorough assessment of any system is important to making suggested changes. This can anticipate barriers to change. Fortunately, I have found many helpful tools along the way that can ease this process (e.g., CSAT's *The Change Book*; Dwane Simpson's work from Texas Christian University, at www.ibr.tcu.edu; the TTM web site at the University of Rhode Island; Rogers' (2003) work on diffusion of innovations). I have also developed some myself.

➢ *Lack of supervision.* Supervising the practice of MI while one is also learning MI is a barrier to implementation. Supervisors will often confide to me that they believe they are learning along with the staff, and this upsets their sense of confidence in their role. Researchers tell us, and I concur, that organizational change works best when the "authority" within the system has buy-in. Agency life can be particularly challenged when confronted with the idea of clinical supervision related to the implementation of a skill-based best practice, such as MI. For example, those who hold the title of clinical supervisor in agencies have many non-clinical tasks, such as staff scheduling, time cards, personnel issues, etc. Time to devote to the clinical practice takes a back seat to other, more administrative tasks. Sometimes this is due to the priorities of the director of the agency; sometimes it is because the supervisor feels more competent with administrative tasks, or administrative tasks can be "done," where clinical supervision of others is longer, more involved and takes time. If the clinical supervisor is also carrying a caseload, this will further erode time to attend to developing counselor skills.

As mentioned earlier, MI in practice takes on a whole new meaning when practice means submitting samples of work that will be rated to provide concrete learning and improvements. Time to think and rate tapes, competency concerns, lack of supervision skill, lack of knowledge or motivation, and other work pressures easily overtake supervisors' time to work with their clinical teams around implementing MI. It is helpful to build in incentives, encourage, and address and reinforce commitment to any process of change for supervisors as well as for line staff and upper level managers. There are many creative ways this can be accomplished in any system. The trick is to avoid the traps of "this is part of your job" (guilt) or "find time" (mandates).

➤ *Sustainability*. External pressures to change often move agencies into action. Getting change that actually benefits the system over time is also tricky. What can systems build in, that will ensure that the changes they are involved with now will remain? I often revisit systems and organizations that I assisted in their early process of change and ask them if our work together resulted in lasting change. Those that say yes have told me it was a key staff member or manager, coupled with a structure we developed, that kept the innovation going over time. For example, many have stated that getting the group that restructured their concept of client change really helped, that having feedback on skills developed was important, and that a management and supervisory system that encouraged ongoing development was a help. Agencies whose staff shared a value of excitement about change for client care improvements, or who could appreciate regulations that shared the value around high quality client care, fared better than those who saw the change as a nuisance or an interference with what they already thought was working. One trap to avoid is being too simplistic about sustainability issues. Inserting a group, or specially trained staff, does not, in itself, address the larger organizational problems of changing how we think about and value the work we do with our clients.

Final Reflections

As I sit here writing this, I realize there is much more that could be discussed about these issues than I am able to write here. I started my process of becoming a trainer with my reading of the first edition of MI in 1992. Little did I know that my journey would lead me to becoming a first time author, writing about system change and how people change, and renewing a relationship with one of my early mentors in life. Philosophically, my commitment to MI really is about my change as a person, a counselor, and teacher. I hope that I will have the opportunity to hear others' stories as we proceed in this journey together. **M**

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Helpful Web Pages with links to other resources on organizational change and change toolkits

1. National Addiction Technology Transfer Centers Web page: www.attc.org
2. Northwest Frontiers Addiction Technology Center web page: www.nfattc.org

Training Corner

A New Training Experience Many Miles from Home

Jacki Hecht

In mid-March I received a phone call from my esteemed colleague, Ken Resnicow: "How would you like to do some training in South Africa?" he asked. My initial reaction was one of excitement and intrigue, but was soon followed by fear of the unknown and self-doubt. After a short deliberation with my family, I nervously accepted this assignment. My preparation consisted of email contacts with the Project Director, Dehran Swart, who lives and works in Cape Town. With minimal background information and little turn-around time, I responded to the requests, and pulled together two 2-day and one 1-day training workshops for nurse midwives, physicians, and public health educators. All the while, I had a nagging feeling; I really don't know much about these practitioners, the issues they face, nor their diverse cultures and languages. An email exchange with a South African researcher who works with nurses indicated that many of the nurses feel over-worked, spread too thin and that they don't have enough time to spend counseling patients about smoking. Ahh, a familiar sentiment.

Given this golden opportunity to visit South Africa, I decided to take my entire family and turn it into a learning experience for all of us. We applied for our passports, received the appropriate immunizations, and made arrangements with my children's teachers (2 children in 6th grade and one in 3rd) to have them journal about their experiences during the 2 weeks they would be out of school. On May 30, we flew half way across the world into the unknown.

Every Road Has Two Directions

A brief meeting with the nursing supervisors on the day I arrived made me feel a bit more confident that I could deliver a successful training. Nonetheless, I continued to have this gnawing feeling that I was under-qualified to train these nurses. After all, what did I know about their lives, their working conditions, and the issues they were grappling with? I realized, though, that on some basic level, this experience was no different than the trainings I do here in the U.S., and that feeling prepared was partly an illusion. I had to keep reminding myself that MI training was more about the willingness to remain open, inquisitive, and flexible enough to identify and meet trainees' needs, rather than offering prepared "solutions." What was different here was the limited time I had to prepare and learn about the contextual issues within which this training was being conducted. The best I could do was to share my experiences and try hard to listen and observe carefully, in hopes that I could learn something about their needs and that together, we could figure out some new approaches that might be worth testing out.

As I worked through the first day of training, I tried to engage as many of the participants as I could; the more I could get them talking, the more I would learn about their diverse perspectives and needs. After introductions and a brief, didactic overview of MI, I had the group break into pairs to practice a basic listening exercise. One nurse talked for 2 minutes about something she was struggling with (or felt mixed about), while the other listened without speaking. At the end of 2 minutes, the listener provided a brief summary of what she heard, and then they switched roles. In the debriefing of this exercise, the nurses commented on how hard it is to listen attentively without asking questions and interrupting. In addition, they noted how much they could learn about a

client's needs and motivations in a short period of time, and how much self-insight they were able to gain by having an opportunity to tell their story.

After further reviewing reflective listening, we broke into groups of 4 or 5 to do an exercise called "four chairs," which I adopted from Ken Resnicow. One person, again, talked about something she was struggling with. The first listener responded with an advice statement (e.g., "you should"), the next listener with a content reflection, the third listener with a "feeling" reflection, and the fourth listener just observed. The most common revelation for the nurses was that the advice statements came most easily, as these were the ones most commonly used with clients. However, most of the nurses concluded that this response was least favored by the speakers, and that if they had to go back to talk about this issue again, they would prefer to go to the nurse who validated their feelings. We spent some time in the afternoon discussing these observations and how these may or may not apply to the clinical situations they encountered. Despite their busy schedules and minimal time spent with clients, many were starting to identify opportunities where they could try some of these listening skills.

We opened day two by having the nurses share their insights from the previous day. We reviewed some of the basic tools that could be used, such as decisional balance, agenda setting, rating importance and confidence, and strategies for handling common objections they were accustomed to hearing. Afterwards, I invited a volunteer to come up and participate in a demonstration of how these "core" skills could be integrated into a brief encounter to address a behavior change that this nurse was struggling with. I then gave nurses time to practice putting these skills together. To further their thinking on how they might use these strategies with clients, I showed the "good doc, bad doc" video from the MI Professional Training Videotape Series (Tape E). This generated laughter (more like disbelief at the bad doc's performance) and further discussion. We ended the training with a rich discussion (that included the nurse supervisors) about ongoing support and additional training/skills-building the nurses might need to further their work in this area.

In debriefing the training experience, the most frequently made comment was "you really opened my eyes" to new ways of interacting with clients. What they wanted more of was to practice and continue to use attentive/reflective listening in place of "you should" statements (or unsolicited advice).

It Takes Time to Learn the Obvious

In comparison to training workshops back home, where I often find that I am racing against the clock to pack it all in, here I opted for a simpler, slower-paced approach. Somehow, it seemed fitting to go with a "less is more" philosophy, which is not my inherent style. By early afternoon, we had accomplished the basic exercises that I had prepared, with everyone having multiple opportunities to share and practice. Faced with a decision about how to proceed, I offered the nurses an opportunity to keep going, or end the day early, giving them a chance to mull over what they had discovered, and have some private time to themselves (which I sensed would be a rare treat). While they opted to end early on both days, nearly everyone returned for the second day of training, refreshed and eager to participate.

For one of the first times in my training career, I truly felt that I had learned to dance with my participants. The mutual guiding and following went back and forth, and we maintained this rhythm throughout the workshops. Despite my initial trepidation and doubts, these three training experiences proved to be my most rewarding. What I learned most was the value of slowing things down, creating time and space for trainees to truly digest their new discoveries.

I want to offer a huge "thank you" to Ken, and all of my other colleagues who have conducted training workshops in other countries. Your stories and experiences have inspired and enabled me to achieve this remarkable feeling. **M**

Research Roundup

Large Scale Research on MI in Swedish Prisons and Probation

Lars Forsberg & Carl Åke Farbring

Implementation of Motivational Interviewing in Swedish Corrections

The Swedish prison and probation administration has invested a lot of interest in the use of MI in its service. Bill Miller met with almost all superior head staff during a conference in December, 2001. Most client-related staff have had the opportunity to attend a 3-day workshop during the last 3 years. Feedback has been overwhelmingly positive, and we think it's fair to say that MI today is widely known and the most favoured method per se, and also used as a complement to evidence based programmes in the organisation. More than 100 internally trained people have received training as trainers by, among others, Steve Rollnick, Jeff Allison and Tom Barth.

The drug situation in Sweden as a whole deteriorated severely during the 90´s, and as a consequence the government funded a launch of 100 million SEK (~12 million USD) to reduce drug use in corrections. Part of the money was used to employ 46 people to work half time with MI, often combining the other half with evidence based programmes or assessments according to the widely used Addiction Severity Index (ASI). They are supposed to work with clients to some extent, but mainly to train and support others to work specifically with MI. A manual and an exercise book, *Beteende - Samtal - Förändring* (BSF) (i.e., *Behaviour, Interviewing, and Change*) (Farbring and Berge, 2003) was authored to guide practitioners through the learning of MI (metaphor: as the owner of a new driver's license you need to practice to

become a skilled driver), but also as a stand-alone intervention for drug users. The work with this manualised "driver´s guide" through MI is the main instrument of the present implementation. Along with the manual, the chapter on "Motivation - a Scientific Analysis" (Viets et al., 2002), as well as *MI2* (Miller & Rollnick, 2003), have been translated into Swedish (Farbring) and made available to all interested MI-practitioners in corrections without cost (externally the price is 220 SEK). An informative booklet has been produced to increase interest among clients to apply and participate in the intervention. Ken Resnicow´s "One-Pass" treatment fidelity rating system supplements the BSF manual with his very kind permission, to stimulate practitioners to get together in peer groups and help each other by listening to tapes and thus enhance MI integrity. A strategy for doing this is suggested in the manual and is a prerequisite for future local funding of the program all over Sweden.

However, we do not know if MI will result in clients giving up drug use and criminality more often than before. We do not have much research about MI with clients serving sentences (Mann & Rollnick, 1996; Ginsburg, 2000). The interesting thing now is that the government has asked for evaluation of how the money has been used, and made evaluation a prerequisite for continuous funding. Thus, 1.5 million SEK has been allocated over the next two years by the prison and probation administration for research on the effects of the MI implementation. Lars Forsberg, from the Karolinska Institutet, carries out this research, and we would like to briefly inform readers of the MINUET about the research. Certainly we are also hoping for comments from this highly skilled network of trainers and researchers.

The purpose of the research is to evaluate if there are any effects of MI on drug use and relapse in criminal behaviour. Three studies are planned. In two of these studies, in prisons and in probation, the MI/BSF programme is evaluated with respect to reduction of drug use and crime. The study of MI in prisons is on its way now and is described below. The study of MI in probation is planned to be a replication of the prison study and is not described further. In a third study the use of MI in everyday prison situations is evaluated, e.g., with respect to reduction of destructive conflicts on the ward, etc.

Study 1. Effects of Motivational Interviewing in Prisons

Study questions:

1. Does motivational interviewing lead to better effects with respect to drug use and relapse in criminal behavior after release from prison compared to treatment as usual?

2. Does systematic feedback based on taped MI-sessions enhance MI skills?

3. Are more skillful MI sessions related to increasingly stronger commitments from clients during the sessions to give up drugs and criminality?

4. Is client commitment during the MI sessions related to reduction of drugs and crime after release from prison?

The Regional Ethical Committee in Stockholm has approved the study of the effects of the BSF programme in prison, and clients in ten prisons all over Sweden are now being recruited for the research. Factors that were important for inclusion of prisons were geographical situation, length of sentence of prisoners, presence of a local MI trainer, available resources (not concentrating all resources on other evidence based programmes). A coordinator in each prison selects clients who meet inclusion criteria and asks them if they are willing to take part in the study. To be eligible, clients

➢ must not have been sentenced to expulsion from the country

➢ must not have had the BSF intervention in remand or any other prison

➢ must be born between January 1, 1954 and December 31, 1984

➢ must have conditional release prior to June 30, 2005

➢ must be drug and/or alcohol dependant

➢ must speak "Scandinavian"

The coordinator assumes responsibility regarding the client's undertaking of ASI, and will inform the client verbally and in writing about the study and ask for consent. Clients who agree to take part in the study will be randomised to one of the following alternatives:

1. Five semi-manualised interviews about the future ("treatment as usual")

2. Five BSF/MI interviews.

3. Five BSF/MI interviews carried out by staff who will receive feedback and support based on taped sessions with clients.

Primary outcome data are measures of drug use and relapse in criminal behavior. The measures are change in index points between baseline and 10 months after conditional release on the alcohol, drug, and crime scales of the ASI. Secondary outcome measures are change in index points on the ASI scales of physical health, psychological health, family and friends, work and maintenance of support, as well as measures of drug use in urine and hair samples, consumption of medicine, and indices of misbehaviour and change in motivational status according to the MAPS (Monitoring Area Phase System) (Öberg, 1997). For clients randomised to any of the two BSF-groups motivational status also is assessed according to SOCRATES, URICA, and graphical estimates of position in the Stages of Change model.

Practitioner skills of motivational interviewing will be assessed according to the Swedish translation of Motivational Interviewing Treatment Integrity Code (MITI) (Moyers et al., 2003). "Blind" coders will code a sample of the recorded tapes of the interviews. The inter-coder reliability will be calculated for two independent coders. The interviews will be categorised in 1) not using MI 2) good use of MI. Guidelines for good use of MI include accurate empathy, good MI spirit, more open than closed questions, more reflections than questions, and more complex than simple reflections.

Client reactions during interviews will be assessed according to a Swedish translation of Paul Amrhein's linguistic analysis (Amrhein, 2003). A Swedish taxonomy is included in the BSF manual. Interviews will be divided into deciles and coded with respect to change talk, specifically commitment language (*do language*) and intent to continue or stop using drugs or criminal behaviour. Also here we will calculate inter-coder reliability. Change talk will be related to actual outcome with respect to recidivism in crime and drug use.

The recruiting of clients started in April of this year, and the target is to

randomise at least 50 clients in each condition. Staff at each prison have been asked about their interest in performing any of the above conditions, i.e., randomisation of clients and/or other research activities (e.g., register data, be a coder etc.). The first interview series have now been carried out. The research activities take place in a context where ordinary daily work in the prisons is a clear priority, which may be an obstacle to the research activities. Research is often seen, by a lot of staff, as a less important daily activity in the prison, and therefore research needs to be implemented and continuously monitored and supported! However, there is also a strong enthusiasm and energy in the research group, now consisting of about 120 people.

After about one month it seems that about 50% of the clients who have been asked about consent, have agreed to be a part of the study.

Study 2. Effects of Motivational Interviewing in Probation

Study question:

1. Does motivational interviewing lead to better effects with respect to drug use and relapse in criminal behavior after release from probation compared to treatment as usual?

The second study resembles the first one, but clients will only be randomised to one of two alternatives:

1. MI/BSF manual with feedback on tapes.

2. Probation as usual (which may contain MI counselling but not according to the BSF manual).

Study 3. Effects of Motivational Interviewing on Everyday Situations

Study question:

1. Is the atmosphere on wards where staff have been trained in using MI in "difficult" situations better compared to wards where the staff has less MI training?

This study is a single case research design with 10 wards, which are followed over a study period of one year. Every month each ward is assessed in the dependent variables. All the wards are going to be trained in applying simple principles of motivational interviewing (along the instruction — listening continuum) to significant everyday situations. The time period for the training of each ward is randomised. Thus, the hypothesized effects of motivational interviewing on everyday situations will appear on dependent variables at about the same time as the ward has been trained. The wards are their own controls and the data before the training is compared with the data after the training.

Staff of one of the prisons have helped to select and describe significant everyday situations, where motivational interviewing might facilitate handling the situation.

The Swedish prison and probation administration presently collaborates as a partner with the University of Wales and Steve Rollnick in developing an interactive training program, aiming to help prison officers specifically to apply simple principles of motivational interviewing to everyday situations. Working with the interactive training program will take about 4 hours, and the plan is that a short manual containing individual tasks, monitored and supported by local MI-trainers, will supplement it.

The primary outcome measures consist of two short questionnaires about the relations between staff and clients, one answered by the clients and the other one by staff on the ward. A secondary outcome measure is a short burnout syndrome inventory of 10 items - MINI-OLBI. We would be grateful for suggestions on more ways to measure the climate of the wards.

It is a Challenge to Implement MI into the Swedish Corrections System

This kind of research has, to our knowledge, not been done before. Our studies of effects of MI in Swedish corrections may very well come up with results that do not favour MI compared to "treatment as usual". That kind of result will hopefully stimulate more thinking about how to implement MI and evidence based programs in real life situations and specifically in criminal justice, rather than giving up on the idea. However, another possible result is that we receive confirmation that MI really works in helping clients in difficult life situations to achieve a healthier and more pro-social life style, and that would very likely serve as an example for other similar organisations in Sweden and in neighbouring countries as well to do the same. We know already that other criminal justice organisations in Europe are following this implementation and the outcome of it with great curiosity. It certainly gives rise to interesting implications of culture change and efficacy in corrections. **M**

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Reflections on Coding

Carol DeFrancesco and Rosemary Breger

Over the spring and summer, six members of our research staff completed an MI coding project. Our task was to code 300 tapes from five different institutions (all part of the National Institutes of Health (USA), Behavior Change Consortium), using the new Motivational Interviewing Treatment Integrity (MITI) coding system. We made ourselves Mighty (MITI) Mouse T-shirts, came up with a cheer ("We are MITI coders, we know we're the best, if you can record it, we will do the rest . . . Gooooooooo Coders!"), and wrote a short skit, satirizing how the group would resolve coding differences (e.g., Sumo wrestling, throwing dice). All these activities provided some comic relief to the daunting task of learning a new coding system, establishing reliability, and listening to a big pile of tapes.

To gear up, our group of MITI coders met for 40 hours of training exercises over approximately two months. We studied the MITI manual and met frequently for practice and skill building. We began by coding tapes with transcripts that had been expertly coded at the University of New Mexico (UNM) and then moved to coding study tapes both as a group and individually. We spoke with Denise Ernst regularly to check our decisions with UNM. After our initial training on UNM tapes, we coded sample tapes from each study site.

The study site populations varied from young mothers to middle-aged fire fighters. The interactions took place in homes, fire stations, clinic offices and over the phone. To handle this diverse sampling of tapes, we trained and established reliability using tapes from one site at a time and then coded all the tapes from that site. We repeated this process for each site, allowing us to identify if a particular coder was losing consistency over time and to test if our reliability was drifting for a specific dimension. This process required an additional two weeks for each study site.

Once we graduated from our training exercises and started coding the 'real' study tapes, we found one of the biggest challenges to be background noise on audiotapes. Fire alarms, crying babies and TV noise sometimes created a cacophony in our earphones. If a tape was too difficult to hear, we would throw it out of the coding mix, a solution we resorted to infrequently.

We expected the project of coding tapes to be a bit like eating lima beans — one of those 'greater good' kind of tasks but not too palatable while doing it. Some of the tapes lived up to our 'lima bean expectations,' but most were far more interesting.

The coding experience, for us, reinforced the tenets of MI. Listening truly is one of the most profound ways to affect change. The interactions we witnessed underscored this. When clients were not heard the change process seemed to stall or was not reinforced to the extent that it could have been. When curious, non-judgmental listening was achieved, the interactions seemed charged with an energy that approached love.

To sit as a coder was in many instances, a privilege — to listen in on the process of change, to witness struggle and discovery, to observe empathy and compassion, to be frustrated by roadblocks, to grow irritated with missed opportunities or rigid agendas, and to be instructed by human interchange. Coding could be interesting — a bit like watching a small weather system move onto land and feeling the curiosity and anticipation of what would unfold. In the string of tallied utterances, stories were told — deep and personal stories about failure, humility, endurance, reflection, and progress. We were examining the ingredients of change, and we were thankful for counselors and clients courageous enough to have their sessions examined in such detail. Denise Ernst and Carol DeFrancesco will discuss the results of this coding project at the upcoming Maine MINT meeting. In light of the withdrawal of the UNM from the coding business, the Oregon Health & Science University coding team has decided to 'hang up its shingle' as 'MITI good coders'. **M**

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Virtual Symposium

Values and Motivational Interviewing: A Symposium
Bill Miller
University of New Mexico, Albuquerque, New Mexico, USA

Values and MI: Need We Always be Arm-Twisters in Recovery?
Jeff Allison
Jeff Allison Training Ltd., Edinburgh, UK

Value Conflict and Value Awareness in the Helping Professions
Hal Arkowitz
Department of Psychology, University of Arizona, Tucson, Arizona, USA

Discrepancies and Values
Tom Barth
allasso.no, Bergen, Norway

Subverting Values in MI: The Ethics of Changing Personal Narratives
Joseph W. Ciarrocchi
Department of Pastoral Counseling, Loyola College In Maryland, Columbia, Maryland, USA

If Giants Grumble, Will Values Tumble?
Chris Dunn
Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington, USA

Values and MI
Carl Ake Farbring
Swedish National Prison & Probation Administration, Täby, Stockholm, Sweden

M.I. Values or Yours?
Mark Farrall
Ignition Creative Learning, Cardiff, Wales, UK

How Neutral Is Neutral?
Steve Gilbertson
Incouragement Communication, Colorado Springs, Colorado, USA

The Directive/Non-directive Paradox
Tad Gorske
Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA

The Burden of Making Choices Under Ambiguity
Hiro Harai
Division of Clinical Research, Kikuti National Hospital, Kumamoto, Japan

Values and Priorities Clarification within the Spirit of MI
Patricia Juárez
Universidad Autónoma de Ciudad Juárez, Juárez, México

Valuing Values
Jon Krejci
Department of Psychiatry, University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, Piscataway, New Jersey, USA

MI and Counselor Values
Patricia Lincourt
Northeast Psychological Associates, Albany, New York, USA

Social and Political Contexts
Jim McCambridge
National Addiction Centre, London, England, UK

The Dark Underbelly of Therapist Neutrality in Motivational Interviewing
Terri Moyers
Department of Psychology, University of New Mexico Center on Alcoholism, Substance Abuse and Addiction, Albuquerque, New Mexico, USA

Values, Trainees, Clients and Me
Michael Peltenburg
Family Physician, Hinwil, Switzerland

The Space Between: Personal Values and MI
Joel Porter
Centre for Gambling Studies, University of Auckland, Auckland, New Zealand

The Primary Care Physician Responds
Richard Saitz
Boston University Schools of Medicine and Public Health and Boston Medical Center, Boston, Massachusetts, USA

MI & Informed Consent: Getting Traction on a Slippery Slope
Paul J. Toriello
Department of Rehabilitation Counseling, Louisiana State University Health Sciences Center, New Orleans, Louisiana, USA

Some Thoughts on the Ethics of Influence
Chris Wagner
Departments of Rehabilitation Counseling, Psychiatry and Psychology, Virginia Commonwealth University, Richmond, Virginia, USA

Anti-Oppression Values Find a Seat at the MI Roundtable
Stéphanie Wahab
College of Social Work, University of Utah, Salt Lake City, Utah, USA

Thoughts on Influence
Henny A. Westra
Department of Psychology, York University, Toronto, Ontario, Canada

Whom Should We Train?
Allan Zuckoff
Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA

Love with a Goal
Bill Miller

Values and Motivational Interviewing: A Symposium

Bill Miller

Over the years our research group has been giving increasing attention to the role of values within motivational interviewing. Exploring client values is an excellent vehicle for MI, in that it can illuminate deeply held values that are important potential sources of behavioral discrepancy, as the work of Milton Rokeach (1973) so beautifully illustrates. For his dissertation, Frank Sanchez (2000) developed and evaluated a values-based form of motivational interviewing. Denise Ernst (2003) examined value-behavior consistency in her master's thesis, and developed a clever system for deriving vector scores from the values card sort. If MI truly does work by developing intrinsic discrepancies, this should be quite a fruitful avenue for future research.

What has received less attention, I think, is the role of counselor values in MI. Some may believe that client-centered counseling is value-free from the clinician's perspective. The counselor simply follows and facilitates the client's own exploration. Personally, I agree with Allen Bergin (1980) that there is no such thing as value-free therapy. An intervention that claims to be value-free is one in which the implicit values have not been adequately explicated and made explicit. I believe that it is virtually impossible to provide client-centered counseling in a value-free way. As soon as one gets very far into the process, there are so many choices that are necessary. Which content should I reflect? Which avenues should I explore? Ten volleys in, a skillful reflective listener is already faced with a catacomb of possible directions. The directions chosen are neither random nor value-free (Truax, 1966).

MI is precisely about being conscious and intentional in choice of direction within a client-centered manner. From the beginning, it has been the directive component and intention that distinguished MI from "nondirective" Rogerian counseling. To be sure, there is value in love without a goal, and there is a large territory within which client-centered counseling is properly nondirective in intent, if not in practice. Consciousness of the directive dynamics of MI should, in fact, be helpful in maintaining equipoise when that is the appropriate counselor stance.

MI highlights, however, that equipoise is not always the optimal or actual value position of the counselor. When a client walks through the doors of the UNM "Center on Alcoholism, Substance Abuse, and Addictions" the broad implicit goals of therapy are no mystery. One can haggle about abstinence, moderation and harm reduction, but clearly the helpers who work behind such a title are there to reduce the human suffering caused by substance abuse and dependence. That is the announced (or at least implied) value of the program and it staff.

Program values are not always made so explicit. In the United States, for example, we have a range of family planning and pregnancy counseling programs that often have rather generic titles. These programs vary on their relative acceptance of various options for a teenager with an unplanned pregnancy. A woman may seek help from a faith-based program, to find herself counseled that abortion is morally wrong in all circumstances. Sometimes a program's value stance is apparent from its name and literature, and sometimes it is not.

In the second edition of *Motivational Interviewing*, Steve and I added a chapter to address some of these ethical issues in MI. We specifically argued that ethical complexities increase with each of five conditions: (1) the counselor has an *opinion* as to the desirable outcome; i.e., equipoise is absent; (2) the aspirations of client and counselor differ; (3) the counselor has an *investment* in a particular outcome, (4) the counselor's per-

sonal investment potentially conflicts with the client's best interests, and (5) the counselor has coercive power to influence (e.g., by consequences) the direction that the client takes. We judged that it is inappropriate to practice MI under certain combinations of these conditions.

Consider a case example. The director and staff of a prenatal care clinic firmly believe that alcohol/drug use during pregnancy places the unborn child at significant risk. The pregnant women who are referred to them are using various combinations of alcohol, tobacco, amphetamines, cocaine, and opioids. The women are usually ambivalent about their drug use, and often about the pregnancy as well. The director of Clinic A wants her staff to learn motivational interviewing in order to help women decide not to drink, smoke, or use illicit drugs while carrying the unborn child. Will you train the staff?

Consider another case example, one that is more impassioned in the U.S. The director and staff of a family planning clinic firmly believe that abortion constitutes the termination of a human life, that an unborn child is a human being whose life and rights should be protected. The pregnant women who come to them are usually ambivalent, considering various options including having and raising the child, adoption, or abortion. The director of Clinic B wants her staff to learn motivational interviewing in order to help women decide not to abort, but rather to carry the unborn child to term and either raise the child or permit adoption. Will you train the

staff?

My guess is that many MI trainers would say yes to Clinic A and no to Clinic B. Why? Most likely this would happen if the trainer shares the belief of Clinic A staff that unborn children should be protected from the adverse effects of maternal substance use, but does not share the belief of Clinic B staff that abortion constitutes the termination of a human life. The difference is not in coercion. Both clinics acknowledge that ultimately it is the woman who must decide, and that her choice to drink or to abort cannot be legally taken from her (although perhaps in both clinics the staff wish that it could). Their hope is to learn MI in order to help ambivalent women make the right choice. Both clinics are concerned for the welfare of the unborn child, as well as that of the mother.

Awareness of this issue for trainers was heightened by a lively discussion on the MINT listserv regarding the use of MI to promote adherence to religious values. Among the goals considered in this discussion were behaviors to increase (e.g., eating fruits and vegetables rather than meat) and decrease (e.g., visiting prostitutes, viewing pornography, masturbation). Other faith-relevant examples would be adhering to fasting prescribed for holy days, increasing prayer time, decreasing judgmental thoughts and remarks, avoiding alcohol, and giving increased time and resources in service to the poor. For a given trainer, some of these goals may be quite comfortable and others more itchy. For some, and I find this particularly among American psychologists, values can be uncomfortable precisely because they are rooted in religion.

Yet religion, and ethical/moral value systems more generally, represent principal sources of ambivalence. Matters of conscience are fraught with ambivalence. A world without ambivalence born of conscience is a hellish nightmare. My own faith sets high standards for me to which I aspire, but of course never fully realize. Perhaps the most common form of human ambivalence is that between our own behavior and the values that we hold dear. When working with ambivalence, we are entering the domain of values and conscience.

Developing discrepancy could be understood as increasing the extent to which a behavior conflicts with important personally held values; i.e., bothers the conscience. We don't much mind doing this with behaviors (like drunk driving) that seem clearly risky or harmful to the person or others. It troubles us more, perhaps, to help change a behavior that seems harmless to us, and still more deeply to promote the practice of a behavior that we find reprehensible or suppress a behavior that we find

pleasant or laudable.

Also troubling are attempts to coerce or coax adherence to religious values among people who do not share those values. We are most comfortable when people voluntarily choose to change, but if that is so, do they still need MI? We are willing to work for change with someone who dearly loves to drink or use cocaine, and whose life assigns central value to drug use. We are disturbed not at all if that person's conscience is troubled by the consequences inflicted on his or her family. Presumably this would be so even if the source of the person's conscience itches were the family values imparted by a religious tradition. Is it different if the subject of ambivalence is the moral teachings of the person's religion with regard to diet? Prayer? Envy? Theft? Pornography? How about child pornography?

Voluntariness is not a black and white issue. Life requires endless choices among competing voices. Is a goal voluntary if it is what I say that I want or need? Wants and needs are matters of degree and relative priority, besides which our behavior is often inconsistent even with those personal goals that we clearly want and value. How familiar is the frustration expressed by the Christian apostle Paul two millennia ago: "I don't understand myself. I do not do that which I want to do, and instead I do that which I hate." Value-behavior inconsistency is part of human nature, and a central challenge for people of faith.

What shall we do, then, when a client, agency, or church asks for our help in decreasing the discrepancy between values and behavior? We have at our disposal many tools, including MI, for promoting integrity in adherence to values. I suggest that the degree of our comfort in using MI to promote a value-driven behavior

change is related to the extent to which we share that value. This is a continuum, from values that we fully share, through values that we can accept but do not share, to those we find unacceptable or about which we are ourselves profoundly ambivalent. The method of MI can work to create behavioral discrepancy with a person's own deeply held values, and thereby to promote voluntary behavior change that is value-consistent. For better or worse, we are agents of such change, with tools to offer or withhold depending upon our own judgment of the worthiness of goals to which they are to be applied.

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Values and MI: Need We Always Be Arm-Twisters in Recovery?

Jeff Allison

Bill Miller suggests that value-free therapy is neither possible nor desirable. This assertion is difficult to challenge. However, I would like briefly to explore whether, if at one end of the continuum there is 'value-free' therapy, and at the other, there is value-explicit therapy, there could be value-moderated therapy somewhere between.

When MI is used to promote adherence to a particular goal, it breaches the spirit of the method. Since doing so presumes at the starting point that the practitioner's goal is irrefutable, a practitioner who promotes any particular goal cannot, by definition, be using MI. Even when the professed goal of the client, e.g., abstinence, is the preferred goal of the agency and practitioner, there is room for doubt and caution if the client is not yet abstinent, since there is ambivalence. What promotes behaviour change is the fluctuating valency in the dilemmas, moral/value contradictions — the ambivalent itches — that MI reveals within the client. MI practitioners may promote the sufficiently rigorous exploration of countervalent influences, but not the goal. In the latter, practitioner values are prominent; in the former they are less so.

What might a value-moderated posture look like? I have attempted, as a trainer, to characterise the essence of the MI posture as one of acceptance, respectfulness and, more controversially, passionate disinterest. The latter invariably evokes a perplexed response since the term appears to be contradictory. How can practitioners be disinterested in the outcome and, at the same time, be passionate about their work? Why should they be disinterested if their role explicitly requires them to change behaviour in a particular direction? Disinterest would surely be an abrogation of responsibility.

As I use the term, 'passionate' refers to passionate curiosity — being wholly focused on understanding what makes clients the people they are, and what makes them do the things they do. Soren Kierkegaard said somewhere that all genuine helpfulness starts with humility. It is wholly appropriate for practitioners to start from the position that they do not — cannot — know the client they have just met. The labelling devices with which clients come to therapy have little explanatory value, yet often practitioners infer far too much from such labels. Bringing curiosity to the fore is part of a respectful posture; respect for another begins in accepting that one knows little of the other. It is essential to understand before attempting to be helpful, and cajoling is not 'help'

as I understand it. There is little room for curiosity when practitioners presume to know what is best.

Does 'disinterest' require or imply lack of caring? It might be argued that 'caring' usually requires an investment in outcome, whereas being disinterested in outcome liberates the practitioner to care about the process of coming to understand. A truly respectful style recognises the relative autonomy of the client. Leaving decisions with clients, and clearly communicating this, eases the course of the conversation, since clients' felt need to defend and justify is limited to that which must be defended and justified only to themselves. The tension arising from this is, of course, grist to the mill of change. In achieving a state of disinterest as to outcome, the practitioner's values 'quieten down' and become less prominent.

It seems to me there is an almost universal notion of commanding practitioner logic to which, once exposed, it is assumed the client's behavioural justifications will wither in subordination. The notion that my case is better than your case is mistakenly seen as the font of change, but this is health practitioner as courtroom lawyer. However, a large proportion of practitioners in training come to see the limiting utility of overt confrontation and the application of 'superior logic'. When faced with the incapacitation of their principal stance they wonder what might replace it. Pressures of time, the demands of their role, and their own beliefs as to the correctness of change, all beg questions about the appropriateness of "backing off and coming alongside" (Rollnick, Mason, & Butler, 1999). "How might I be different with my clients without appearing to collude, to be lost or weak?" is a question that often hovers. For some, the solution is to be more devious and guileful; for others, the

answer appears to lie in making themselves and their agency's expectations less prominent in the conversation. Moving from 'instilling' to 'eliciting' doesn't require practitioners to change their values, only their beliefs about how to achieve the tentative goal.

Being discomfited by the client's behaviour, and saying so — value clash — does not often change that person's behaviour. It is being discomfited by one's own that has the far greater motivational push. As a trainer, I am often surprised that practitioners who talk for a living rarely ask themselves why they say the things they do. What drives their speech is as mystifying to them as what drives their clients'. The values and moral loading in their own speech is often undetected and unappreciated, since their words are not merely what they say, but also represent a part of what they 'are'. If the general thrust of MI is to make more explicit the relationship between personal value systems and behaviour, then the general thrust of MI training should include a similar examination. Do practitioners expect clients to examine and perhaps change *their* values, beliefs and behaviour more readily than they would their own?

The usual consequence of articulating opposing values is the reinforcement, rather than the reconsideration, of the other party's position. When practitioners face an unyielding struggle to promote change, I wonder sometimes if they choose to give up and instead, assert their own beliefs in an effort to sustain themselves — and, in so doing, endorse their rightness and the client's wrongness. It is not the primary goal, but it enables the practitioner to attribute blame and feel comfortable. I believe that in less optimistic settings, where positive outcomes are infrequent, such conversations are common.

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Rather than attempting to change clients' values, the question that practitioners might more gainfully address is, where might we look to find existing but nascent inconsistencies? How clients hold things together when they are falling apart is the stuff of MI. In revealing the troubling disconnections, the goals and reasons for change often fall naturally into place. To start by pushing for specific goals is to put the cart before the horse. This is not just a matter of getting ahead of the client's state of readiness, but also of causing dissonance. Changing values and beliefs must always be hardest, if not impossible, since to change them requires clients substantially to redefine themselves. To explore existing but nascent inconsistencies is merely to bring to greater prominence that which is already there. My belief (prejudice) is that those practitioners who endeavour overtly to change their clients' values, goals, and beliefs will be disappointed. People choose to change their behaviour when they find good cause, and are able to, not usually when someone else has demanded it of them. Whilst short-term change is possible through coercion, long-term change is governed and sustained from within. Coercive therapy has a capacity to promote change but only so long as the pressure is applied — like pushing a car that will not start, which soon stops moving if you stop pushing. With a naturally time-pressed issue such as whether to continue with a pregnancy, a coercive practitioner posture may well force a decision later regretted by the client. This is wholly different from an enforced period of sobriety being later terminated.

'Acceptance', I believe, is the key to moderating the dominance of one's own values in practice. Acceptance is not disengagement or a concession of defeat; it is genuine commitment with obligation. The determination of the arm-twister has little love in it; it is self-serving, rather than being of service. In communicating acceptance of clients as they are, practitioners acknowledge clients' humanity and display their own. An MI practitioner, perhaps, is the quiet and reflective voice of the troubled conscience of another, made louder through discussion. In acceptance of clients we respect their uniqueness. Michel Foucault (Rabinow, 1984) wrote, "You can't find the solution of a problem in the solution of another problem raised at another moment by other people". Bill Miller's reminder of the apostle Paul's own perplexing ambivalence suggests we are well-advised to proceed cautiously in presuming to understand the nature of human motivation. What we are engaged in is a prosaic yet mysterious phenomenon: that as a consequence of conversation, one person influences the behaviour of another. The values of both are the catalyst in the equation.

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Value Conflict and Value Awareness in the Helping Professions

Hal Arkowitz

Bill raises a number of important issues concerning values and value conflict. His points are relevant not only to motivational interviewing, but to all forms of counseling, psychotherapy, and health care. Despite the importance of values, it is unfortunate that they are rarely discussed. Bill's paper is a welcome catalyst to a public exchange about the role of values in the helping professions.

First, I have an admission to make: "My name is Hal and I'm a wordaholic." I love words and dictionaries. So it occurred to me that although I've used the words "values" and "ethics" all of my professional life, I wasn't entirely clear on their precise meaning. So, off to my online Oxford English Dictionary I went. And I found the following definitions:

Ethics: "The rules of conduct recognized in certain associations or departments of human life."

Values: "The moral principles by which a person is guided."

"Moral?" I had to look that one up as well. However, rest assured that I didn't need to look up any other words in that definition. My OCD does have its limits.

Moral: "Of or relating to human character or behavior considered as good or bad; of or relating to the distinction between right and wrong, or good and evil, in relation to the actions, desires, or character of responsible human beings.

I also looked up "equipoise," a word I liked a lot, but I'll spare you the definition, except to say that it sounds like what it means.

From these definitions, you might better understand why our professions are so much more comfortable discussing ethics than they are in discussing values (on which those ethical rules are often based). Values are so…judgmental. They are highly personal and subjective, and to complicate the picture further, as Bill pointed out, they are often rooted in religion. Perhaps we worry that if we acknowledge our values and their role in our interactions with clients, we will lose the "non-judgmental" stance that we are told is at the core of counseling and psychotherapy. But we do have values and we do make judgments, and these judgments can influence our work with clients for better or for worse.

One of the central questions raised by Bill's paper is: What happens when the values and goals of the counselor conflict with the values and goals of the client or agency? I believe that counselors' awareness of their own values and the potential role they play is one factor that can help reduce possible value conflicts in our work.

Because many of us have been trained in the myth of value-free counseling and the importance of a non-judgmental attitude, it may feel unprofessional and inappropriate when we find ourselves privately making value judgments of our clients and their behaviors. But it is not unprofessional. It's human. I believe that the more important issues relate to our awareness of these values and judgments and what we do with them, particularly when they conflict with those of the client.

The relationship between counselor and client is one of the most effective ingredients in all approaches to counseling and therapy. Unacknowledged value conflicts can interfere with and even undermine this relationship so that clients may not get the help that they seek and deserve. Consider an example in which a man seeks help for depression and in the course of counseling reveals that he has been having extra-marital affairs through-

out most of his marriage. Further, assume that the counselor has strong values relating to the sanctity of marriage, and that the client's behavior conflicts with those values, leading to strong and unexpressed negative reactions in the counselor. The counselor may try to rationalize or suppress these judgments because he believes he "shouldn't" have them. Such a situation creates a confusing context for the client to openly explore his depression and other aspects of his life. As a result, the counselor may give the client a "double message" in which the nonjudgmental attitude to which he aspires is contradicted by certain comments, types of questions, and non-verbal cues reflecting a negative reaction whenever the client discusses his affairs. In other cases, counselors may not be aware that their values and judgments are activated, and this lack of awareness can be detrimental as well.

Becoming aware of values that may conflict with those of the client creates possibilities for resolving such conflict. By acknowledging that that their values are being activated, counselors are in a position to examine what the consequences of their judgments might be for the client, and what if any action they might take to reduce the value conflict. With an awareness of the problem, the counselor described above might find that he has gotten too invested in changing the client's adulterous behavior. This counselor might conclude that these values work well and are important for him, but that he need not be so invested in changing the client's behavior as long as it doesn't relate to other concerns for which the client is seeking help. However, if the counselor cannot reduce his investment in wanting to change this aspect of the client's life, then he might take some remedial actions. These might include seeking the counsel of another counselor or discussing the situation openly with the client to see if they can find a way to proceed comfortably in their work together. If not, a referral to another counselor might be more appropriate.

Lack of awareness of our values, the strength of our value judgments, and the degree to which we're invested in changing clients in the direction of our own values can undermine the counseling relationship. With awareness of our values and how they are operating, we are able to make choices about how to proceed in ways that maintain our integrity and the client's welfare.

Discrepancies and Values

Tom Barth

In many ways, Motivational Interviewing is a very young method. One of the signs is that our concepts are not always very well-defined. This is very clear to me at present, since Christina Nasholm and I are writing a Swedish MI-book. We have had some serious discussions trying to define concepts like discrepancy and ambivalence. I'm sure many of you have run into this discussion when somebody in a workshop asks: *"What is the difference between discrepancy and ambivalence?"*

We ended up defining discrepancy as a 'disturbing difference' (störande skilnad) — and ambivalence as having two or more incompatible thoughts, feelings or attitudes (perhaps even values?) towards one and the same issue. In the book we try to describe the process by which '*a something*' gradually can become '*an issue*' and even turn into '*a concern*' — how the idea of change can get linked to this concern and the nature of the ambivalence that arises when we contemplate change. We believe that MI is one method for assisting clients in all phases of the process.

Observing a difference catches your attention — this is in the basic programming of our psychology. Most differences have no significance, and are disregarded, but some may have importance for us, and we go on to "think about it". And thinking about it could result in some investment of feeling or affect — we could end up with a "disturbing difference". Now, the easiest way to handle discrepancy is to stop thinking about it. To get around to changing something, it is helpful if somebody keeps us on the track or holds focus — without pushing us into a defensive position (resistance). The idea of ambivalence is much more advanced than the "either-or" of denial. Ambivalence suggests that change can be at the same time both a good and a not-good thing for me — and if one has the necessary endurance in exploring, it often leads to decision-points. That's when we really start hearing "commitment talk"-the tasting of what change will do to me.

It is fairly easy to see how MI can assist such a process:

➢ asking permission to introduce certain topics,

➢ eliciting clients' thoughts through open questions,

➢ exploring and building understanding through reflections and summaries....

MI is directive not so much because it leads to change-talk, but because an MI-conversation systematically invites the client to think in terms of something like the process described above. In our understanding (Christina's and mine) MI constructs a model for understanding oneself in relation to change, and offers tools (both micro-skills and strategies) that are helpful for assisting a client through such a model.

We believe that non-directive counselling can still be MI. When I give counsel to a young person who is considering an abortion, I instruct myself to be neutral. Knowing, of course, that it impossible to be completely neutral, but trying as hard as I can to give my client a balanced picture of her own ambivalence, rather than working to reach a certain solution. But this is still MI! I will be using MI micro skills, the MI understanding of ambivalence, MI strategies for preventing resistance. This is something more than "nondirective Rogerian counselling." We strongly believe that the definition of Motivational Interviewing should be on this level- rather than focusing too exclusively on "chasing change-talk".

What about values, then? One special type of discrepancy in MI is built upon differences between personal values and actual behaviour. But there are many other ways of inviting clients to think about "disturbing differences". For example, the difference between a ggt value of 215 compared to the normal 50-80. (This is a blood serum test suggesting that the patient may be drinking a little more alcohol than his liver "is happy about".) When and why do we choose to base MI on central values rather than superficial blood tests?

Is the value discrepancy more MI-ish than the other kind? And are there personal and cultural differences in which ways we choose to promote

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change?

Many years ago I taught that short interventions should be based on "little discrepancies". If you have a well-functioning family-man with high alcohol consumption, you should start building change on health and welfare discrepancies. If you start talking to the man about how his drinking relates to his ideas about being a father, you can get into deep shit in a short time and may need to work really hard to wrap up all you have whirled up. And I would say that if you have a client with a BIG problem — in an inpatient setting, allowing you to do more intensive therapy — that's the time to engage values.

But now I'm not so sure anymore. We also see that gently informing a person (in some kind of MI-compatible way) that "*your behaviour could lead to your death in the long run*" can have a strong behaviour change-effect on a strong and healthy person, but no behaviour change-effect on a very sick person, who actually is in danger of dying. It only makes him more miserable. So big discrepancies aren't always best for big problems.

The strength, and the problem, of working with values, is that values are not *specific*. Values are global, general guidelines for our lives, and relate to our behaviours in many ways. Therefore, many values are easily mobilized, and linked to certain sides of ambivalence. But this also makes it more possible to manipulate through value-mobilisation. (Can't we see these days, for example, how both sides in Iraq refer to the same basic values of justice and freedom to defend their atrocities?) Sometimes, when I watch heavy, value-engaging MI, I think: "What right do we have — to go crusading in other peoples' lives like that?"

To conclude: values and ethics are very closely connected. A strong value-involvement in treatment requires an active ethical reflection process. Personally, I am careful with engaging values in my clinical work (*which, of course is a value in itself*), and I am strongly opposed to the thought that developing discrepancies between personal values and actual behaviour should be "the gold standard" of MI.

Subverting Values in MI: The Ethics of Changing Personal Narratives

Joseph W Ciarrocchi

A central question behind the values discussion appears to be, "When it is it ethically legitimate for a therapist to facilitate subverting a client's worldview?" We are cooperating with clients in subverting their worldviews, and this speaks to the inherent power entrusted to us and the delicacy of the goal-setting within the therapy relationship.

According to historians (Wright, 1992) and expectancy-value theorists in social-cognitive models (Carver & Scheier, 1998), worldviews drive behavior through the stories and narratives people create for themselves and then live out. Stories based on worldviews create aims and intentions (higher and lower-order goals) that can be seen in people's symbols and praxis (motor behavior, dispositions to act in certain ways in certain situations).

Do clients enter treatment aware that their stories are about to be subverted? Implicitly they do, in most cases. As Bill points out, when people walk into the Daisy Hill Substance Abuse Treatment Program they know it's not a bowling alley. Implicitly they know that something about their personal narratives isn't working. They may not understand yet at what level it's not working. They may be malfunctioning at the most abstract level, i.e., the worldview itself. A heavy drinker's worldview may be that she does not believe she can cope with her emotional pain without alcohol. At the concrete level of praxis, a heavy drinker who is committed to abstinence may also have chosen an ineffective praxis (or strategy) to attain the worldview goal of abstinence. For example, the person may insist that one should get sober while having beer in the refrigerator. Each knows that the personal narratives have gone awry due to some relationship with alcohol and/or drugs. Therapists utilizing motivational interviewing assist clients in gaining awareness of their stories and praxis and support examining the necessary changes to reach their goals.

The client's explicit presence in this context represents, to my way of thinking, informed consent to explore the personal narrative. Such explorations imply, further, that one's worldview is now open to critique and revaluation. When a depressed client enters the Cognitive Therapy Clinic she may have only a vague idea of what cognitive therapy is. She may have no idea whatsoever that as therapy proceeds she will uncover an extensive worldview (needing to please others in nearly all situations) that is contributing to or maintaining her depression. Change for her, if she agrees to it, will involve a subversion of a personal narrative built on a lifetime of experiences within a certain worldview.

Little of this is controversial. What few may appreciate is how intricately linked MI is to values and worldviews. Often the most potentially enduring reasons for change that clients give are those related to values. James Prochaska gave a talk at a gambling conference I attended, and told of research he was doing attempting to get needle-sharing drug addicts and sex workers to practice safe sex. He said that the number one reason given by the participants for wanting to change was so that they could feel like decent, moral human beings. Thus, even less advantaged groups link moral or spiritual values to reasons for changing. If motivational interviewing therapists run from spiritual, moral, and religious values, we avoid a central source of motivation. Yet, our training and ethics have rightly sensitized us to refraining from imposing our values on clients. This has unfortunately generalized to *not bringing up values* in therapy — a stance that eviscerates MI's range.

The fact remains, however, that people's spiritual and religious worldviews create values that are often prosocial and growth-enhancing. I suggest several ways to incorporate these worldviews within the context of motivational interviewing and

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remain within our own areas of competence.

It seems legitimate for motivational interviewing therapists to:

1. Facilitate clients' exploration of precisely how their worldviews serve the clients' change goals. For example, if on the Values Card Sort the client ranks being a moral person as *important* or *very important*, discussion could ensue as to how doing crack cocaine relates to the moral goals implicit in being a good parent. The anxiety-provoking issue in working with religious motivators is how they up the ante for most people. We have legitimate concern about using religion and spirituality precisely because they have so much power to impel people to act. Power, as John F. Kennedy liked to remind people, is not an obscene word. The better question is power for what cause or what ends? Motivational interviewing intends to harness all varieties of internal and external power to achieve the client's goals. Religion can lead people to build bridges or blow them up. Motivational interviewing therapists can harness the growth-enhancing power of religion and spirituality so that clients will direct it positively.

2. Facilitate clients' self-monitoring regarding the religious or spiritual worldviews. Ogden Lindsey, Skinner's lab partner and pioneer in behavior analysis, demonstrated at a behavior therapy conference in the 1970s how to use an ABAB, single-subject design to graph "God-thoughts" for a nun who wanted to increase their frequency. When the audience snickered at his graph he asked, "Why is this a problem? Especially if you're Catholic?" Even a radical behaviorist could operationalize spiritual behavior as a response subject to reinforcement.

3. Even though no direct attempt to subvert or change the worldview is agreed to, there is always the possibility that changing praxis can change portions of worldviews. At a minimum, people's self-efficacy changes when praxis changes. Also, when people reduce their drug or alcohol intake they often create new life narratives that were inaccessible when ravaged by the repetitive substance consumption.

4. Finally, mental health professionals need humility to do our jobs well. It is good to remind ourselves that, for the majority of people, psychological health is not the source of ultimate meaning. The fields of philosophy, religion, and literature — to name a few — would challenge the notion that psychological well-being is the be-all and end-all of existence.

Many sensible people make all sorts of decisions that lead to reduced psychological well-being as measured empirically. Having young children invariably leads to protracted periods of reduced happiness (Baumeister, 1991) — yet people insist on continuing to reproduce and raise offspring. Few therapists, fortunately, dissuade clients from having babies solely on the basis of the stress they will bring. When they refrain from doing so, therapists are thinking from the perspective of their broader worldviews and values rather than that of psychological well-being. Therapists are cooperating in a praxis that clients believe will contribute to their flourishing as human beings but will not necessarily maximize their psychological well-being, as currently measured. Conversely, people put great energy into goals that are weakly related to well-being, e.g., the pursuit of wealth (Myers, 2000). The therapist's goal, again, is not to dissuade people from pursuing wealth, but to explore client expectations in relationship to typical reality outcomes. The point here is that therapists frequently help clients choose goals that are based on the therapists' worldviews as to what a good life is — and this does not mean we are acting outside our range of competence. It means that we have sensibly put psychology in the service of human flourishing. If we believe that all that we do professionally is based on science, we are living an unexamined life.

Motivational interviewing allows its practitioners to feel justifiably proud that we have an effective helping model that permits an active engagement with people's worldviews and values. MI, in a sense, has untied mental health's hands from the bondage of mere psychological motivators. Just as, in my opinion, some believers have a God who is too small, therapists can have worldviews that are too small to motivate. Our ethical dilemmas sometimes arise because we have failed to see where the client and our worldviews are going, and what adjustments are required at the level of praxis or schema. Motivational interviewing tells us to use whatever it takes, especially values and worldviews, to help unbind people from their debilitating compulsive behaviors.

Note: An expanded version of this article is available from the author at jciarr@comcast.net

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If Giants Grumble, Will Values Tumble?

Chris Dunn

Dear Bill: Your provocative piece on MI and ethics has had a disquieting intervention effect on me. You have reminded me that as a counselor, I may find it hard to transcend or escape my own values, and therefore, I should pay close attention to what my values are. If I don't, the methods of MI influence that I use with patients might spill over into control, and my investment in my patients' outcomes could spill over into greed (Miller & Rollnick, 1991). You have reminded me to consider being explicit with my patients about what I am going to do before starting to do MI with them. In effect, you have challenged me to err in the direction of over informing them rather than under-informing them. Drat. Bill, why don't you just stick to stretching your own discrepancies and leave mine alone? Too late. My sleeping giant of ambivalence has woken with the grumps, so I'll have to deal with him somehow — either by changing my counseling behavior or by redefining my values! Now I must decide whether to try to jump higher or lower the bar...

Seriously, I am uncomfortably ambivalent not only because of the ethical itch to better inform my patients and get their explicit — not implied — consent for opportunistic

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counseling. I am also uncomfortably ambivalent *about what my values actually are* regarding the autonomy of injured trauma patients who misuse drugs and alcohol. I'd like to chew on just this one portion of this humble pie that Bill has served: how much should I tell injured patients about the MI intervention I am being paid to do with them?

I started doing this opportunistic work in 1994 as the MI interventionist for a randomized trial testing whether a single MI session reduces drinking or reinjury. Those who got the intervention drank less at one year and were injured *again* 47% less than those who didn't get the intervention. There were no effects on morbidity, however (Gentilello et al., 1999). The hospital then hired me to do MI brief interventions as a daily service, and I have been doing them ever since. I have done almost 4000 bedside brief interventions, and not one of those who received it asked for the intervention.

Here's what the playing field looks like. My injured patients are in pain and lying in a hospital room with little privacy; I speak quietly and hope others in the room can't hear us. These patients are under the influence of opioids for pain, and most have substance abuse problems ranging from mild to severe, but I don't know how severe. I usually know the results of their blood alcohol and urine drug screen labs that were drawn when they were admitted. Patients don't know that I am looking up their labs in the hospital computer to identify them as brief intervention candidates. Then I walk in the room and try to make the intervention happen so I can bill them for it. They almost always have concerns they want to discuss, but these concerns at that moment are almost never substance abuse.

Here's what erring in the direction of under-informing patients looks like. I have learned to tell nurses that if they want me to counsel a patient whom they think has a substance abuse problem, not to ask the patient if they want to see Dr. Dunn, a substance abuse counselor; the answer is inevitably, "No thanks." Instead, the nurses call me without asking the patient's permission, and then I go see the patient. I've learned that MI "techniques" are useful for getting into the room ("Hi. Boy, you don't look real comfortable. Is there anything I can get you?") and getting the counseling going without explicitly asking their permission. Let's count the truths and the lies. If they look confused about why my badge says "Psychiatry", I reflect that confusion immediately: "You seem puzzled by my psych badge (true). Don't worry, I'm not here to psychoanalyze you (true). My job is to check in with all my patients if they have drugs or alcohol in their system when they get hurt (true). I'm not here to judge you (true) or to try to change you (lie) or to get you into treatment (usually a

lie). Instead, I'd just like to hear how you see alcohol or drugs fitting into your life, so you can decide if this is something you want to change — or not — after you leave here (true)." Let's see, that's 5 truths and 2 lies. That's okay, isn't it? After all, isn't preventing reinjury in the patient's best interest? After all, we all know that the more trauma you suffer, the more PTSD you get. Once they develop a substance abuse problem, aren't most people better off sober?

What if I were to err in the direction of over-informing them? I might say something like this: "At Harborview, we have learned that if we spend about 30 minutes talking to patients who come in with some alcohol in their system, that they get reinjured about half as much over the next 3 years as those who we don't talk to while they are here. So I'd like to talk with you now, if you are willing. But if you say no, it will not affect your medical care at all. I will not try to persuade you to make any changes you aren't ready to make. We don't have perfect privacy in here, but this is the only place we can talk. Among other things, I will try to help you explore how your drinking fits in with your personal values, which may at times make you uncomfortable. Would you be willing to have a talk with me if I don't judge you or give you unwanted advice?"

I confess uneasily that I have put considerable energy into manipulating patients into talking to me. Partly out of fear of being rejected, partly because it's faster just to start the MI. I wonder if they would benefit more from the MI if they first explicitly bought into it? Maybe the explicit consent process would add a sense of ceremony or weight to a conversation that they might otherwise discount in hindsight?

When I say that I'm not really sure where my values lie about patient autonomy in this situation, I risk rationalizing. I am really only sure of one thing: I'll remain uncomfortable unless I change. That grumpy giant of ambivalence may fall asleep again, but only temporarily. So. I have decided to try making my patient consent

much more explicit. I'll just try it for awhile. Like an alcohol vacation. I can always lower my standards later...

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Values and MI

Carl Âke Farbring

I was a bit surprised over the heated reactions to my postings on the listserv on this topic a few months ago. It's clear that our network contains MI-people with polarised views on values, directiveness versus non-directiveness etc., which I think only makes our debate more interesting. (As an aside: isn't this a strong argument against certification of trainers? There are so many different opinions about MI-couldn't someone who rejects a directive stance, and has the power to perform certification, judge negatively someone who works with MI from a directive position, focuses on eliciting change talk, etc.? Even though, in my understanding, this should be an issue decided by empirical evidence of which understanding of MI produces more effective providers, rather than by views or ideologies?)

Having met close to a thousand drug abusing clients in criminal justice who applied to come to our quite successful therapeutic community (TC) (Farbring, 2000) explicitly to change, I have always found it natural to take a directive stance in my work with my clients. In MI we are working with values and trying to increase discrepancy between the

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present situation and deeply held intrinsic values. But, based on the experience with my clients, I think it's clear that values are not static and should not always be treated as such in our work with clients. As everyone knows, it's an unforgivable breach of code in prison to be overtly disloyal to fellow prisoners and to cooperate with the police. At one time in our TC-project all the prisoners on my ward sent a congratulations telegram to the police for busting a gang of drug peddlers in Stockholm. They had changed lots of anti-social behaviour prior to this, but this action showed how they as a consequence also were ready to take on new values. The telegram was not so popular in other wards of our TC, where clients had not come so far in their change process... Values can change and often do so; they are often context-bound and sometimes a part of the survival process.

True, there are instances where I would find myself less directive, or even not directive at all. Take for instance the example in *MI2*, where a woman is ambivalent about whether to move to another city to get a new life for her and her daughter after going through a divorce. Do we think of ourselves as rigid in our stance as counsellors regardless of the situation, or do we move along the continuum depending upon the clients and situations that we are facing? Generally though, with clients who have been overtly ambivalent up to 30 years or more about changing their life situation in spite of their suffering and the suffering they are causing others, I just could not find myself neutral about the concept of change.

Some of the ripostes that I received on my listserv postings put in doubt whether my stance conforms to MI at all. This is a bit hard for me to understand, as there really is such a thing as directive MI. In my understanding this contains everything including making clients feel "seen" as individuals and not just as clients (which is my interpretation of *affirm*), listening, open questions, eliciting problem recognition, increasing discrepancy, etc. As long as my clients are willing to talk to me — and that is always my first priority — I'll try to elicit problem recognition and change talk. My experience has told me that clients who have said for more than 10-20 years that they need to keep an open door back to their old habitat, often say that because they feel insecure, less confident and even are afraid of where change is going to take them. Note that this is not the same thing as *imposing (my)* views or values on clients, though my values can of course be discerned from my continuous work to explore and elicit wishes and alternatives from my clients. But, instead of merely accepting the expressed views of the client, I have found that one can go a long way further by extending hope — as Yahne & Miller (1999) put it, *clients sometimes need to borrow hope from us until they can get their own*. They often have failures behind them which make them more cautious about making that attempt again. I don't think a non-directive stance would be nearly as successful with this kind of long-time ambivalent client — but that is of course also an empirical question.

In contrast to many others, it seems, I was quite enthusiastic about the finding by Amrhein et al. (2003) that change talk (do-language) correlates with behaviour change. I also liked the metaphor offered by Terri Moyers; she compared us with surgeons (asking why *we as counsellors* do not automatically become more effective with years of practice when surgeons do), and noted that we now possess two instruments (i.e., resistance and do-language) to give us immediate feedback on how we are doing with our clients. Put differently, we now have the possibility to take a compass bearing to a direction where we want the client to go, and to have the client tell us immediately if we are on the right track. There is no doubt in my mind that this correlation is reflecting a true causal relationship; I can find hundreds of incidents, from my own life as well as the lives of clients and friends, where this is true, even though I think one must distinguish between do-language that is volunteered and that which is elicited. Perhaps my positive interest, in contrast to the scepticism from many others, can be explained by the difference along the directive — non-directive continuum, but it may also have something to do with an empirical stance. It certainly has put more emphasis for me on the directive stance in MI, especially with respect to drug using criminal justice clients, clients who are suicidal or lead lives that are self-destructive and destructive for others. Here I cannot — from a simple humanistic perspective — see any alternative to a directive style in MI.

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M.I. Values or Yours?

Mark Farrall

'Values and Motivational Interviewing': a seemingly straightforward subject to which to respond in this symposium? Yet on immersion the issues and possible distinctions are of such subtlety that they slip though the mental fingers like seawater, seemingly clear but risking making the eyes sting.

In the phraseology of Bill's piece I can find little to resist: I can only agree that

> *...An intervention that claims to be value-free is one in which the implicit values have not been adequately explicated and made explicit.*

For me, the values practitioners bring to their use of MI are crucial and inevitably effect the interaction; nothing contentious there. Yet the listserv discussions on these points were at times very heated and even suggestive of polarisation. What then is the difference? Perhaps the 'itchy' issues are around i) the degree of self awareness of their own value system and ethical stance by the practitioner, and ii) the question of what 'directiveness' means.

If "MI is precisely about being conscious and intentional in choice of direction within a client-centered manner," then the crux must be about how we marry 'client centred' with 'directive' and the way in which our

value systems impinge on that. Admittedly, my position that all value and ethical frameworks are relative, and that there are no universal 'good's other than the ones we decide upon, is at odds with some humanistic beliefs (including Rogers') that humans (if unimpeded) will tend towards ethically positive functioning; it is also at odds with religiously-based belief systems which (at least in the monotheistic Judaeo-Christian tradition) tend towards a 'God given' notion of what is 'right'.

Bill has directed attention toward the issue of faith, and so I will follow. He cites the example of a 'faith based' pregnancy counselling service which might counsel that "abortion is morally wrong in all circumstances," and which would therefore focus its M.I. directiveness towards obtaining or facilitating a particular decision not to abort. I would argue that this is not then person-centred practice, as the counsellor has already decided on the desired outcome. If they consciously explore only certain avenues of the 'catacomb' of possibilities in order to reach their desired point, then I think counsellors are guilty of 'bad faith' in an existential sense and are serving not their clients, but themselves: this is arrogance. There is also the question of exactly why a service with such a stance does not name itself explicitly? Perhaps they are afraid that to be clear in their name would give potential clients too much information and allow them to make decisions the service would not like, i.e., to go elsewhere for a less partisan view?

If a service and/or practitioner within it do make absolutely explicit their value system, and is entirely conscious of it, does this then justify their approach? I believe it would be more honest, and would demonstrate a higher degree of self-reflexivity, but therein lies the rub. How can a person or agency standing on god-given values and moral certainties exhibit the self awareness necessary to be aware that such a belief system is relative and only one among many? This is the paradox of faith: that you must believe your particular brand is right, its value system is right and (inescapably) the others (and nonbelievers) are wrong.

Counsellors taking this view, that the faith they hold is only one belief among many and has no intrinsic 'rightness' or divine origin but they choose to believe it has, would satisfy my demand for self-awareness around beliefs: but if they then steer clients towards particular outcomes, they would not be practising what I understand as MI. Training them would mean teaching techniques, but the spirit of the approach would be incongruent with their beliefs, and the result would not be MI.

This brings us back to asking what 'directiveness' means? Bill cites the discussion on the use of MI to "promote adherence to religious values" around behaviours to increase (e.g. adhering to fasting) or decrease (e.g. visit-ing prostitutes), and states that the difficulties occur when (as workers) we find it troubling to

> ...help change a behaviour that seems harmless to us, and still more deeply to promote the practice of a behaviour that we find reprehensible or suppress a behaviour that we find pleasant or laudable.

But are we helping to do this? Building on my earlier arguments, there is a problem if we are attempting to 'promote' the practice of any behaviour: this implies a predetermined direction in which the directiveness operates, i.e. to the liking of the practitioner for an end consonant with his/her own value system, and not to the end of developing discrepancy or resolving ambivalence in order that the client can make his/her own decision, however the practitioner feels about it.

Discrepancy has to be between clients' own values and their behaviour, not society's values and their behaviour; the latter results in a clash which leads to control, coercion or punishment, not individual change. As practitioners, we must perform the 'doublethink' mentioned in previous listserv postings, of being able to hold in mind simultaneously contradictory beliefs a) that (to us) one outcome might be preferable to another, but also b) that people will be able to make and maintain change more effectively if it fits within their values, aspirations, hopes and fears — not ours. That is, they have a right to choose (whatever the choice), but also a responsibility to deal with the consequences.

This is why, to return to my own familiar field of criminal justice, I believe there is a deep issue of bad faith in believing that it is more 'natural' to be directive with offenders than anybody else, or that they somehow need more 'directiveness' than anybody else to get to an end (like cessation of offending) we think is somehow intrinsically 'right' or 'best for them' or society, or is behaviourally or existentially preferable. For a practitioner to act is if this were the case implies a deep disrespect for the autonomy, agency, choice and essential humanity of the offender or other client, and because of the recourse to a pre-existing and 'self evident' 'good' also implies an un-thought out or un-self aware ethical position, however well-meaning or based in a wish to 'reduce harm' or 'do the right thing'.

Finally, for M.I. to be M.I. it must be about opening up possibilities, opportunities and perspectives, rather than a 'corrective' process — turning 'bad' into 'good'. M.I. as a person-centred directive stance is process-focused about opening doors to the possibility of change (wherever that leads), not goal-centred about what the change 'should' be. Acceptance facilitates change.

How Neutral Is Neutral?

Steve Gilbertson

Bill Miller states, "An intervention that claims to be value-free is one in which the implicit values have not been adequately explicated and made explicit." I would go one step further and state that the concept of a value-free intervention is laden with explicit values.

Obviously, the first value that is present is the position of being value-free. Value neutrality, or moral relativism, is an ethical position that values the complete autonomy of the individual in making decisions above all else. That is a definable position, and therefore has implicit values. These values are made explicit in the statement, for example, that "There are no moral absolutes," which in and of itself is an absolute statement. Incidentally, the statement is self-refuting, and it assumes a view of reality that is at least metaphysically libertarian — once again, a definable position.

I have worked in the addiction field

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for several decades, and it is apparent to me that those who work in the field have values about temperance, at least, and abstinence as a goal. The most commonly held value is that alcohol and drug dependence are destructive behaviors, and that it is the counselor's task to work with clients to reduce the damage. Harm reduction as a methodology must first posit that harm exists. I have as yet to meet anyone who has the equipoise to watch a client destroy his/her physical, mental, emotional, and spiritual health and remain completely neutral. Even if they allow the client full choice to continue that destruction, counselors experience some level of personal regret for the client that is real, felt, and at times stressful. That is not value-free.

When we take into account the five conditions identified by Bill and Steve under which ethical complexities increase, how many of them exist for court-ordered clients with alcohol and/or drug dependence and legal problems?

First, the counselor has an opinion as to the desirable outcome. With federal funding in the U.S. moving more to an outcomes base, programs receiving federal funds will have to be concerned about positive outcomes. The recent bids for federal funding to states for substance abuse treatment through Access to Recovery evidence that move, as abstinence is a required outcome in order to maintain funding past the first year. Counselors will have to have opinions as to desirable outcomes.

Second, the aspirations of the counselor and client differ. Most court-ordered clients I have worked with did not see value in sobriety, and were more interested in staying out of jail. The courts want sobriety; the counselor has to walk in between the client and the court. Valued sobriety, which equals success for the client, fulfills this second condition.

Third, the counselor has an investment in a particular outcome. Funding systems are always looking for *effective* interventions. That means abstinence in most cases, and a percentage of clients have to be successfully discharged with a history of abstinence to meet those expectations. This condition could be amplified when a particular program or counselor must meet expectations of sobriety at discharge, particularly if overall outcomes are at or below a required level.

Fourth, the counselor's personal investment potentially conflicts with the client's best interests. I have seen this in cases, for example, where a clinician has recommended termination of parental rights due to a person's substance abuse, not because the client was a bad parent, but because the counselor was under pressure from a child welfare agency to terminate. The counselor could not afford to lose the business from the agency, and risked losing that business if he did not agree with the agency. There are other similar situations where the pres-

sure of business enters into judgment.

Fifth, the counselor has coercive power to influence by consequences. I have worked jointly with federal and district probation, with state parole, and with other referral sources that required abstinence, required reporting of violations (e.g. a positive urinalysis), and would frequently "drop the hammer" on those who were non-compliant. Stating that the consequences came from somewhere else really only attempts to sidestep the issue. Reporting in gives a counselor coercive power.

Given that much of substance abuse treatment fulfills, at some level, all five conditions or a combination of conditions, our central focus in much of motivational interviewing would have to cause as much concern as the issues of training a prenatal care clinic (as referenced in Bill's article). As an MI trainer, carefully considering my own values has to come into play when training staff at an organization. There is no way around this issue, and in my view, claiming to be value-neutral is only a way of ignoring the problem. It behooves each of us to do a thorough personal assessment of our own values and carefully choose those opportunities to train where there is at least a workable congruence between the trainees and ourselves.

That leaves me to ask a hypothetical question: would MI be effective with someone who is ambivalent about abstinence, if the people wanting to be trained were bartenders at a local pub which happens to be down the street from an Alcoholics Anonymous meeting? Could you train the bartenders if their goal was to help people resume drinking? If you have been in the field for very long, the answer is probably not. You see, we really are not value-neutral purists at heart, are we?

The Directive/Non-directive Paradox

Tad Gorske

I agree with Bill's premise that counseling, specifically client-centered counseling, is not a value-free endeavor. The notion of directiveness is usually the sticking point for most. Bill states that MI is about being "conscious and intentional" in the choice of direction. This issue makes most people nervous due to the inherent power differential in a counseling experience. Regardless of what values a counselor holds, there will always be an implicit power differential; the counselor has the power and the client does not. I hear this implied belief during trainings when I explain the more nondirective interpersonal methods MI uses to enhance the likelihood of change. Audience members will use words like "manipulation" and "brainwashing." Another example occurs when I conduct role-plays, and a participant finds him/herself stuck with the particular client another audience member is role playing. When I ask the participant where he/she thinks the sticking point is, a common response is, "I want to *get them* to see…" This statement reflects a belief that counseling is a coercive and manipulative process. Counselors really want to help and *make* a difference, and often believe they must *make* this happen. The difficulty is encouraging counselors to trust the process and realize they don't have to make things happen, versus creating a condition where healing is able to happen.

To create a healing environment where change is possible requires a counselor to hold values consistent with the "spirit" of MI. The MI spirit is not easily defined and any attempts to do so fall short. Given the limitations of language, the MI spirit reflects a willingness of the counselor to collaborate with clients, respect where they are in their own change process, and allow them to be autonomous human beings who have control over their personal life space.

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The incorporation of the MI spirit is a difficult process because it suggests that one values "letting go" and detaching on so many levels: letting go of the need to change, the righting reflex, outcomes, and the need to put ourselves on pedestals as champions of health and growth. It is the ability to be aware and let go of all the needs, motivations, and desires that counselors have that are roadblocks to truly being present in the moment with clients. It is a state of being that brings to life words of the founder of Psychodrama, Jacob Levy Moreno:

A meeting of two: eye to eye, face to face. And when you are near I will tear your eyes out and place them instead of mine, and you will tear my eyes out and will place them instead of yours then I will look at you with your eyes... and you will look at me with mine.

So where does directiveness come into this process? Once a healing environment is created through the counselor's expression of the MI spirit, further healing takes place as the counselor knowingly and respectfully relies on the use of self to facilitate growth in the other. The use of self in therapy begs another challenge to the counselor, that of congruence. Rogers' notion of congruence is simply defined as the state of a person whose inner world is consistent with his/her outer expression. More abstractly, it is the state of one who has a sense of wholeness — wholeness not meaning perfection, but rather the knowledge and acceptance of one's strengths, weakness, and commitment to ongoing personal growth. In regard to directiveness in counseling, this is a person who offers guidance, direction, and advice, with the humility to recognize the limitations of this advice and the fact that it represents one small worldview. Clients sense this humility, or lack of it, and will respond appropriately. Two brief examples illustrate opposing ends of this continuum:

"Client A is meeting with counselor M regarding problems he is having in a drug and alcohol group therapy program. Client A doesn't like the religious references of AA/NA because he is an atheist. Counselor M, a strong 12-step believer, attempts to explain the benefits of a 12 step program and confronts client A's denial of his need to surrender to a higher power. Client A becomes more resistant and angry and an intense argument ensues, with Client A ending the session early. They continue therapy together but their sessions are very unproductive."

"Client A meets with counselor N for the same issue. Counselor N is also a strong 12-step believer; however, she also values individuals' need for autonomy, respect for their own beliefs, and the right to have command of their life path. Counselor N listens to Client A's concerns and her empathic and humanistic style opens client A to explore the meaning of his distaste for the religious messages of the 12-steps. Afterward, Counselor N offers her thoughts on the issue which reflect, in her experience, that the 12-step programs are the most effective programs that she knows of to help people with substance use, but that there are other programs Client A might find helpful as well. Client A is clearly more willing to dialogue about this issue and hear Counselor N's opinions. Although he still is unwilling to compromise his view he is open to Counselor N's perspective."

There are counselors whose style is highly directive, yet who do not seem to engender resistance in their clients. I believe this is because, while the expression of their style is directive, their way of being is one of respect for individuals as autonomous human beings. This is a deeply held value that is hard to fake with "nondirective techniques". It is a greater challenge to incorporate these values. In training, counselors who hold onto values reflective of a need to direct and guide the client have difficulty with nondirective techniques, whereas counselors who appear naturally nondirective seem to embrace these techniques. These are the trainees who often come to talk to trainers during breaks and at the end of a session and express gratitude for the information and the experience. There seems to be a need by individuals in the helping professions to move away from the "in your face" confrontational approach to behavior change. Helpers are realizing the need for clients to have their autonomy and individuality respected while they explore the painful realization that personal change is necessary and possible. Thus, many helpers are truly thirsty for the MI spirit.

Those of us in the MI field struggle to decide how we can best communicate these nondirective values to others without falling into the same cycle of coercion and trying to *make* other counselors change. I don't claim to have an answer, but one thought comes from a saying by Father Martin: "You can lead a horse to water but you can't make it drink…but you *can* make it thirsty." Perhaps our job as MI proponents is to continually make others thirsty through a process of ongoing personal growth in ourselves that challenges us to fully integrate the values of nondirectiveness and respect for the autonomy of others.

On the MI listserv, there are occasional requests for help in trainings with audiences whose values about change clearly fall into the manipulative or coercive category. Perhaps the struggle is not how can we create an environment where the audience may change, but how can we create a place within ourselves, as trainers, where despite the value conflict, we can still value and respect our audience for their beliefs. Certainly this is a challenge and will not work in all cases. Yet, perhaps by doing this, we can emanate a way of being that our audience members, and our clients, will see, hear, touch, and experience in such a way that the natural process of change is suddenly and gently unbound.

The Burden of Making Choices Under Ambiguity

Hiro Harai

MI may be called a tool to make choices about lifestyle changes. Though it may deal with patients' decision-making process about key events of their lives and their value systems, it is still a tool. The same applies to other medical interventions. As a physician informed by the concept of Evidence Based Medicine (EBM), I believe medical practice should follow "the integration of best research evidence with clinical expertise and patient values" (Sackett, 2000).

The problem of EBM is the relative lack of evidence. Even if a clinician were to make a confident clinical decision about a certain intervention based on unequivocal research evidence, he or she could offer only ambiguous comments about whether the future outcome would satisfy the patient or not. Indeed, it is unethical to make unequivocal promises about the success of an intervention. At the same time, almost all human beings

hate the ambiguity of the future.

In the early days of the development of MI, the major therapeutic target was chemical dependence or abuse, which often would result in legal entanglements. As long as the President waged a "War on Drugs", and law enforcement worked diligently without mercy, the therapist could confidently tell the patient, "If you use, probation will be revoked." However, as to soft targets like tobacco use, diet, exercise, or other lifestyle habits, therapists cannot say with certainty what will happen in the long run, if patients were to make seemingly bad choices. Patients must make decisions about their lifestyle change for the ambiguous future.

As Bill wrote, "Life requires endless choices among competing voices." I would like add to this, "And nobody can tell which voice will guide you exactly where you want to go in the future." If you have 100 percent confidence about what will happen in the future, that confidence is called "faith." Therapists with such confidence would be called "prophets." Therapists value patients' values because therapists do not have such confidence in their decisions. Therapists and patients should tolerate the ambiguity of the future and the burden of making choices based on ambiguous evidence and opinions. Probably, however much progress medicine or psychotherapy may make, the burden of choice under ambiguity will not be lifted.

A therapist says gently to a patient, without an authoritative attitude, "I value your preferences." He might as well say, "The burden of choice under ambiguity is on you."

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Values and Priorities Clarification within the Spirit of MI

Patricia Juárez

I agree that exploration of values and life priorities is a very useful way to elicit discrepancies between them and conflicting behaviors. This exploration most likely will increase clients' awareness of what really matters to them. More importantly, we should focus on how MI attempts to create an environment where people can safely explore these issues, by communicating a spirit of acceptance, respect, genuine interest in the unique experiences and views of the client, a sense of collaboration, personal responsibility, and respect for the clients' own decisions.

As therapists or counselors, if we really try to communicate this spirit, and really try to understand how a particular client perceives his/her behavior and priorities, then perhaps our values could more easily be kept to ourselves. Of course, as health professionals, we want the best for our clients, and perhaps have a strong opinion about how it would be best for them to go about their lives. Especially so, if we agree that most people, regardless of ethnicity, background and culture, want pretty much the same things to one degree or another (e.g., sense of purpose, safety, stability, no suffering, belonging, connection, etc.). Thus, we can try to focus our interventions around these types of explorations, but always communicating respect for clients' own decisions, even if they decide to go in a direction we disagree with. The tricky part would still be when clients decide to keep engaging in behaviors that step over the boundaries of another person's rights and freedoms as human beings (as in the example of the drunk driver Bill mentions).

In the trainings I have gone to, and the ones I have conducted, one message has always stood out: that considering the wheel of change, our main goal should be to facilitate movement to the next stage, even if that means only decreasing resistance and helping clients to consider the possibility of change in the future. In our roles as facilitators of change, I believe we need to learn to be comfortable with this outcome, and help our trainees be comfortable with this outcome too. Because if we adhere to the spirit of MI, chances are the person will want to come back and talk to us when change seems more of a possibility for him/her.

In terms of training clinic staff with goals and values we may not agree with, I would say, train them! But we should keep emphasizing that, in the end, the clients are the ones who should make their own decisions, and that, as MI facilitators, they should also try to respect this, even if when they don't agree with the clients' decisions. This way, as a trainer, one would have the opportunity to "motivate" change in a clinic's approach, from trying to persuade people to go in certain directions, to helping clients get to where they really want to be for themselves.

In the case of behaviors that seem harmful or reprehensible to us, as Bill suggests regarding certain religious practices, then I believe our role is even more crucial. I think we may want to go in with an open mind and try to understand what the people requesting the training want to do, and their reasons, and then present MI as a way to try to elicit this same reflective process from their own clients, so that those clients can decide what is best for them.

So, in terms of my job as a clinician and as a trainer in motivational interviewing, I think my main goal should be to communicate that clients should become more aware of their behavior and its consequences, as well as its importance to them, but also consider all possible aspects of a decision — and learn to respect that in the end, clients are free to decide what is best for them.

Valuing Values

Jon Krejci

I could not agree more with Bill's contention that, like all forms of therapy, MI necessarily engages the values of the practitioner. I believe it to be both dangerous and naïve to assume that by respecting client perspectives, client-centered therapies are value-free. Every clinical choice point represents a decision to pursue one avenue at the expense of the other. Since none of us is perfectly empathic or altruistic, I agree that

such a decision cannot be made without involving the values of the practitioner.

However, I question whether "the degree of our comfort in using MI to promote value-driven behavior change is related to the extent to which we share that value." I suggest instead that our comfort is affected to a large degree by whether we see the behavior in question as reflecting a true value or as driven by preference, and hence whether we see opposing that behavior as violating the client-centered value of equal respect for the values of others. I will try to illustrate using a thought experiment.

I am a Democrat of the moderate liberal persuasion. I am appalled by what is referred to in America as "neo-conservatism." Now let's pretend a liberal advocacy group offered to hire me to go door-to-door, using MI to encourage voters to vote against neo-conservative issues and candidates. Why would I refuse such an offer? I would refuse because although I would be promoting a value-driven behavior with which I agree, by doing so I would be violating a higher value: that of accepting the right of others to live according to their own values (except, of course, when doing so causes unjustifiable harm to innocent others). Similarly, I would refuse to work for Bill's hypothetical family planning clinic not just because I am pro-choice, but because I see the central mission of the clinic to be to oppose one set of values with another. The nature of those values would be largely (although I concede, not entirely) irrelevant to my distaste for their enterprise.

So why would I most likely accept the offer of clinic A? Here, in my opinion, is where the central ethical "itch" lies. I think the reason I (and most of us) would accept this assignment is *because we do not see harmful drug and alcohol use as reflecting a true value*. Rather, we see it as an attitude or, as so eloquently expressed by Chris Wagner and Francisco Sanchez (Wagner & Sanchez, 2002), a "preference for experience." And because values represent abstract ideals, they inhabit a moral dimension, and thus enjoy an intrinsic pre-eminence over preferences and attitudes. In short, we can readily imagine protecting a fetus from the effects of noxious chemicals as the outgrowth of a deeply held moral vision. It is harder to imagine defending substance use in the same manner. I believe that it is this unspoken belief that makes it possible for those of us who are comfortable with MI's more directive aspect to explicitly endorse "eliciting change talk" around drug and alcohol use. We believe that we are not imposing our moral vision on clients, but rather that we are following a universal rule: values trump preferences in the universe of defensible stances.

However, there are enormous implications if I am mistaken in my assumption that substance use does not represent a true value. For if true, this would imply that I have no basis for believing that, once the pros and cons are appropriately explored and tallied, clients' "true, underlying" values would usually lead them to prefer change to the status quo. Rather, it would imply that preferentially eliciting change talk is little more than a veiled attempt to coerce clients to adopt my values and abandon their own. And while I might have some basis in this instance for believing that my values are intrinsically superior to my client's, I would have to concede that I have taken the first step down a very slippery slope.

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MI and Counselor Values

Patricia Lincourt

One of the reasons that I was first attracted to MI was the model's consistency with what I value very highly as a clinician: a client's right to self-determination. Although motivational interviewing is directive, it is so within a client-centered, genuine, warm, and respectful client therapist relationship. Although the therapist encourages a particular change, or at least the contemplation of that change, it is clearly the client's decision whether to pursue change or not. MI (like psychotherapy in general) is a pretty straightforward pursuit when client and therapist values align, as is usually the case. Clients value their freedom, health, family, or any other array of value-laden goals and dreams. Often these values conflict with the behavior that brought them to treatment, and both therapist and client pursue a conversation that leads to a very nice dance between the two.

Where MI and psychotherapy become more difficult is when values lie on a continuum left to the judgment and discretion of the therapist, who has the most power in the relationship. In this case it is sometimes murky where to draw a line, one direction or another. Taking "directiveness" as a concept, I see "directiveness" vs. "nondirectiveness" on a continuum rather than as a black-or-white dichotomy. With any particular client on any particular change, a therapist can chose to be very directive or not at all directive or somewhere in between. A non-cooperative suicidal client who refuses intervention is an example of a client who the therapist will likely chose to be extremely directive with, taking matters into the therapist's own hands. A couple choosing whether or not to continue a relationship is an example of where the therapist will likely take a very nondirective approach. And finally a client who is engaging in self-destructive behavior is likely to evoke a more directive than nondirective approach.

Good therapists differ on when and how intensely to intervene directively with clients, based largely on our own values. When working with a client who is engaging in a self-destructive behavior, I am much more likely than many colleagues to allow for an exploration of the positives of the behavior and to work with the client with a currently active self-destructive behavior. This is because I have a great respect for the wisdom of individuals, especially those who have been traumatized. In my experience, clients chose a self-destructive avenue for positive rather than negative reasons. It is the self-destructive behavior that brings relief from distress, expresses extremely negative emotion in a way that is less disruptive of relationships, or has secondarily positive reinforcers such as eliciting help from others. I have found that allowing for an exploration of the positive increases the dissonance found in the negative because the negative consequences stand in such stark contrast to the initially intended positive goal. Clients often respond very positively

to working through their own ambivalence and almost always decide in favor of change.

Many of my colleagues value more highly their role as healer in the client's life and would intervene with a request for the client to stop the behavior very early in the therapy. Many clients meet with this type of intervention with relief and report feeling cared for and understood. I do not believe that there is a "right" or "wrong" approach to these clinical situations, but there are values-congruent and values-incongruent responses for the therapist. Therapists' belief in the model of treatment they are using is a factor in successful outcome, and I suspect that therapists pick models consistent with their own values. Perhaps it is an important outcome variable that therapists are practicing in a way that is perceived as congruent with their values.

Stickier still are value laden clinical situations in which therapists' own values are in conflict. Examples of this are abundant. As a therapist I value very highly, perhaps most highly, the client's right to self-determination; however, I also value the client's safety and well-being, my own license to practice, and a good night's sleep. It is often in situations where the therapist's role as social control agent conflicts with the primary role of helper where dissonance is likely. Also, in cases where clients are deteriorating, and it is less clear that they have the ability to control a behavior which is becoming increasingly dangerous, that the value of self-determination may conflict with the value of protecting others from harm.

In my own experience it has been as an agent of social control that I have had the most challenging value conflicts. Some examples include: clients who need letters for court, or for a safety-sensitive position; child abuse cases, where a report will surely end the therapeutic relationship; and probation officers, who need reports and do not believe that approximations should be seen as success. There are also family situations in which the therapist's own values may be challenged: marital situations in which the therapist learns that one member of the couple is being unfaithful, or family situations in which a child does not know the truth about something important in his or her own life.

There are very often no "right" answers to these dilemmas, and therapists must decide often based on how they prioritize their own values. I recently reported to the child abuse register in New York State, as I am mandated by law to do, a case of an otherwise very supportive parent who "lost it" and left significant bruises on an adolescent child in her care. I valued the working relationship with the family, the safety of the child, the "message" to the parent around expression of anger, the "message" to the child about limits of "O.K." behavior, as well as my own

safety in practicing, my promise to report these instances, my reputation, and my working relationship with the therapist who referred the family. Clearly, not all of the things I valued could be equally respected, and I had to make a choice. Would another therapist have made the same decision based on the same values? Most likely there would be many who would resolve the dilemma differently, and who can say which is right? How do we judge which is right? By outcome? By principle? Although in this case there were only two choices, the values dilemma is as individual as we are as people and as therapists. As Dr. Miller points out, there is no such thing as value-free psychotherapy.

Social and Political Contexts

Jim McCambridge

We have been witness to the enormous growth of interest in, and application of, MI over its relatively short history. It has become a defining feature of the addiction treatment systems in many European countries and is now also being widely applied throughout healthcare systems and beyond for varied purposes. This approach to individual psychology has now become transformed into a sociological phenomenon.

A key underlying assumption of MI is that healthy change is a core human value. In MI we are thus seeking to elicit what already exists in an individual's values and goals, and not seeking to impose our own. Values and goals are not static, however, and may also often be in conflict. With MI, we employ strategies to influence the outcome of value conflicts. Routinely we choose to disrupt a valued relationship with, for example, a damaging pattern of drug use, for 'good' reasons. This actually goes far beyond merely eliciting; in shaping and enhancing preferences for healthy change, we are at the same time diminishing the importance of less healthy values. Most of the time this

can be unproblematic. Less so, when there is value conflict between trainer or practitioner and client. On the basis of our own values, we seek 'good' outcomes for those we wish to help, but who are we to define what is good for others?

One of the striking things in training and other introductions to MI is the regularity with which a charge of manipulation is encountered. Within MI, the 'defence' has been constructed largely as an ethical issue. I've found in talking to people about this issue that those who are most appreciative of the spirit of MI are most receptive to this account. I'm struck also by how prevalent is a particular type of response among the well-disposed, along the lines of, "Yes, it is manipulative, but for 'good' reasons". Conversely, those who are less interested in the spirit of MI are those who remain most suspicious.

If we were to interpret the prevailing suspicion about the directiveness of MI as resistance, then we should hear alarm bells ringing and ask ourselves what is going on. What can we learn from these views of people with whom we disagree? Maybe what is being signalled to us is that the construction of this matter as an ethical issue is inadequate. Isn't manipulation largely concerned with the covert exercise of power? The concept of power belongs to the realm of politics, as well as that of ethics.

We don't ordinarily frame the issue in this way, as it seems incongruent with our professional training and may have an uncertain place within our own value system. Most practitioners and trainers have received basic training in psychology or other holistic approaches to helping individuals, and most discussions about MI take as their frame of reference the MI conversation. A broader perspective on the nature of power can be gained from the social and political sciences. For example, in the work of Antonio Gramsci, power is seen to be most effective when exercised quietly, while resistance or overt conflict occur as a consequence of the blunt administration of power.

The concept of power is recognised

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within the ethical account, and an important distinction is drawn between the use of power which is coercive and that which is not, with reference to consequences. I wonder how strong a distinction can be maintained, however, if we were to consider that the exercise of power, by definition, always has consequences for those acted upon, consequences which may be either helpful, unhelpful, or both. Coercion may be a label we attach to types or degrees of exercise of power with which we feel uncomfortable or of which we disprove. Coercion may be gentle as well as brutal. Maybe this is a difficult issue, and we don't have a sufficiently well-developed vocabulary to make talking about it any easier, and does it really matter anyway?

Everitt Rogers' work on the diffusion of innovations teaches us that 'external' social processes and institutions will be strongly influential in dictating the future course of MI. Within individual helping and training sessions and in research studies, it is probably unavoidable that MI will be practised, taught and studied in ways and for purposes that vary from core principles. The misuse of MI could well take the form of the misuse of power. As MI becomes more influential, it seems to me important to develop a consciousness of issues relating to the use of power. The likelihood of the misuse of power will be enhanced in the absence of the continued development of strong 'internal' norms. (Is this one way to understand the emphasis on 'spirit' within the community?) A micro-politics of MI might focus on how power is exercised within individual contexts.

I'm interested in using and studying MI for public health purposes, for the benefit of the community as a whole, however that may be defined. The core principles of MI also require a macro-political perspective, with careful attention being given to the use of MI in this project to persuade populations to become more healthy. 'Healthy' equates to 'good'. The issues raised here are not at all specific to MI: the nature of the relationship between the state and the individual is at issue in most areas of health promotion.

Questions about values and MI thus have social and political contexts which may be both interesting and important to explore further. Perhaps when you next experience 'ethical itches' about your practice, whether it be as a practitioner, trainer or researcher, it might be helpful also to ask whether the itch has any political content.

The Dark Underbelly of Therapist Neutrality in Motivational Interviewing

Terri Moyers

As a graduate student, I learned a painful lesson about the impact of my own values upon my work. In my very first session with my very first client (a young woman frightened to death by her shoplifting habit) I wore a dark blue business suit with sensible shoes and a severe white shirt with one tiny white bow (for a bit of relief). After the session, I went directly to meet with my supervisor, ready to answer any possible question about my client. Instead, he asked about my choice of clothing and did not accept the minimizing response I offered. What followed was a lesson about my desire to inspire my client's confidence with my attire and how that worked in the service of covering up my insecurity as a new therapist. My deeply held value for competence and confidence smacked right up against my work as a therapist and I'm here to tell you, that whole thing hasn't stopped yet.

Along with some others in this virtual symposium, I am convinced that psychotherapy, perhaps especially MI, is inevitably influenced by the values of the therapist. I recall the studies in which Carl Rogers' students showed his differential reinforcement of particular client themes in his choice of reflections — patterns of which he was not aware. Although Rogers did not want to be directive, he could not avoid it. This point was brought home to me again recently in reading Yalom's (2002) *The Gift of Therapy*, which has a chapter devoted to the myth of the blank slate. In urging therapists to disregard antiquated notions of therapist neutrality, he describes Freud's own repeated and irreverent violations, including incidents when Freud teased clients about their resistance, attended social functions to see them in other settings, and smoked congratulatory cigars with them after particularly insightful breakthroughs! It seems we therapists are hoist on our own petard

when we deny the influence of our values in our work. They will out, whether we like it or not.

And there is the rub that worries me. For if we do not honestly admit to ourselves the way in which our values will influence our choices as therapists, we cannot guard against the very intolerances and bigotry that concern us the most. In an odd way, being clear about our values may be the best insurance against foisting them on others in a distorted way during the therapy hour.

One of the most troubling examples of this is the tendency of some mental health providers to be blind to our own value in favor of social conformity. This profession, which overtly honors the diversity of human expression and behavior, has a dark history of well-meaning therapists who have "treated" symptoms in their patients that were nothing more than natural human oddity and rebelliousness. I would rest easier if these therapists were the Josef Mengeles of the mental health world. Instead they seem to be comprised particularly of individuals who were progressive, compassionate and tolerant, but blind to their own distress at nonconformity. As one brief example, let us consider Freud's abandonment of the seduction theory (Masson, 1984).

Freud, listening carefully, heard the complaints of his female patients and arrived at the conclusion that their hysterical symptoms were related to their coercive sexual experiences as children at the hands of the adults around them. It should not surprise us that the social censure that resulted in the publication of this theory was nearly catastrophic to Freud's career and what followed shortly thereafter was his retraction of the seduction theory. Instead, lamentably, we ended up with the Electra Complex, which casts the hysterical complaints of women far afield from the childhood exploitation which was so unbelievable to Freud's contemporaries.

For an example even closer to home, I don't think we have to look further than the current use of psychological treatments to address driv-

ing under the influence (DUI). In the United States, we are deeply ambivalent about how we should address this problem of drunken driving. We have laws on the books mandating lengthy jail sentences for those who are convicted of DUI, yet we lack even a fraction of the legal manpower and prison cells it would take to really enforce them. The solution, I regret to say, has been the "therapization" of DUI, such that anyone caught is sent to psychological screening and treatment, thereby avoiding jail. Although I see some potent advantages to this approach, I worry about the impact on the integrity of the therapeutic process. How can we, on the one hand, say that we believe the effectiveness of our treatment depends upon an honest, egalitarian, and accepting collaboration between the therapist and the client, and on the other hand require therapists to disclose to probation officers that clients have been drinking when they aren't supposed to? Why is there not even a dialogue about the ethical complexities of grafting a treatment based on the client's full and willing participation onto situations where he or she is coerced? I am not salved, by the way, with the response that the client is free to choose jail instead — this was the same argument used to facilitate many forms of abusive mental health treatment in the past. I still worry that our own hidden need for social conformity (and making money!) has blinded us to the potential down side of "psychologizing" DUI. I am deeply skeptical that this is really in the client's best interest in the long run.

What does all this have to do with the therapist's values in using MI? It is about asking ourselves why we are wearing the blue suit to the therapy session. The direction of our MI interventions will inevitably reflect our values, whatever they happen to be, whether we appreciate that or not. Better the value you know than the one that is hiding from you. The process of examining, acknowledging, and being explicit about the influence of our values is the best way to avoid distressing distortions of a therapeutic approach based on genuineness, egalitarianism, collaboration, and empathy.

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Values, Trainees, Clients and Me

Michael Peltenburg

Whatever values are, wherever they come from, most of us do have some, some of which we might even share as humans, as health care workers, as counsellors or as teachers. As we do have values, trainees and clients have them too. But, values we live up to are the exception; usually we can be proud if we try to live up to them.

MI, defined as a more or less explicit set of knowledge, skills, and attitude, is profoundly rooted in Carl Rogers' ground. The therapist offers genuineness, unconditional positive regard, and accurate understanding. Hence the acceptance of ambivalence. Since ambivalence is seen as a natural stage of possible transition, it becomes an explicit focus of the MI counsellor, with the intention to guide the client to where she wants to go. "The counsellor is trying to influence/create a healthy process. [He] is not trying to influence or manipulate the outcome." (Michele Packard, Listserv communication, August 8, 2003).

Unfortunately, it is probably not as simple as that. It might be that the differing values of MI counsellors, trainees, their institutions and clients drive them into different directions. "Guide the client to where she wants to go" raises the question: Where is "where"?

Trainees or their institutions might see "where" as some goal defined by law, culture or religion; they might see "where" as the institution's, the counsellor's or the client's goal, or as the agenda that results from a shared decision based on a common ground created by a negotiation process … or?

The client might see "where" as the counsellor's responsibility, quite opposite to the counsellor's own view, and may only slowly and often reluctantly accept her own responsibility for the choices she makes.

Where does that leave me? What is the place I have to find for myself? Can I orient myself on the values I share with the MI community?

With clients it is not always easy to offer unconditional positive regard. Though it might hurt, I am glad my client feels it when I lack genuineness. She changes counsellor. Quite a different issue in a setting where the client has no choice or is dependent on me — am I open enough to let her know? To let her see my lack of professionalism or perfection? Honestly, I am not sure I am. But I am glad to be able to choose supervision.

With trainees it's not easy, either. Sometimes I do not share their values or theirs are in opposition to mine. What is my role: to contest, to question or to refuse to work with the trainee?

Might it be that my way of working with the other, even if he has values clashing with mine, without giving up my own — that is, accepting her unconditionally, genuinely and empathically — gives me the chance to live up to my values? But, as I said, it might be that I only tried and failed. On the other hand, it might be that my modelling creates a discrepancy between what people are and what they want to be, a cognitive dissonance within the trainee, that it starts a process which goes "out of control", puts the trainee in conflict with his institution. Am I responsible? Is this a desired outcome, or do I have to protect my trainee from destabilizing? Do I have the trust that, as my client is responsible for the choices and options she makes, the trainee is responsible for what she does with what I am trying to teach? I know there are moments I fail to trust.

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The Space Between: Personal Values and MI

Joel Porter

Our starting point, the proposition that being human means being conscious and being responsible, is reaffirmed in the moral sphere.
(Frankl, 1986, p. 45).

In a recent supervision session, I worked with a counsellor on incorporating the Personal Values Card Sort into her work with problem gambling clients. After we went through the exercise, she stated, "This is a serious intervention". This sparked a lively conversation on values and the place of the counsellor's personal values in the process of counselling. The focus of the conversation centered on the ethics of imposing our (counsellor) values into the world of the client. Since that session I have been wondering, where do my personal values leave off and those of the client's begin? Is it a similarity in values that makes for a good match between counsellor and client? Moreover, what is it that is makes motivational interviewing so effective for so many clients, and appealing to so many counsellors and health care professionals? I am starting to think it has something to do with being conscious of my own values and being responsible for how they interact within the counselling process. I have found that this is much easier said than done in the moral sphere of human interaction.

The reason that I have become passionate and engaged with MI is not so much because of the impressive and robust evidence base that supports its efficacy. It is simply that the spirit and principles of MI are well attuned to my personal values. I like to think the way I practice psychotherapy, training, and supervision is a reflection of the way I strive to live my life-as consciously and in the first person as possible. Indeed, it is impossible for me to think of any aspect of my existence that does not involve my personal values. However, in order to be helpful to others, it is important for me not to confuse my personal values with the client's personal values. Rogers (1965) brings this point home with the following statement:

One of the cardinal principles of client-centered therapy is that the individual must be helped to work out his own value system, with minimal imposition of the value system of the therapist. This very commitment is, of course an expression of a value, which is inevitably communicated to the client in the intimate course of working together. This value, which affirms the individual's right to choose his own values, is believed to be therapeutically helpful (p. 292).

I am not aware of any other approach that consciously recognizes the therapeutic value of directly encouraging people to explore and work out of their own value system as objectively as MI. MI's collaborative and counter-confrontational approach creates a relationship that encourages clients' autonomy, as well the exploration of their values and beliefs. Through the utilization of the Personal Values Card Sort, I have found that is not uncommon for clients to become conscious of personal values that have been suspended for quite some time in order to maintain their personal relationships with addictive behaviors. I believe that feelings and thoughts that follow these experiences of value re-discovery naturally lead clients to consciously enter into the moral sphere, and explore their ambivalence and the discrepancies between their personal values and current behaviours — which leads to experiencing the realities of their present life, and in turn opens the door to making informed choices about how they are going to live in relation to their addictive behaviors.

I have discovered that MI is an intensely intimate and meaningful way to join with and affirm people who are struggling with deeply personal problems and who are often ambivalent about changing their relationships with their addictive behaviours. The process of MI is transpersonal. The spirit and principles of MI transcend natural human obstacles to changing addictive behaviours such as shame, fear, anger, and suspicion, through compassion, understanding, direction, and empathy — while at the same time, MI allows clients to objectively explore their ambivalence and make their own informed choices. I believe this power of choice is the most powerful action we have as human beings.

Personal values are the foundational building blocks that guide and inform personal choices. Choices are clear reflections of personal values. For instance, if I value the opinion of others more than my own, then my choices will reflect what I believe others would want of me. Choosing to live my life in such a way will, more often than not, leave me feeling out of sorts with myself and even resentful of others. Irrespective of what I say about myself, my choices are going to speak louder than words. Since the act of intentional choice is the most powerful action I possess, it is essential that I remain conscious of my values and take full responsibility for the outcomes of my choices.

There is an important interrelated existential/humanistic/spiritual connection between values, consciousness, choice, and responsibility. In the domain of MI, it is imperative that we are able to remain aware of how this existential dynamic is being played out, in order to know the best direction to take when "faced with a catacomb of possible directions" in a session. As Bill so clearly put it, "MI is precisely about being conscious and intentional in choice of direction within a client-centered manner". I take this comment to heart. I know that the more congruence there is between my level of consciousness, intentionality, and choices, the more genuinely client-centered I am with others.

One of the challenges for me as a psychologist is to remain conscious of how my personal values are manifesting themselves in the therapy room with clients from moment to moment. Client responses to reflections not only inform the counselling process, they also keep me conscious as to the whereabouts of my personal values and how they are influencing the counselling process. The more I practice and teach MI, the more I realize that the more congruence there is between my thoughts, feelings, and values, the more I am able to listen, empathize, and trust my own intuition when working with people who are often confused and quite stuck in their problems.

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The Primary Care Physician Responds

Richard Saitz

Much like the sign that welcomes patients to Bill's CASAA, patients who seek primary medical care expect the physician to work to improve their health. They expect the physician to advise physical activity, healthy diet, adherence to medication, and against smoking, drug, and excessive alcohol use. This advice may be given as an admonition, an argument, in the form of a pamphlet, or in the context of a more structured counseling style, like MI.

Bill suggests that it is virtually impossible to provide client-centered counseling in a value free way, and that one of the key qualities of MI is that it is directive. I agree, and I believe this is one reason MI has become so popular for discussing health behaviors. MI or no MI, the physician is obligated to work to improve her patient's health (definition admittedly loose and/or debatable). Directive counseling is one way to do this. MI may be the most respectful and effective form of directive counseling.

Should physicians be troubled that they are counseling patients with intent to improve health? Not at all. Can patients disagree with the direction? Of course. But it is far better the disagreement and all of the values and options involved be laid out clearly by both the physician and the patient.

Are there health issues that can be discussed without choosing a direction? Sure. Risks and benefits are not always on the same metric. For example, someone with arteries to the brain that are narrowed may choose not to undergo surgical correction because he/she prefers the long term risk of stroke and death to the risk of immediate death during the surgery today. Another person might decide the opposite. A Jehovah's Witness with a low enough blood count that risks imminent death should be made aware of this fact, and the fact that a blood transfusion would decrease this risk. Would I use MI (or any other counseling or advice) to encourage a transfusion? Absolutely not (this patient believes that transfusion increases a far more important risk). For Bill's example regarding abortion versus adoption, it is not clear that one is healthier than the other. As a result, it would not seem appropriate to use MI in the health care setting to encourage one over the other. The principle there, is to leave the professional's religious beliefs out of the counseling room (that's not what the patient comes to me for; there are many others better at that) and understand and respect the patient's religious beliefs. However, if the sign says "Family Planning Adoption Clinic," I think one can anticipate the advice that would be given. Provided the motives are explicit, whether or not MI is used is not the issue (though it may become the issue if this is the only service available to a patient; a political and social issue).

My patient who smokes cigarettes would be shocked if I did not advise quitting. During an MI conversation, I might learn that the pleasures of smoking, and the fact that the long-term risks of increased mortality, heart disease, lung and bladder cancer, and need to carry around an oxygen tank, do not accrue to all smokers, lead this patient to rationally conclude he should continue. My directive counseling is aimed at abstinence. But MI allows it to become clear to me that in weighing the pros and cons, the patient is convinced he should continue smoking. So be it. I will continue my directive counseling in the future. Why? The patient will return, he expects me to advise him to quit, I know it is better for his health, and the balance may eventually tip. In the mean time, we continue a solid relationship and work on improving health in other ways.

So, should MI be used for every health-related behavior in the primary care setting? No. But can it be used in a directive fashion to change patient behavior to improve health? Yes, as long as the goals are explicit and understood. Is the definition of health complicated and subjective? Yes. That is why this is controversial, complicated, and fun. Am I worried that my use of MI might lead patients to do something contrary to their core values? Not in the primary medical care setting in the context of a physician-patient relationship. First of all, counseling is not that potent. Second, MI will make the patient's values more explicit. Might the patient end up with a less healthy behavior? Yes. That is a risk. But the patient will be aware of the opinion of his or her trusted advisor, and there will always be next time.

MI & Informed Consent: Getting Traction on a Slippery Slope

Paul J. Toriello

My answer is the same as Neo's. Neo is the hero in a cinematic trilogy known as "The Matrix." At the trilogy's conclusion, Neo is facing his nemesis, Mr. Smith, for their final battle. Neo is not winning the battle, and Mr. Smith vehemently asks something to the effect of: "Why do you continue to fight when there is no chance of your victory…why do you continue, knowing the absolute truth of your inevitable defeat…why…why??!!" To this impassioned interrogation, Neo simply says, "Because I choose to."

I do not equate my struggles with those of Neo, however I do agree with Neo. I believe our human condition provides us the capacity to make autonomous choices regardless of socialization, neurochemical activity, and genetic predisposition. I cannot prove that this belief is true any more than someone, let's call someone Mr. Smith, can prove the opposite belief (i.e., that our behavior is completely determined) is true. Mr. Smith and I can make rational arguments for our positions; we can quote scripture, theorists, and develop elaborate analogies. But at the end of the day, Mr. Smith and I are left with the dilemma: do we choose or is choice an illusion? I believe the former is correct. I do submit to the notion that my choices are influenced by my socialization, neurochemical activity, and genetics, but I make choices independent of these influences.

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Operating from this belief elicits corollary beliefs in regard to my practice and training of MI.

My goal as a clinician and trainer is to maximize the autonomy of my clients and students. To that end, MI seems a very good fit. Bill wrote an essay about how addiction reduces the volitional control (VC) of the addicted person (Miller, 1998). I think that unexpressed ambivalence reduces VC and thus, the habitual or "unhealthy" behavior is perpetuated. During a motivational interview, as ambivalence is expressed, a sort of pressure is released (maybe in the form of change talk) and the VC of the person is increased. I equate VC with autonomy: if one's VC or autonomy is increasing, then one's choices are more independent of the force that would constrict them (i.e., unexpressed ambivalence). With unexpressed ambivalence one has less of a choice; the unexpressed pressure requires immediate gratification. If one expresses ambivalence in the context of another person's genuine and empathic acceptance, then one has more of a choice. However, even if one's autonomy is increased, that person may still freely choose the "unhealthy" behavior.

As Chris Wagner stated, when I am conducting a motivational interview, I am "passionately neutral" about the choices a client makes (Wagner, TNT, Wintergreen, 2003). However, I communicate this neutrality only after I have communicated my "position" during an informed consent process at the beginning of the relationship. Informed consent is critical for at least two reasons: (a) informed consent is another mechanism to increase client autonomy and (b) facilitating informed consent is a value of the profession I belong to (Corey, Corey, & Callanan, 1993). If I work for a treatment agency, then I ascribe to the values of that agency. I need to inform my clients of these values: what are the therapeutic goals of our agency…what is expected of the client…what are the consequences if the expectations are not met? After my position is clearly stated and the client consents to that position, then I can become passionately neutral. I no longer need to argue my position, the client is informed. The interview becomes about the client's position, values, and choices. I believe that this mixed message of informed consent and MI can coexist. Facilitating informed consent, or communicating the values I have chosen (as a member of an agency), then frees me to elicit the values the client chooses. If I am trying to get a client to do something against their will, then I do not believe I am doing MI.

I think the process of informed consent is equally important when a group asks me to train them in MI. I need to be informed of their position and they need to be informed of mine. Thus, I ask the following questions: what are the target behaviors of your agency…what are you asking your clients to change? What are the consequences if clients do not meet the target behaviors? I then tell them how I think MI works, and when I disagree with their target behaviors, I tell them I disagree. After we are informed on each others' positions, I then state that I believe I can effectively train their staff in MI if they want me to; I become passionately neutral about their target behaviors.

I would choose to train any group to use MI as long as all parties are informed. After my training, whether they choose to use MI is up to them. If I am trying to get students to use MI against their will, then I am not training MI. If I am trying to get students to change their mind about target behaviors by training them in MI, then I am not training MI. If people I train in MI are using MI to get clients to do something against their will, then they are not using the MI that I trained; they are not, in my mind, using MI.

Can I have a position and be passionately neutral about the position? I think yes. Again, my goal is to maximize the autonomy of my clients and students. After informed consent, if I become biased in my communication with them, then I will elicit resistance, thereby creating a context that will reduce autonomy.

Both Mr. Smith's and Neo's positions make sense to me. I do not believe my choice of Neo's position is an illusion. Mr. Smith may then ask me, "How can you possibly believe that you can have a position…a bias and at the same time be passionately neutral??!!" My response, "Because I choose to."

Acknowledgements: I would like to thank those giants who let me stand on their shoulders and those who are letting me climb up their backs.

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Some Thoughts on the Ethics of Influence

Chris Wagner

Writing about the ends to which motivational interviewing may be directed, Bill states that "MI is precisely about being conscious and intentional in choice of direction within a client-centered manner." Directiveness has been a key element of MI, and the definition of "direction" continues to be refined, from resolving ambivalence, to resolving ambivalence in the direction of "change," and likely on to an even more refined distillation.

Bill's piece challenged me to think more about the meaning of "direction of change," and to define the grounds on which I might make choices to influence clients in a directional manner. In the treatment of substance use disorders, perhaps the meaning of "direction of change" is clear — there is excess in a set of behaviors, and change implies reduction or elimination of those behaviors. But the "direction of change" may not always be so clear when therapy focuses on other issues.

Bill mentions that our values can guide the directions we pursue or support in training and therapy, "depending upon our own judgment of the worthiness of goals." I agree that it is impossible to interact with a client without my values coming into play. And it can be challenging to determine which of my values are professional, generally shared by those in my discipline, and which are strictly personal, unrelated to my profession. Yet I don't want to abuse my role as a licensed psychologist by propagating exclusively personal values in a professional role. My professional association's code of ethics states that "psychologists' work is based upon established scientific and professional knowledge of the discipline" (APA, 2002). Thus, I think it is my ethical responsibility to limit the directions I support or pursue to those emerging from scientific and professional psychology or related

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fields. My personal values certainly limit the kinds of initiatives I am willing to be involved in, yet it seems I should not rely upon them to set the direction for therapy or related endeavors when they fall outside the realm of "established scientific and professional knowledge."

Generally, I think therapy can be directive without extrinsically influencing clients toward particular ends. Guiding the process of therapy so that resolving ambivalence and moving into action remain central is a way of being directive in process, if not in regards to the content of client's decisions. This "directive in process" stance is more directional than Roger's non-directive stance, which trusts the client not only to determine the direction he or she wishes to take in life, but generally to lead the process of therapy as well (Rogers, 1946).

However, I also recognize that there are times when even this "directive in process" stance may not be optimal. Clients may desire more direction, public agencies may be funded to achieve specific goals, and research projects may be directed toward particular ends. Thus, I think it is appropriate to consider what constitutes "established scientific and professional knowledge" upon which I might base decisions to try to directionally influence clients (while also recognizing the ethical hazards Steve and Bill describe). I can think of three general directions toward which I might encourage or influence clients: toward reduction of symptoms of a defined disorder, toward those directions that evidence suggests is promising, and toward directions that accepted and supported psychological theories suggest are healthier. While my personal values likely color how I interpret the source material for these therapeutic directions, I believe my personal values should not themselves provide the source of direction.

I'll consider the two scenarios Bill describes in light of these three directions, as they serve (for me) to highlight differences between seemingly similar situations, and lead me to conclude that I have ethical grounds to attempt to influence clients in one situation (to move away from compulsive or harmful use of substances), but not the other (to make a decision one way or another in regards to abortion).

One difference is that one scenario focuses on eliminating the symptoms of a defined psychiatric disorder, whereas the other focuses on a decision of conscience unrelated to any defined disorder. I think it is acceptable to use influencing techniques in the service of symptom reduction, particularly symptoms that may influence the person's motivational or decision-making capacity (e.g., depressogenic thinking). Two symptoms of (DSM-defined) substance abuse are use that is physically hazardous and use that results in a failure to fulfill major role obliga-

tions. I think these provide the ethical grounds to pursue a direction that focuses on elimination of use in this situation. I am unaware of any professional consensus that choosing to have an abortion represents a "problem behavior" or reflects a symptom of a psychiatric disorder. Thus, I don't believe that I can rely on the same ethical base to use influencing techniques regarding this matter of conscience.

Although symptom reduction provides one basis for direction, I don't believe that it provides the only ethical basis. Many issues discussed in psychotherapy fall outside this domain, including existential concerns, choices about careers and relationships, identity issues and so on. When these issues become the focus of therapy, am I ethically limited to a non-directional stance because they are not elements of defined disorders? I don't think so. I think I also have license to engage in directiveness to the extent that evidence suggests one direction is more likely to lead to a better outcome than another. In Bill's two scenarios, there is good evidence that elimination of substance use during pregnancy generally promises a better outcome for the client than continuation of substance use. I think it would take exceptional circumstances to expect continued use to lead to the better outcome.

The empirical basis for direction in the case of an ambivalent pregnancy is more limited. There is research describing negative reactions to abortions, but it is based on convenience samples, and thus susceptible to investigator or interpretive bias. Still, I would be supported in mentioning this evidence, as I would in mentioning that use of certain substances during pregnancy may harm a child in the other scenario. However, I don't believe that I would be supported in attempting to influence a woman based upon this scant evidence, or implying that a client would be likely to experience abortion — related trauma. I think it could be useful to explore abortion in the context of her values, but care would be required to avoid selectively focusing on values I

agree with while overlooking values that have less resonance with me. Further, I think that intentionally developing discrepancy between a possible choice to abort and a woman's religious values carries a risk of inducing a subsequent trauma (should the woman still decide to abort) and may be contrary to the maxim to do no harm.

Psychological theories comprise the third basis upon which I consider it appropriate to choose direction, although perhaps to a lesser extent. I don't have space to detail this here, but I can see a reasonable theoretical basis for influencing a client to eliminate compulsive use of substances (i.e., maximizing psychological freedom/autonomy). I know of no compelling psychological theory that supports influencing a choice about a pregnancy.

To bring it back to the issue of religious values, I think that clients' religious, spiritual or moral values are valuable components to consider when pursuing intrinsically-defined directions, and I am comfortable incorporating them into our work. But I think it is important to not confuse this with influencing clients toward living by my personal values, or the values of a particular religious group that the person is in contact with as a result of exposure or family legacy. If a client indicates "I wish to live by these religious values," then they become an important reference point for our work. But it seems to me that counselors who pursue a direction primarily based upon their personal or religious group values may be practicing something closer to indoctrination than professional counseling. Even when I resonate to the values being propagated and think the goal is worthy, I believe that when acting in a professional role, it is appropriate to limit my efforts to supporting directions emerging from psychology and related disciplines.

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Anti-Oppression Values Find a Seat at the MI Roundtable

Stéphanie Wahab

Bill Miller eloquently proposes that a trainer's level of comfort with providing MI training for a value-driven agency depends on his/her level of value alignment with those of that particular agency. I agree with Bill's proposal, AND I would like to suggest that the trainer's comfort level might also be informed by how able to support the MI spirit the organization is perceived to be.

I will build on Bill's examples by using clinics A & B to explain my point. Clinic A provides alcohol and drug treatment to pregnant women. The clinic strongly believes that drug and alcohol use during pregnancy places the unborn child at risk, and wants to learn MI in order to help women decide to abstain during pregnancy. Clinic B is a family planning clinic that wants to learn MI in order to dissuade women from having abortions.

If Clinic A were to state that it would refuse a woman services if she chose to continue using, I might be reluctant to provide training, despite the fact that I share its value/belief that pregnant women should abstain from drugs and alcohol. Similarly, should Clinic B mention that its staff are not at liberty to explore abortion as an option with women, nor are they available to support women who choose to have an abortion, I would also be inclined to decline the invitation.

While I share some of Clinic A's values concerning what is best for its clients, I do not share those of Clinic B. My reluctance to provide the training (for Clinic B) has little to do with the fact that I am pro-choice and they are pro-life, however. My reluctance, rather, is rooted in my perception that the clinic's approaches and protocol do not leave room for the practice of MI. Specifically, the way in which the clinic's organizational values inform its protocol and practices severely limits its practitioners' abilities to practice key MI components including respect for self-determination, exploring a menu of options, and client centered practice. If practitioners are restricted from: (a) exploring all of a client's options; (b) supporting her should she choose to have an abortion; (c) supporting her should she continue to use drugs and alcohol, how can MI be practiced? The restrictions I just mentioned represent three of the five ethical complexities Steve and Bill highlight (Miller & Rollnick, 2002) as conditions where it is inappropriate to practice MI.

I recognize that my suggestion (above) raises a gate keeping issue — something I'm sure Bill and Steve grappled with when they were considering sharing MI with the world. To what extent do we, as trainers, need to get responsible for what people do with MI training they receive? Is it in MINT's interest to act as gatekeepers of the MI flame(s)? If so, how do we determine our roles and responsibilities in our efforts to maintain and facilitate the integrity of MI? These are important questions that merit thoughtful dialogue and go beyond the scope of this response.

Bill also asks us to contemplate why we would/wouldn't provide training to a religious institution that wishes its constituency to practice behaviors in a number of areas (diet, prayer, theft, pornography) that are more consistent with its values. Here I turn to my original post on the listserv, in which I shared my dilemma around providing MI training to a group of practitioners affiliated with a religious institution. While those requesting the training stated that they wanted to learn MI in order to help individuals (referred by their Bishops, wives, family members and the court) stop masturbating, viewing porn, and engaging in other "sexually deviant behaviors," I had good reason to believe that they were also interested in exploring MI as an alternative to reparative therapy for work with gays and lesbians, as same sex sexual behaviors are considered both sinful and deviant in this religion. Many stakeholders in the religion believe that gays and lesbians can (and should) become heterosexual (through therapy, religious counsel, and behavior change).

Consequently, the marginalization and oppression of gays, lesbians, bisexuals, and transgenders (GLBTs) is as prevalent in this religion as it is in numerous others. Some of the ways in which religions perpetuate oppression of GLBTs include denying their rights to self-determination, denying them access to resources available to heterosexuals, and teaching them that they are unacceptable as they are and need to change.

Oppression is different from discrimination and prejudice in that it involves the systematic exploitation of one subordinated social group by another (dominant group) for its own benefit; it involves institutional control, ideological domination, and the imposition of the dominant group's culture on the oppressed group (Adams, Bell & Griffen, 1997). Discrimination on the other hand is not always systematic or institutional, nor does it always involve a dominant group acting against a subordinated group. Vegetarians, as a social group, are not oppressed. People with addictions are not systematically (and across most institutions) denied access to social, political, and economic resources as a social identity group. Women, however, are oppressed as a social group, and abortion is situated within a discourse of oppression of women. Similarly, gays, lesbians, and bisexuals are also oppressed by virtue of their social group memberships and behaviors.

A personal and professional commitment to values of liberation and social justice render me an unlikely candidate to support institutions that wish to learn MI to use it in a way that further oppresses individuals and groups. I further propose that the spirit of (personal) liberation and social justice is consistent with the spirit of MI. That is, liberation, social justice, and MI as social constructs intersect where they embrace self-determination, autonomy, and self-actualization.

Consequently, trainers who are particularly concerned about the rights to self-determination, autonomy and

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self-actualization of oppressed individuals and groups may consider inquiring into and listening to the intentions of those organizations requesting MI training. Do the organization's intentions for using MI perpetuate a face of oppression (sexism, racism, classism, heterosexism, etc.)? How is the agency supported to support individuals' self-determination, autonomy, and self-actualization? While this proposition begs for a discussion of what constitutes liberation and social justice, I believe that constructs embraced in MI discourse such as agape (Miller, 2000), self-determination, and unconditional positive regard are akin to such existential contemplation.

One might be inclined to adopt Bill's argument and claim that I am disinclined to provide the group with MI training because my values are not aligned with those of this particular religious organization's. While it is true that some of our values are not aligned, I also know that this particular agency is not at liberty to support individuals who wish to continue masturbating, viewing porn, and engaging in non-heterosexual behaviors. Gays and lesbians who do not make the change to heterosexuality (in the church's eyes) are frequently told to leave the church. In addition, I've been advised that practitioners who would accept and support an individual's "choice to continue his/her gay lifestyle," would likely be fired. Consequently, I do not view this religious institution as able to support and work with the MI spirit when non-heterosexuality is concerned.

Bill posed the question, "Is it different if the subject of ambivalence is the moral teachings of the person's religion with regard to diet? Prayer? Envy? Theft? Pornography? How about child pornography?" To which I answer, yes, there is a difference. The difference rests in the extent to which the moral teachings perpetuate and/or interrupt oppression.

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Thoughts on Influence

Henny A. Westra

Miller and Rollnick (2002) point out that most ethical dilemmas concern influence. And the directive component of MI clearly involves an attempt to influence the client, in this case to increase motivation for some change that the client regards as desirable. Indeed, all of psychotherapy is about influence in a 'healthier' direction (although who defines what is 'health' can vary, as many folks on the listserv aptly point out).

But what is the nature and reach of influence? Before exploring implications for MI, allow me to consider some findings from experts on influence — social psychologists studying persuasion and influence (e.g., Cialdini, 2001). There exist intriguing parallels between processes in MI and the principles of influence that have been uncovered by social psychologists studying persuasion. The work of Bem on self-consistency is one example that has been posited as being at the heart of MI, but there are other influence dynamics that may have implications for understanding how MI works, and for considering issues of autonomy in choosing the direction of change.

One finding from the influence literature is that many of our judgments, and much of our decision-making, are not based on rational, carefully weighted processes but rather operate according to judgmental heuristics (Chaiken & Trope, 1999). We prefer to see ourselves as influenced primarily by reason, but in fact we often use cognitive shortcuts that allow for simplified thinking. These heuristics include such decision rules as, "if an expert says it, it must be true", "if many people agree with it, it must be right", "if I committed myself to it, it must be worthwhile". Others include the tendency to agree with people we like, and the tendency to rely on emotional cues in making judgments. There are also interpersonal expectancies that shape responding. For exam-

ple, even if they are not explicitly stated, clients can infer their therapists' values. We have all heard clients state, "I know what you're going to say....", or; "I know you won't like this but..." The point here is that people are influenced, even strongly influenced, by automatic decision rules and reliance on peripheral cues rather than explicit, central processing and careful weighting of arguments. I am reminded of a recent listserv discussion of the importance of emotions in MI, as we considered what the influence of affect might be on people's decision-making.

Let me draw your attention to three important aspects of this research that I personally find frightening when considering the issue of the extent of and the means through which counselor values impact client decisions.

(1) *Heuristics are capable of exerting enormous and automatic influence over our thinking and behavior.* Consider the heuristic "experts are right". So, if Bill Miller says something, I am more likely to believe it. Is this not true? In fact, Jerome Frank (1973) pointed out that one of the healing aspects of psychotherapy is the presence of an expert or a healing context. Kanter, Kohlenberg and Loftus (2002) discuss the notion of therapeutic demand characteristics, and define this as "the sum total of cues that convey the therapist's wishes, expectations, and worldviews to a client and become significant influences on the client's behavior, specifically influencing the client to confirm the therapist's wishes, expectations, and worldviews with subsequent behavior". A recent study conducted by this group reveals the potency of such demand in shaping beliefs. Kanter, Kohlenberg, and Loftus (2004) presented two opposite versions of the CBT rationale for depression. One version stated that thoughts precede emotions and the other the exact opposite. Participant responding on a post-rationale task was highly consistent with the rationale they had been given. That is, when asked to notice which came first, a thought or a feeling, partici-

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pant responses were highly consistent with the rationale they had received. Even more startling, many participants were shown to reverse their pre-rationale belief in the precedence of thought or affect.

Or consider an example of the power of the commitment heuristic to alter one's beliefs. American POWs during the Korean War had endured sophisticated psychological manipulation techniques, including the use of commitment language such as getting the men to seemingly 'volunteer' small pro-Communist statements which seemed inconsequential. Commitment to such statements (e.g., making them public) was gradually built over time. What is striking about these procedures, however, is how effective they were in actually shifting core attitudes. In many cases, indoctrinated beliefs persisted after liberation from captivity. In examining returning POWS, Segal (1954) noted that among many men, beliefs about communism had substantially shifted. While they expressed antipathy toward the Chinese Communists, they also praised them, remarking on the "fine job they had done in China" and that "communism is a good thing for Asia".

(2) *Heuristics operate beyond awareness but nonetheless exert strong influences on behavior and attitudes.* Miller and Rollnick (2002) point out that one may be influenced by processes beyond one's awareness but change nonetheless. I may not be aware that my attitudes are being shaped because of my liking of someone, but I am nonetheless influenced. Perhaps this is one reason why alliance is related to outcome in psychotherapy? A positive, warm, trusting relationship, increases influence potential (and therefore outcome) via heuristic activation. Yet, I would likely deny that my judgment has been affected by this type of peripheral processing, and rather attribute my behavior/decisions to more 'reasoned' factors such as greater self-understanding, etc. In fact, social psychologists tell us that if one is aware of the intent to persuade, influence is diminished greatly. If I know you are attempting to influence me, you cease to be influential. Parenthetically, this may be one reason underlying the crucial importance of spirit in MI. If a persuasion cue is present, influence is greatly reduced. That is, the decision must be perceived to be freely chosen in order for attitude change to occur.

(3) *Heuristics are more operative in certain conditions than others.* Uncertainty and vulnerability are particularly rich terrain for the use of heuristics to guide decision-making. When we are uncertain, we look to others to determine how we should behave and what we should think. This is highly adaptive in that our own thinking processes have not solved the problem. Regardless, it opens the door for greater influence. In other words, when we are uncertain and vulnerable, we are more easily per-

suadable. Every therapist has heard the familiar pleading of a distressed individual "What do you think I should do?" Perhaps what the client is expressing is activation of a social influence heuristic.

So what is the point? How does all this relate to MI? MI has relied on cognitive processing (resolving ambivalence, weighing pros and cons) and verbal processes (commitment language) to explain its effects. But in doing so, are we staying in the comfortable territory of conscious processing? We can confidently state that our conscious intent is not to influence the client according to our values but allow them freedom and autonomy to chose the direction they feel best. However, if the principles of influence operate outside of conscious awareness and are powerful, especially in uncertainty, does this nonetheless open the door for our values to shape client decision making? Coercion implies conscious intent, such as a salesperson deliberately trying to sell you something you don't want. But where does this leave unconscious processes? Can we fall back on the safety of saying clients' intrinsically valued directions will carry the day? Or is this abdicating the enormous influence we have in shaping the perceptions of vulnerable individuals? I am reassured by Miller and Rollnick's argument (2002) that MI offers a protective precondition from coercion, since behavior change is postulated not to occur unless clients perceive it as in their own best interests. However, if I play a powerful role, unintentionally and unconsciously, in shaping what clients perceive as in their own best interests, my conscience once again leaves me feeling 'itchy'.

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Whom Should We Train?

Allan Zuckoff

> If motivational interviewing is a way of being with people, then its underlying spirit lies in understanding and experiencing the human nature that gives rise to that way of being. (Miller & Rollnick, 2002, p. 34)

Bill Miller describes MI as a "tool" for promoting voluntary behavior change that is consistent with clients' values, used by counselors who believe that particular changes are in clients' best interests. Tools are value-neutral; value (and thus ethical judgment) applies only to what the tool is used to accomplish. By this logic, MI cannot offer guidance as to what clients' best interests are, any more than a hammer can tell us what needs to be hit; rather, this is a value judgment made by each person, agency, and/or trainer who wields the tool. I will offer an alternate perspec-

tive: there are values inherent in MI that can guide us in deciding what goals it should be used to accomplish, and whom we should or should not train to use it.

The remarkable lines from *MI2* cited above suggest that the MI "way of being with people," which values collaboration, evocation, and autonomy, arises from, and reflects, the inherent nature of human beings. Miller (2003) makes the origins of this outlook explicit:

[I]n spirit MI is unmistakably part of the humanistic-existential tradition…The human potential movement of Maslow and Rogers started from [this] assumption: that there is this natural potential in human beings… an inherent natural tendency for individuals to evolve in a positive, healthy, pro-social direction given the right conditions of acceptance and support. (p. 2)

But how, exactly, is this "healthy" direction to be defined? According to Rogers (1961), persons engage from infancy onward in a process of *valuing*, a fluid, flexible, "organismic" (embodied) process of determining whether or not a given experience tends to move the individual toward survival and self-actualization. Gaining access to, and trust in, this spontaneous valuing process—i.e., increasing *openness to experiencing* — is the hallmark of the maturing or increasingly "fully functioning" person.

The stance, therefore, for which Rogers has been most roundly criticized — that therapists' values must not influence their interventions (i.e., that therapy must be "value-free") is not exactly his position (although his writings readily lend themselves to this misunderstanding). For Rogers, therapists, like all human beings, *cannot help but engage in an ongoing valuing process* as they experience their interactions with a client, and in fact must trust their ongoing valuing process to guide their responses.

This position could be a recipe for chaos; one could imagine each therapist being guided by an idiosyncratic valuing process that is more or less engendering of client well-being. However, Rogers also observed an *emergent universality of values directions*: the tendency of all maturing persons to move toward openness to experience, genuineness, autonomy (self-trust and self-direction), self-worth, creativity, appreciation of deep intimate relationships — and toward valuing these directions in others as well.

I claim that Rogers did not advocate a counseling process that is value-free. How is it that so many (including, at times, Rogers himself) have concluded the opposite? Rogers' great crusade was to free clients from what he called *conceived values*, and to keep therapists' conceived values from impinging upon clients' healthy

process of becoming free and open to experience. Understood as fixed ideas, "introjected" in exchange for assurances of love, approval, and esteem, these rigidly held conceptions of what is good or desirable constitute the "conditions of worth" that, through their inevitable discrepancy with the inherent valuing process, lead to self-estrangement and psychopathology.

Thus, the emergent values directions of the maturing person constitute both the method *and* the goals of client-centered therapy. By offering a relationship "in which [the client] is prized as a separate person, in which the experiencing going on within him is empathically understood and valued, and in which he is given the freedom to experience his own feelings and those of others without being threatened in doing so" (Rogers, 1989), the therapist is not engaging in a value-free process, but in one that values, as constitutive of "the good life," an increasingly mature and healthy valuing process in the client.

MI, of course, differs from client-centered therapy in its intent to promote specific behavior changes, rather than global maturation. By this account, *the value valence (+/-) of any behavior change goal can be determined by asking whether it tends to promote or retard the movement of clients towards Rogers' universal values directions, rather than the living out of any conceived value*. This also allows for the reality that a particular behavior change may promote this movement in many clients, but not all. Because it is hard to imagine how smoking crack cocaine could enhance a person's openness to experience, freedom, creativity, or care for others, a general goal of "reducing the human suffering caused by substance abuse and dependence" is MI-values-consistent; at the same time, the decision to abstain may be a complicated one for a particular person at a particular time, and may even be counter-productive. Thus, the counselor can be guided by the wish to promote a specific behavior change, and maintain a healthy humility about this goal as well.

Religions may function as locations in which individuals plumb their personal valuing process — or as systems and enforcers of conceived values. Thus, religious values should not be privileged in determining the behavioral goals that most promote the increasing freedom and maturity of the individual. Religions can be forces for freedom — but as forces for social control through instillation of guilt, shame, and fear, demonizers of the body and its essentially sexual nature, and creators of factions split against each other instead of supporters of our shared humanity, they have as often promoted values inimical to those of the healthy valuing process as consistent with it. "Ambivalence born of conscience" may thus be either healthy or pathological; it may reflect the struggle to free oneself of the pernicious influence of conditions of worth, and the defensiveness, rigidity, pretense, and conformity they engender, in order to live out one's emergent values — or the self-alienation of the individual who has introjected rigid values having little to do with his/her spontaneous *valuing process*. "Doing what I hate" may reflect a failure of integrity — or the emergence of my genuine, healthy desires despite my efforts to suppress them.

The answer to the question, therefore, of "Whom should we train in MI?" has to do with both the values, and the valuing process, that a group supports and espouses. An organization that insists upon adherence to rigid, externally imposed rules as determinants of action, that believes it has a monopoly on the truth, takes a moralistic stance towards others as well as its own members, and seeks to inhibit the inner freedom of its members and others to act autonomously and in accordance with their spontaneous valuing process — such an organization cannot promote the well-being and actualization of human beings, regardless of whether its ideology is "right-wing" (e.g., anti-abortion) or "left-wing" (e.g., anti-meat). Similarly, an organization that seeks to promote specific behavioral changes that conflict with the values

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of MI — e.g., greater use of corporal punishment, which teaches self-mistrust, in the raising of children — should not be trained to use MI to promote such changes. And, given the *investment* of many religious therapists in promoting religious beliefs, and the *coercive power* they potentially hold when counseling members of their own religious groups, use of MI in such contexts seems ethically complicated according to the guidelines promulgated in *MI2*.

Fortunately, MI is inherently subversive of any group's efforts at exerting social control via moral suasion, seeking as it does to enhance individuals' awareness of their own core values and help them to act more in accordance with those values, as well as to enhance counselors' interest in and respect for the values and aspirations of their clients compared with those of any supervening authority. In such cases, the MI trainer may optimally act as a kind of MI therapist to the organization, seeking to move it towards a healthy valuing process involving openness to experience, flexibility, and trust in individuals to make their own choices according to their own valuing process — or, more simply put, towards a spirit of collaboration, evocation, and autonomy.

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Response to Commentaries

Love with a Goal

Bill Miller

I am digesting the small book that emerged from this first MI virtual symposium, and facing the challenge of how to respond thoughtfully and succinctly to the wise offerings of twenty-three colleagues who include my first graduate school mentor (Hal Arkowitz), Tom Barth who participated in the birthing of MI, and a significant proportion of those who have written about MI over the years. The articles are replete with quotable quotes. I am impressed, too, by the mutual respect, so characteristic of MINT, with which all have addressed issues that have such fertile potential for rancor.

It is tempting, as a discussant, to name each author one by one and reflect on the value of what he or she has offered. It would be easy so to do, but I choose instead the task of synthesis, of responding to threads that seem to run through these twenty-three contributions.

First, I am fascinated by the idea, eloquently expressed by several writers, that there are certain meta-values (such as self-determination or autonomy) inherent in MI, and that discomfort with specific applications of MI may have more to do with violation of one or more of these higher central precepts than with specific value content per se. Is it, perhaps, even the case that the practice of MI tends to lead one toward these core values, and in that sense is "inherently subversive" in the same way that Carl Rogers in his later years came to view his own work as revolutionary (Rogers, 1980)? Rogers, C. S. Lewis, Jung and others believed that all humans share certain core values that are hard-wired into us. Perhaps MINTies, too, have common core values.

If so, one of them would seem to be that the counselor's values ought not be imposed upon clients. Taking this a step further, direction itself might be construed as violating the spirit of MI. Certainly Rogers eschewed directiveness as inconsistent with the humanistic spirit of client-centered counseling, at least in some of his writings. Yet Steve and I have pointed to the directive aspect of MI, intentional movement toward a goal, as a defining characteristic of MI that distinguishes it from a Rogerian client-centered approach. Here, then, is a second thread that runs through some of these commentaries: to what extent direction is appropriate or inappropriate. Naturally it depends on what one means by "direction." MI does not include coercive methods to enforce adherence, or even incentive strategies to reinforce particular outcomes — both common approaches in addiction treatment. MI is not about *making* clients have specific outcomes, but it does aim to help them *want and choose* certain outcomes over others. That implies a valuing process whereby certain choices are better than others, but still necessarily leaves the choice with the client.

I will make the further assertion that MI will not "work" to encourage choice A over choice B unless choice A is better from the *client's* perspective. MI is not magic, not post-hypnotic suggestion that bends the client to do my will against his or her better judgment. It is the client's better judgment to which we appeal, to what Marsha Linehan calls the "wise mind" within each person. In this sense, we are imposing the *client's* values on the client, superimposing their own core goals on the present behavioral reality, calling them to integrity with their own values. What does it matter if a client's behavior is inconsistent with my values? It is only a discrepancy with the client's own values that will trigger change. The interviewer, with an outside perspective, anticipates the consequences in choosing various paths,

and directs the client to reflect on those consequences in light of the client's own goals.

At the same time, I want to acknowledge the validity of another understanding of MI that seems more compatible for those who are itchy about directing clients toward any goal growing out of the counselor's valuing. This perspective is that MI helps clients explore and stay with their ambivalence long enough to resolve it. The normal human experience of ambivalence, I believe, is to think of a reason why one should change, then of an argument against change, then to stop thinking about it. It is an internal conflict-avoidant process, akin in some ways to classic defense mechanisms. If that is the nature of normal conscious processing of ambivalence, then it is no wonder that people can stay stuck there for a long time. MI helps the person *keep thinking* about the pros and cons, exploring both sides of the ambivalence in an accepting atmosphere. I see an analogy here to exposure-based treatments for anxiety disorders. A phobic person generally avoids the feared situation, but may periodically draw a little closer to see what happens. What happens is that fear increases and the person backs off, thereby reinforcing escape and avoidance and exacerbating the phobia. What works for anxiety disorders is exposure therapy (in a supportive atmosphere) that helps the person stay with the arousal long enough for it to peak and subside without avoidance. Even in this ambivalence-resolving approach to MI there is still a goal (to keep exploring and resolve ambivalence) as well as implicit valuing (e.g., that it would be good to resolve the ambivalence, that moral relativism is an optimal stance in counseling). If you, like Rogers, believe that people inherently choose in a healthy direction when exploring in a climate of acceptance and empathy, then you would feel no need to try to tip the process toward a particular outcome. The client will choose whatever is best. My own itchiness about this is my skepticism that it is indeed possible to be nondirective in client-centered counseling. Certainly one can consciously take steps to maintain balance, but even Rogers was, without realizing it, contingently reinforcing certain directions in his counseling sessions while

believing that he was not (Truax, 1966).

Another theme that crops up in these commentaries is faith. I feel obliged here to express a dissenting view about the nature of (religious) faith, which is characterized in commentaries as 100% certainty, or as confidence that one's own particular beliefs are absolute Truth whereas other beliefs are in error. This may describe some very visible religious/political perspectives, but certitude of inerrancy is not at all the bedrock for most people of faith I know. Deep, disturbing, soul-wrenching doubt is a normal part of subjective reality for many people of faith, as it was for so many of the admired saints (Pargament, Murray-Swank, Magyar, & Ano, in press). Neither is it necessary, or even doctrinal, for people of faith to believe that they know the one and only Truth, and that all who disagree with them are misguided infidels. Humility is a cherished and much-needed virtue in mainstream world religions. Unfortunately it is the religious extremists who occupy the headlines and airwaves. The spirit of MI that I have described and seek to manifest in my life is deeply rooted in and informed by my own Judeo-Christian faith. These roots also clearly lie beneath the work of Carl Rogers (Kirschenbaum & Henderson, 1989) and the 12-step programs (Kurtz, 1987).

Is it necessary to engage client values in order to do MI or trigger change? Certainly there are no procedural requirements in MI to complete a values card sort, or to ask people what they care about most deeply. Change can be triggered by very concrete information, as we did in one study through mailed feedback (Agostinelli, Brown, & Miller, 1995), without asking people about their values. I suggest, however, that it would be very difficult to trigger change without engaging values. Giving a client the information that her GGT value is elevated above the normal range is unlikely to make a difference unless she cares that this is so. What matters is not the information itself, but client values that the information engages, creating discrepancy between status quo and important goals. I recognize that I run the risk of circular argument here, but I do believe that informational or other interventions are likely to fail to trigger change unless they somehow engage values that matter to the client.

This brings me back to the counselor's own caring. When I counsel someone with an alcohol or other drug problem, I care what happens, what choices the client makes. I can be detached in the sense that I do not have a personal stake in the outcome. My own worth and welfare are not uplifted or degraded by what the client chooses to do. Yet I am not neutral, not unmoved by or indifferent to what happens, because I have seen these two choices played out so many times before. One path leads to the risk and often reality of suffering, illness, disability, even death for the client or innocent others. The other path can lead to some of the most remarkable, sweeping benevolent change that any therapist is privileged to witness. To care is to have a goal, even if that goal is just to bring a resolution — any resolution — to the stuckness of ambivalence. Sitting across from a fellow human being who is caught in the trap of addiction, I care what happens — a compassion that itself involves a discrepancy between a goal and status quo — and I call the client to care, too. I seek, on my best days, to practice love with a goal. Ⓜ

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