MINT Bulletin

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From The Desert

Bill Miller

Amsterdam and Autonomy

It is said that if a mentor can just succeed in having students who understand and adopt his work and who are able to reproduce it with the same quality, then he has failed; for the mentor's true task is to prepare others to go beyond where he has been.

This year in Amsterdam I had the wonderful experience of sitting in the back of the room with Steve, watching the next generation of mentors stand where we have stood and train new trainers. The five of them—Jeff Allison, Cristiana Fortini, Kathy Goumas, Karen Ingersoll, and Dave Rosengren—created and implemented a creatively different approach for the TNT, something that I would not have tried myself, and it worked like a charm. It was such a pleasure to watch them guiding this group of new MINTies and finally receiving their "I learned . . ." sentence-stem affirmations from participants at the end of the workshop. Steve and I enjoyed our new backstage role, and were grateful to be releasing the reins into such capable and creative hands.

The MINT meeting also went off wonderfully well. This year Steve and I purposefully had almost no role in organizing, planning, and running the MINT Forum. It could not and would not have been better had we been guiding it. We each made a presentation, and otherwise were free to attend and participate in whatever sessions we chose. Again it was freeing to sit back and watch the thoughtful and creative process unfold.

In the course of the meeting it struck me, and others commented on it, that a delightful aspect of the MINT Forum is that it is organized precisely backward from the pyramidal structure of the usual scientific or professional conference. At the annual meeting of a professional association, for example, there is President who presides over the whole affair, and a few Big People (BPs) up front talking to the largely passive audience. The BPs are usually identifiable by the number of ribbons hanging from their name badges. Then there is the middle class of upwardly mobile experts, often with one-ribbon badges, who make presentations to largely passive smaller audiences. Finally there are the plebeian masses with ribbonless badges, who shuffle from presentation to presentation accumulating notes and continuing education credits. If there is any time at all left after speeches within a session, audience participation is usually limited to a few questions, often posed by the upwardly mobile middle class, designed to upstage the middle-class speakers and demonstrate the questioner's cleverness.

The MINT Forum is structured more like the 12-step programs. There is no President presiding, no coven of BPs dominating the podium, and often no podium. A majority of the 85 or so participants in the MINT Forum this year led or co-led at least one of the sessions,

Editor's Choice

MI Is All Around

Allan Zuckoff

I write this column fresh from attendance at the 11th International Conference on Treatment of Addictive Behaviors. Listening to the plenary presentations—not only those of Bill Miller, Terri Moyers, Jim McCambridge, and Gillian Tober, but also of Thomas McLellan, Jon Morgenstern, Mats Berglund, Rudolf Moos, Linda Sobell, John Norcross, Larry Beutler, Michael Lambert—I was struck by just how taken-for-granted was the efficacy and importance of MI by these leading psychotherapy researchers. I was also impressed by the clear confluence of addictions treatment research and psychotherapy research generally regarding "what works"—such common factors as empathy, therapeutic alliance, collaboration on goals, objective feedback to both clients and therapists, matching of therapist directiveness to client resistance level, engagement of social networks and significant other support—and the extent to which practice and training of MI incorporates these common factors. Was it just because we were in Santa Fe, at a conference co-chaired by Bill and Terri? Or could it be that MI works, at least in part, because it is a common factors therapy *par excellence*?

In This Issue

From the Desert, **Bill Miller** reflects on the nascent autonomy of MINT, clears up some recent concerns about the death of ambivalence, and adds some notes on the newly named phenomenon of "feedbackfire." We then present the first installment of the long-promised and equally-long-deferred feature ***Feedback:*** **Jeff Allison, Tom Barth, Michael D. Clark,** and **Carl Åke Farbring** each respond to last issue's consensus statement on change talk by Paul Amrhein, William R. Miller, Theresa B. Moyers, and Stephen Rollnick, as well as to Grant Corbett's series of columns on the same topic. Next, current SC chair **Chris Wagner's** *Steering Committee Update* is complemented by organizational news in the ***International Forum***: **Paul Delaney** describes the birth of the Irish Association of Motivational Interviewing Practitioners in *MI Advances in Ireland,* and **Cristiana Fortini & Pascal Gache** recount the first meeting of the Association Francophone de Diffusion de l'Entretien Motivationnel in *MI Across Language Barriers: Its French-speaking Fans are Growing!* We then present an original research article on MI training by **Thad R. Leffingwell,** *Motivational Interviewing Knowledge and Attitudes Test for Evaluation of Training Outcomes.* This is followed by **Grant Corbett's *What the Research Says...About MI Training*** and, in the ***Training Corner,*** **Claudia Salazar's** *"Salsa Dancing": An Exercise to Demonstrate the Spirit of MI*.

The remainder of the issue is given over to the special section, **MINT Forum 2005**, which presents highlights of our annual meeting, held last September in Amsterdam, The Netherlands. In the pages that follow, you will find contributions by: **Bill Miller, Peter Prescott, Denise Ernet & Mary Velasquez (with Lynn Williams and Kelli Drenner), Denise Ernst, Tom Barth & Christina Näsholm, Suzanne Habib & Joel Porter, C. Å. Farbring, L. Forsberg & S. Rollnick, Hiroaki Harai & Henny Westra, Jeff Allison, Brendan Murphy (with Lisa Ford), Peter Prescott, Astri Brandell Eklund & Peter Wirbing, Maurice Dongier, Jim McCambridge, Mary Velasquez, Allan Zuckoff.**

Looking Forward

I hope that the contributions in the special section willremind those who attended the 2005 Forum of its richness, and tip the balance in favor of atendance for those who are considering coming to Florida for MINT Forum 2006. Though these meetings have grown larger, and inevitably more structured, with each passing year, they remain a friendly, multicultural port of call in a sometimes roiling sea.

Readers can look forward in coming issues to articles by Bill Miller, Grant Corbett, and other regular contributors. But what of those many, valuable voices among the MINT membership that are never heard in these pages? My fondest wish is to have an ever-widening circle of participants in this "dance of possibities...", this "safe haven for loving dialogue without diatribe, for critique without competition" (Bill Miller, *MINUET 11.3).* Is there something you'd like to see here that you have not yet seen? Have an idea you think just might interest your colleagues and friends? Write... and join the dance. MB

participated as respondents in a panel, and/or served on the organizing, planning, or steering committees. The modal session involved a brief presentation to trigger discussion, followed by substantive contributions (not just questions) from a majority of those attending. Sessions ran overtime not because of long-winded speakers, but because the group discussion was so lively and useful.

As the final plenary panel and discussion unfolded, I framed in my mind an indicator of whether the MINT Forum had achieved independence. Steve and I were both sitting at the back, at different tables, and had made no comment throughout the session. Would the moderators or anyone else, after all who wanted to had spoken and silence fell, call upon us for some "closing remarks" or such? In my mind, to do so would bespeak a lingering need for an authoritative benediction, some papal wisdom or blessing to permit a proper closing of the proceedings. My tension rose as thirty or forty people made contributions, and then came the silence that signals readiness to leave. The conveners thanked everyone for coming, and we adjourned to farewell embraces. I exhaled and smiled within. MINT has achieved autonomy.

Has Ambivalence Been Resolved?

But perhaps I was a bit too removed in encouraging autonomy. During my presentation at the MINT Forum, I previewed a forthcoming article (Miller & Moyers, in press) on "Eight Stages in Learning Motivational Interviewing." Two days later I learned rumors had been circulating that because I had not mentioned the concept of ambivalence during my talk, perhaps ambivalence was no longer considered important and was being discarded from the conceptualization of MI. This had apparently been discussed in break-out sessions, generating some distress among ambivalence aficionados, and despite my presence throughout the Forum no one had even asked me about it!

So first let me extend an invitation. If a concern like this arises, particularly regarding my own thoughts about MI, simply ask me: e-mail, phone, snail-mail, in person, whatever. My intention is to stay out of a directing role in MINT, but not to be aloof, unavailable, or mute.

Now regarding ambivalence, I don't even feel two ways about it. Ambivalence remains a central concept within MI. The data indicate that if a person is not

ambivalent (i.e., has already decided to change or is doing so), MI is unnecessary and may even be countertherapeutic. Furthermore, if the person has no goal or value that potentially conflicts with the status quo, then MI has no raw material with which to work and change is unlikely to occur. I wouldn't go so far as to say that ambivalence is a prerequisite for MI. MI may cause someone who is not even considering change to become ambivalent (precontemplation to contemplation in the language of the transtheoretical model) and thereby to begin considering it. The process then continues toward the resolution of ambivalence in the direction of change.

In any event, the construct of ambivalence is alive and well in MI. I guess.

Feedbackfire

Assessment feedback is the defining difference between MI and MET. There is research evidence that feedback with norms can suppress alcohol use, including a study in which we simply mailed the feedback to heavy drinking college students (Agostinelli, Brown, & Miller, 1995). I am also, however, seeing evidence that feedback can backfire. Among people who responded poorly to MET, commitment to continued drug use increased during assessment feedback (and discussing a change plan), whereas commitment to abstinence increased during pure-MI phases of the session (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). Working with college students, Scott Walters found a backfire effect with MET group participants faring (non-significantly) worse than controls, apparently due to group collusion in resistance (Walters, Bennett, & Miller, 2000). In contrast, students who simply received feedback through the mail without a MET group showed the usual reduction in drinking.

A paper presented at the 2005 ABCT meeting offers another interesting finding (Leffingwell, Leedy & Lack, 2005). Thad Leffingwell from Oklahoma State University developed a computer-based assessment and feedback program, with an on-screen host presenting the information. After each piece of feedback, students were asked to enter their reaction in an open text box on the screen—a feature intended to increase engagement. They were surprised to find no beneficial effect of the program, in contrast to prior personal feedback studies. They examined what students had typed into the reaction boxes, coding responses with the MISC-2 categories, and found that 40% of responses were counter-change resistance. It is possible that by eliciting verbal (in this case typed) responses, they inadvertently activated defensiveness that over-rode the usual assessment effect.

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MINT Bulletin

Editor
Allan Zuckoff

MINT Steering Committee
Chris Wagner, Chair
Rik Bes
Kathy Goumas
Theresa Moyers
Christina Näsholm
Michael Peltenburg

In Association With
William R. Miller
Stephen Rollnick

Submissions
Inquiries may be forwarded to
Allan Zuckoff, Ph.D.
University of Pittsburgh Medical Center
Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213 USA
Tel.: +1 412-246-5817
Fax: +1 412-246-6030
Email: zuckoffam@upmc.edu

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Feedback

A Consensus Statement on Change Talk
Paul Amrhein, William R. Miller, Theresa B. Moyers, & Stephen Rollnick
What the Research Says About... Change Talk
Grant Corbett

Resistant Ramblings

Jeff Allison

Recently I read the Amrhein et al position paper in the *Bulletin*. It's a stimulating and exciting read—God bless our research community! And an especially heartfelt thanks to Grant Corbett for his considered analysis.

Below are a few first thoughts in response—a bit of a rave, but with a serious purpose. The essential point is this: one of the most important aspects of MI for me when I was a practitioner, and certainly for me as a trainer—and the practitioners I've trained over the last ten years—is the way MI helps us get alongside and curious. Moderating the defensive postures and utterances of clients is the foundation work of enabling helpfulness. The position paper, quite understandably, focuses on change talk. But I'm concerned that the whole notion of resistance talk—however one conceptualises it—may be relegated to the status of a poor relation.

There are, self-evidently, utterances that are the counterpoints of change talk—the motivational vectors restraining change—the string on the helium balloon, against which the balloon tugs in an effort to achieve its goal of floating free and 'being' itself. Perhaps the string sorely resents the balloon's insistent nature. Doesn't the string similarly have an essential, though somewhat less insistent nature? Its unwillingness only becomes apparent when it's tied to the balloon.

It is suggested by many philosophers and psychologists that we are more balloon than string. That given the right conditions, we 'grow' and achieve our essential nature—to drift free and rise, unencumbered, into the sky of opportunity and fulfilment. Perhaps it is so; for some. In adopting this, some might say, apolitical perspective, we may fall into the trap of assuming we share our 'normal' aspirations with our clients: change = a good notion, resistance to change = a bad notion. For some years we have used the term, resistance talk (I've never used the term 'counter-change talk') and regarded it as representing resistance to change. In their position paper, Amrhein et. al. inform us that the new terminology is "...under construction". I would like to offer a couple of thoughts on the matter before the mortar is dry.

I have always felt discomforted by the term 'resistance', if used to describe resistance to change as opposed to resistance to 'less helpful' or incompetent practitioners. There is, within the former, a subtle implication that change is the desirable or 'aspirational' state. As far as I'm aware, no one has ever suggested referring to change talk as 'resistance to status quo talk', or 'counter-status quo talk'. It would seem singularly weird to do so, but why? Is it not because change is our supposed stock-in-trade?

It's interesting, for our purpose, that the antonym of resistance is surrender—to admit defeat—is this not the language of another age of addiction 'treatment'? Demands made by practitioners for capitulation have no place, as I have always understood it, within MI. However, isn't capitulation to be inferred from the term, resistance? So what might be used as a generic term for all those thoughts and feelings that sustain the 'focus behaviour'? I suggest that those charged with the responsibility tread carefully in deciding on the terminology to be selected, for from it, much may be implied. The utterances of the authors, no doubt, will be subjected to Talmudic scrutiny. Dr Amrhein will be more aware than any of us how within words lie worlds of meaning.

Maintenance Talk

My own stab at selecting a suitable term is Maintenance Talk. How ironic that a term hitherto used to describe the end stage of the process of change could be employed to describe its own genesis—oops, there I go making assumptions that one leads toward the other. See how easy it is to slide into Aspiration Talk? Maintenance suggests conscious effort to sustain. Things fall apart—it's in their nature—they require maintenance. Sustaining a drinking problem, for example, is often a heroic effort in the face of adversity. Keeping things as they were, despite the evidence that they will, inevitably, slide into chaos is every bit as demanding as maintaining a behaviour changed.

You may last year have seen the mountaineering film, 'Touching the Void'—based on a book by Joe Simpson—in which two young climbers, one severely injured, attempt to descend, in the teeth of a howling blizzard, a terrifying mountain in the Andes. After they attain the summit there is a scene where the uninjured one is lowering his comrade on a long rope, down a snow ramp of dizzying angles. His feet and backside are planted in a small platform dented in the wet, collapsing snow. He's losing his stance and the prospect appears hopeless. His comrade is at his mercy, dangling over a ledge, his body broken, at the other end of the rope. He's quite helpless. They are resisting the inevitable fall and their position is growing ever more desperate. They can't see or talk to each other because of the noise of the blizzard. Which climber is the natural state? Gravity pulls at both. The state of each is threatened by the other. They remain immobilised in their predicament for hours. Who is resisting who? Both are sustained by hope, courage and determination; they are brothers, tied together in an embrace of death; for one to live the other must die. Neither knows what lies below and

beyond, all they know is that they cannot sustain their predicament much longer.

Resistance talk is a heroic maintenance of that which, inevitably, is unsustainable. We know that; clients know it too. It deserves a better nomenclature, one that is more accepting and resistant to misinterpretation. It must be drained of criticism and ostensibly as value-free as 'change talk'. We owe that much, at least, to all those we seek to guide through the mountains. If and when change occurs, it will do so of its own intent (and a wee shove), not because the 'naming' of its parts demands it. The power to name is the power to control. Neutral terminology resounds with its own hopefulness. Calling someone 'bad' never made them 'good'; calling the status quo 'resistant' never made it less so.

So, my dear professors, how about employing the term, 'Maintenance Talk? Don't you think it has a certain dignity?

Consensus and Change Talk

Tom Barth

It is interesting that the term 'consensus' is being introduced to the MI community. It is helpful when we try to clarify our concepts, but I hope it will not restrict the openness of our discussions, and the development of motivational interviewing.

From a Scandinavian language point of view, I feel we have a problem with the translation, but I guess that is for us to sort out. The problem is that one possible translation gives associations like 'chatter', or even 'gossip', and the alternative is too formal—more like 'speech'.

What troubles me more, is the danger that the definition of motivational interviewing should be too strongly linked to the process of "eliciting change talk". In the "Consensus Statement" by Amrhein, Miller, Moyers and Rollnick, it is stated clearly that Paul Amrhein's coding system "...required a specific goal proposition, in essence the target behaviour change".

I would argue that psychotherapy is not always about facilitating behaviour change. A more general definition could be that psychotherapy is helping people test out different "possible selves" (see Miller's "From the desert" in the same issue) In an MI-style, the testing out is typically done by exploring ambivalence. Sometimes, yes, very change oriented—in other settings not necessarily so. We define MI as "client centred and directive", but it may be directed also towards non-behavioral goals like insight, or clarification of feelings, or choosing not to change. In that kind of process change talk is not always so important, and in fact sometimes can be understood as a premature closing of a dilemma.

Also, even when we are working in a change-focused way, there are phases when "counter-change talk" is understood as a step in the right direction. Working with clients who have no problem recognition (in precontemplation), we are trying to help them understand that something they "just do" could be regarded as "perhaps a problem" instead. The next step then is to encourage their willingness to test this out—again by exploring ambivalence. The first sign of this willingness is often expressed through "resistance-sounding language". For example *"I wouldn't call that a **problem**!"* To my ear, that sounds like somebody who might be open to the idea of ambivalence, which could be a major step forward. The simple coding of change talk does not easily capture such steps.

In our session in the 2005 Amsterdam MINT meeting, Christina Nasholm and I commented that there may be different styles of MI, and that some of us seem to focus more strongly on the exploration of ambivalence, while others are more solution focused, and naturally put more importance on eliciting change talk. One style might be more efficient than the other, but most likely, they are good for different purposes. And perhaps even match different counsellor / therapist personalities.

Again, my sincere wish is that the process of suggesting consensus does not reduce our openness to explore the reflections above.

A Difference that Makes a Difference

Change Talk and the Confusion Surrounding the Constructs of Reason and Need

Michael D. Clark

I've followed the change from "Eliciting Self-Motivational Statements" to "Eliciting Change Talk." I personally like the switch in terms. I also liked the mnemonic acronym of "DARN-C"—a wonderful aid constructed to recall the five important linguistic catalysts for behavior change. However, in the training rooms, these constructs do not all seem to enjoy the same degree of comprehension. There seems to be widespread understanding and agreement for the definitions of Desire (D), Ability (A), and Commitment (C). Not so with the other two terms, Reason (R) and Need (N).

Trainers and trainees alike report that reason and need can often lag behind in specificity. On occasion, I have noticed training groups voicing some frustration when R and N are reviewed. They complain I haven't delivered definitions for R and N that offer a clear difference between the two ("I know you've explained them, but I'm not clear." "You're just using double-talk—you're really saying the same thing!" "Could you give me more examples?"). Even with only occasional misunderstandings brought to the large room, it left me with the nagging feeling that it was a good bet that more trainees were experiencing the same confusion (but were not speaking up). With my confidence uprooted, I seemed to be pulled into their gravitational field—beginning to doubt my own definitions for these constructs. With this situation, if one were to

take off the letters "RN" from the acronym DARN, then one is left with "DA," which seems awfully close to the doesn't-have-a-clue expression "Duh!"

What could help me clarify these terms and differentiate between them?

My interest peaked and my attention sharpened (a reverse benefit to frustration), so I began to monitor the MINT listserv during the summer and fall of 2005. As was happening in my trainings, I noticed the same type of confusion (i.e., overlap) between R and N occurring on our listserv. I found MINT members addressing the terms of D, A and C with descriptions that seemed both reliable and valid, yet there would be just enough variance in how trainers spoke of R and N to continue my uncertainty. In different postings, I would occasionally find the same descriptors used for both terms!

I turned back to gather all the MI references I could find that offered definitions for the constructs of DARN-C. My review began with the landmark article for the field of MI, Paul Amrhein, et al. (2003). In rereading this article, I was surprised that although brief descriptions for D, A, and C were mentioned, there were no definitions offered for R and N. I was out of luck in turning to the two published editions of *MI*, since this linguistic MI research occurred after the publication of both of these texts. That left our MINUET/MINT Bulletin and the 2003 MISC Version 2.0 (Miller et al., undated) to help inform this lack of clarity. The definition of terms offered below represents a synopsis from both of these sources, as well as a conversation with Paul Amrhein.

Reason

Reasons involve issues of incentive, motive, or rationale (I should or why do it?): "Smoking really flares up my asthma." I've even heard reasons expressed as "excuses" or justification for changing behavior or coming to a decision. Reasons generally emanate from a place one could call "making sense." They involve a more logical pronouncement of "I should do it for this reason/these reasons." Amrhein believes most talk in an MI session is related to Reason. If this is true, then a helpful counseling effort would involve eliciting and strengthening the other areas of D, A, and N—all necessary linchpins to impel Commitment talk.

Need

The term *need* is a construct that deals more with necessity and what is emotionally charged, rather than detached or dispassionate logic and rationale (I must, because it's important, got to). The difference for the term Need can be found between "must" or "have to" rather than "should" or "why?" Need moves beyond logical reasons and moves into urgency.

The Difference between Reason and Need

To better understand the difference between reason and need, a helpful mnemonic could be "Reason=Rationale" and "Need=Necessity." Paul Amrhein (Amrhein, personal communication) notes that another way to decipher the difference between R and N is that anything that might be said after linguistic markers "or else," because," or "so (that)" is generally the Reason.

In these examples, anything said before the marker involves the N but anything uttered after the marker is generally the Reason:

- "I need to quit drinking *because* ___R____"
- "I have to get out of this court *so that* __R___
- "I must find a way out of cocaine *or else*___R__"
- "I've got to get my marriage back so ___R__"

Another rule of thumb that may help trainers in a pinch is to partner thinking/logic with reasons but pair feelings/emotions with needs.

Commitment

Commitment implies an agreement, intention, or obligation to change (I might, I will, I'm going to). As with D and A, Commitment certainly seems more straightforward, and there has been little or no confusion with this term. This construct seems to have subsumed the earlier idea of "readiness." Within the construct of DARN-C, it is important to keep our "eyes on the prize," and that prize is Commitment. It was Commitment language—actually the strength of commitment language—that accounted for behavioral change in the 2003 linguistic MI research. Another caution is that when you consider Commitment, it's "quality, not quantity." It's not verbosity or number of utterances that makes the difference, so avoid counting frequency of commitment language and focus instead on the extent and strength. A wise trade would exchange five "I'll try's" for one "I will."

In this puzzle of influence and outcomes, one should not diminish the sway of DARN talk, as the strength of these constructs influence Commitment. Armhein (personal communication) used a wonderful analogy of geology for how DARN-C combines to aid behavior change. After a full day of searching for a certain rock, a triumphant geologist might find a specimen and pick the rock up for review. If the rock were to represent Commitment, then it would be the forces of nature that shaped the rock into being (heat, cooling, pressure, etc). It is these "forces of nature" that would represent DARN talk. A whimsical rhyme says it all, "DARN is the blend, but it's Commitment at the end!"

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Consensus on Change Talk

Carl Åke Farbring

Somewhere in *MI2*, if I remember correctly, Bill and Steve write that clients can talk themselves into change, but they can also talk themselves into non-change...

In many experiments in social psychology individuals have been manipulated to advocate against their beliefs—and consequently changed their attitude (at least for a while). When I wanted to quit smoking in my early twenties—I was studying law and was completely unaware of psychology—I put up a message in the lobby of the 9-story building where I was living: I, C Å Farbring, will stop smoking on 4th March 19xx. Many of my neighbours tapped me on my shoulder and encouraged me. They probably thought it was lunacy to put up the note but it worked (...for 2 years, and when I relapsed I had moved to Lund to study psychology). I had talked myself into change and increased the cost for relapse. Clever car salesmen have used the knowledge of change talk for years: "What particularly do you like about this car? So how do you plan to use this car? What colour would you prefer?" And the poor customer is talking himself deeper and deeper into a ruining purchase.

To me it is not surprising that you can talk yourself into non-change as well as change. My observations with the clients that I have worked with over the years have displayed a very clear pattern. Many of them had been ambivalent for 20-30 years and already knew all the "advantages" of using drugs and being sentenced by courts. It was not helpful to have them *exploring* the positive side of drugs and loss of freedom at length.

This experience alone and its implications for change talk has been enough to make me doubt its congruence, at least in my line of work, with an emphasis on developing and working with ambivalence by exploring the positive side of non-change at full length. Isn't that in fact a contradiction to change talk—reinforcing positive and sometimes even new cognitions about the positive side of the status quo (non-change)? Merely touching on it to recognize that there were reasons for the client to take up the habit, I would define as a sign of empathy, but not eliciting non-change talk.

Recently, on the MINT listserv, Bill Miller noted an article by Mike Ashton (Ashton, 2005) that pointed out that reviewing the pros and cons of change was observed in three studies to create *negative* impact on clients who already had begun to consider change.

Logically I would not be surprised if the decisional balance exercise (taken at length) had the same impact on clients who have been ambivalent for years. That's why, in a post to the MINT listserv, I quoted Amrhein et al. (2003) in their discussion of backfiring and back-pedalling in commitment in the 5th and 10th deciles of protocol-guided MI sessions:

> *It is also noteworthy that MI practitioners are sometimes advised to query the client´s perceived positive aspects of current drug use (Saunders, Wilkinson, & Allsop, 1991), before proceeding to discuss the darker side. Doing so, however, could exacerbate equivocality and thereby promote at least a reduction in the strength, if not change in direction, of the client´s commitment.*

From my observation point this is not more speculative than the idea that reinforcing and developing new cognitions about the positive side of the status quo with clients in criminal justice settings would be helpful for them! Empathy and what people are saying that they are going to do are empirically the most predictive aspects of MI as far as we know today.

So I have no problem with the "Consensus Statement", in fact I would like to take it further. To me change talk is the very compass in MI and at times clearly trumps technical proficiency in methods even like, e.g., reflective listening.

Recently I was listening to a tape with a very skilful counsellor who excelled in reflective listening. For at least 45 minutes it was a beautiful example of good MI counselling. Suddenly the client departs from the track that they have been following and starts talking about a car accident in the south of Sweden. The counsellor follows the new track equally proficient in reflective listening and loses direction of the whole conversation and change talk withers. But in coding MI he would have scored high in reflective listening.

To have a compass direction in conversations with clients in criminal justice is important. Non-change talk is in fact not even always resistance, but merely going back to old tracks of conversations about this and that—so common in our context. If the counsellor just instinctively follows such a track in listening s/he loses a good opportunity.

Lately I have included *compass direction* as an important variable to monitor in our implementation. I have noticed that many of our (angry) clients very often offer different tracks even in one simple statement: one that could be interpreted as resistance, e.g., complaining about shortcomings in society (often uttered angrily), and another track clearly offering problem recognition. Which one should the counsellor follow? Based on what I have heard so far I would suggest following the change talk track:

Client: This damn society is punishing my children as well, I don't want them visiting me here in prison, that would be harmful for them, and you are denying me the right to have a 24 hour leave as I think I deserve... You are fascists (angrily).

Counsellor: (resistance track) You are disappointed with society and the rules here. It doesn't seem fair to you.

Counsellor: (change talk track) It's important for you to be a responsible father, you want to be with your children... How do you see your life with your children in the future? What kind of father do you want to be?

In the second example, having detected problem recognition, the counsellor goes back to the change talk track. It's too early to use "do-language" (Paul has permitted me to use this term for commitment

talk) at this stage, so the counsellor chooses to elicit more on the preparatory level. I suppose this is at least in part related to what the authors of the consensus statement mean by differentiating between counter-change talk and resistance.

Bill Miller has proposed as an empirical question "how much is added by specific differential eliciting of change talk... once you have provided the collaborative and autonomy-honoring aspects of MI" (MINT listserv, 4th October 2005, quoted by permission). Another interesting matter for research would be to see if there is any difference where change talk is (more or less) volunteered and where it is elicited. When I stopped smoking it was volunteered and I suspect there is a difference.

I have wondered why preparatory change talk—such as desire and ability for instance—do not predict change per se. According to Bandura, ability is predictive and based on my experience with clients I would agree that it is strongly predictive—more so perhaps than desire.

There is also, especially in corrections, a danger in eliciting change talk, especially on the desire and need categories. First there has to be a balance between desire and ability, and that's why the stages of change model sometimes does not provide enough or perhaps even accurate information for MI. If you increase desire and the ability dimension is neglected the client is very likely to give up on the change enterprise and perhaps be reluctant to try again. Then there is a second danger in eliciting change talk. Very often our clients are severely handicapped since resources to help them with practical preparations for post-prison life are limited. Here is a risk for a backlash: the client wants to change and desire is rooted emotionally (need), but options are closed—social authorities are not interested or have no money, and rigid rules in prison may be an obstacle for seeking out practical social work. The client may well give up and continue his criminal career, feeling that his genuine effort to change was not met by corrections or society. Perhaps in our context there is an optimal moment for motivational work, not just applying therapy or methods at any time.

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MB

Steering Committee Update

Chris Wagner
SC Chair

The MINT-SC has remained busy as we have transitioned through our first rotation of members since reforming in 2003. Christina Näsholm of Sweden and Michael Peltenburg of Switzerland have now replaced Gary Rose and David Rosengren, both of the US. The remaining voting members include Rik Bes of the Netherlands, Kathy Goumas of Northern Ireland, Terri Moyers and myself, both of the US. Bill Miller, Steve Rollnick and Rich Saitz remain on as non-voting participants, and Gary and David will remain in non-voting participant roles for a time as well.

2006 promises at least three training of trainer events. Jeff Allison, Rik Bes, Nina Gobat, Kathy Goumas and Steve Rollnick are leading an English-language TNT in South Africa on September 13-15. This event is hosted by the Motivational Interviewing in South Africa (MISA) group, and is prioritizing applicants from developing countries through February, at which time applicants from other countries will be considered. Tom Barth and Christina Nasholm will offer a Nordic-languages TNT September 11-15. The US Florida TNT and MINT Forum event is still being organized, and will likely be in early December. In hopes of beginning to move toward multi-year planning, we are also working on plans for a European 2007 TNT/MINT Forum event.

The SC continues to devote most of its energies to the "nuts and bolts" of MINT operations, including an upcoming dues collection effort for members who joined through the 2005 TNT events. At the same time, a recent MINT member email list discussion about "big picture" issues has underscored the need for the SC to not lose sight of the forest for the trees.

MINT is a multi-national, multi-lingual, multi-disciplinary network of MI trainers, researchers and clinicians. We have grown as a grassroots network, from the ground up, based entirely on volunteer and donated effort. With 500 members, we are growing beyond the capacity of our current volunteers to handle all of the tasks involved, and are entering a period of necessary structural change. Our work over the past two years to streamline dues collection, develop an SC rotation system, and other initiatives reflects some progress toward a reformed MINT, and at the same time, there is much work ahead. We are working toward being able to poll MINT members on issues, elect SC members, and make other strides toward becoming a more integrated network, although movement in this direction may eventually require paid staffing, and a corresponding increase in dues to cover the salary of an administrative worker. Naturally, there are mixed opinions about these issues. This emphasizes the need for MINT to develop web-based polling solutions, so that the SC is not required to guess at what members prefer when making decisions. If there are any MINT members who would like to participate in this effort, we would welcome offers of help (chriscwagner@gmail.com). Until we have a polling mechanism in place, the SC must make decisions somewhat "in the dark."

MB

MI Advances in Ireland

Paul Delaney

After many years of discussion, the idea of having an association for practitioners of motivational interviewing in Ireland has finally come to fruition. The inaugural meeting of the Irish Association of Motivational Interviewing Practitioners (IAMIP) took place in a city centre hotel in Ireland's capital city Dublin on the 8th of October, 2005.

Both existing Minties and aspiring Minties attended, but all had one thing in common: the development of their own practice in MI. All of those present use MI currently in their work situations, and over the past few years through various training courses and workshops run by Irish Minties had requested the establishment of a group that they could belong to in order to develop their practice.

A small steering committee of six people has been charged with drafting a plan for the development of the IAMIP. The steering committee represents the interests of MI in health services, addiction treatment, academia, criminal justice, and social inclusion. Its members are: Jimmy Kelly (Chair), Drugs Programme Coordinator; Paul Conlon, CEO, Addiction Treatment Centre; Kathleen Meagher, Training Officer, Health Service Executive; Sean Foy, Addiction Counsellor; Paul Delaney, Coordinator, Young Offenders Programme; Maria Plunkett, National University of Ireland Addiction Studies Programmes.

If all goes as planned, the first annual general meeting and official launch of the organisation will be held in June, 2006. It is hoped that the new organisation will be a support vehicle for the many hundreds of practitioners including psychiatrists, psychologists, doctors, addiction counsellors, drugs workers, probation officers, health specialists, and others who have been trained to an advanced level in MI throughout Ireland. MB

MI Across Language Barriers

Its French-speaking Fans are Growing!

Cristiana Fortini & Pascal Gache

In 2003, the French-speaking association for the diffusion of MI (AFDEM: Association Francophone de Diffusion de l'Entretien Motivationnel) was born, uniting MI trainers from Belgium, Canada, France, and Switzerland. After two years of training sessions (many), informal contacts (quite a lot), organizational quibbles (a few), and the creation of a web site (www.entretienmotivationnel.org), we organized our first one-day meeting to share our training experiences.

It was Friday, 25th November. Three Minties from Geneva, Switzerland had organized this meeting. Sixteen people met at 9 o'clock in the morning for coffee and croissants (except Cristiana, she got stuck in snow and didn't get there until 10!). Since we didn't all know each other, we started by introducing ourselves. Wow, what a bunch of interesting people! Some of us come from the addictions field (alcohol, drugs, gambling, and eating disorders), others work with adolescents and young women (prevention of at-risk sexual behaviors...); some of us are mainly clinicians, some are mainly trainers, others combine both.

We shared training experiences, didactic material, thoughts and ideas about the training process. We discussed the necessity of ongoing training and supervision, as well as the wonders of coding tools such as the MITI (translated into French by one of our Lausanne colleagues).

The best part of the day was lunch—oops sorry, that slipped out (although it was rather yummy!). No, the best part was realizing that we all want to share our experiences, share our ideas, share our difficulties, so that we may learn from one another and get better at what unites us: the practice and teaching of motivational interviewing.

We decided to meet again, once a year, so that this sharing process may continue. In the meantime, we have started a forum of discussion on our website, which will keep us all in contact.

This will not stop us from keeping close contacts with the international MINT network, no no no! On the contrary! It's just a question of facilitating exchanges in a language with which most of us feel more comfortable.

In that same logic, we are also planning our first FDF (that's French for TNT, it stands for *Formation de Formateurs*). We will make sure this event stays within the same spirit frame as the original TNT, and for that we will "check in" with TNT trainers and the Steering Committee to ensure quality and content.

We are glad to have this opportunity to share our initiative with all the Minties out there. We are, of course, open to all suggestions (contact@entretienmotivationnel.org), to new ideas, and, last but not least, to all those who wish to join us! *Au revoir!* MB

Motivational Interviewing Knowledge and Attitudes Test (MIKAT) for Evaluation of Training Outcomes

Thad R. Leffingwell

As the data continue to accumulate regarding the efficacy of MI and closely-related interventions (Burke, Arkowitz, & Dunn, 2002; Burke, Dunn, Atkins, & Phelps, 2004; Dunn, Deroo, & Rivara, 2001), training demands increase among professionals interested in using the intervention in their practice settings. Effective training is an important component of dissemination of evidence-based treatments and of maximizing the effectiveness of treatments in real-world settings. One evaluative domain of training effects should be cognitive changes in knowledge, beliefs, and attitudes.

Evaluating knowledge and attitude change for MI may be especially important. Several of the fundamental assumptions and prescribed behaviors of an MI approach are contrary to prevailing beliefs about substance use and intervention with substance users. Alternative beliefs give rise to very different intervention approaches (e.g., confrontation). Understanding, retaining, and internalizing the foundational ideas of the MI model should be closely related to practicing the "spirit" of the model in addition to the structural components.

One prior study evaluated changes in MI knowledge directly as a function of training. Rubel, Sobell, and Miller (2000) used a 15-item multiple choice test in a pretest-posttest design to examine potential gains in knowledge as a result of a 12-hour continuing education workshop. They found modest increases in correct responses to the multiple choice test and improvements on written responses to an open-ended clinical vignette. Other researchers have focused on behavioral coding evaluations of training outcomes (Barsky, & Coleman, 2001; Miller & Mount, 2001; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). This is certainly the gold-standard for evaluating training outcomes but is too demanding and costly to be broadly useful to trainers as an evaluation of training outcomes. Miller & Mount (2001) also included a self-report measure of training outcome in their study but chose to measure self-ratings of perceived knowledge acquisition rather than knowledge changes directly. However, self-perceptions of knowledge acquisition are likely to be only moderately correlated with actual learning. A simple, reliable test of knowledge changes would be useful to evaluate training in a variety of contexts.

This article describes the early-stage development of a simple test for evaluating changes in knowledge and attitudes that are expected to occur as a result of training in MI. The objective was to design a simple measure of changes in MI knowledge and MI-consistent attitudes that could be used by trainers for evaluating the effectiveness of their workshops, or as an additional outcome measure for investigations of training efficacy. The measure was evaluated in a pseudoexperimental pretest-posttest pilot study of novice MI trainees.

Method

Participants. The participants in this study were 71 child and family home-based care providers in the state of Oklahoma. The participants provide family-based interventions for at-risk families, and frequently encounter substance use among one or more family members. The participants had a variety of training backgrounds and broad range of experience in the social work and child welfare fields. No participants had any prior training in MI, and only a few endorsed any familiarity with the approach.

Measure. The MI Knowledge and Attitudes Test (MIKAT) measure includes two components:

(a) a true-false quiz that includes ten myths about addiction and substance users widely held but not supported by data and contrary to MI (e.g., "substance users must 'hit bottom' before they can change") and four assumptions or principles consistent with an MI approach (e.g., "resistance is best thought of as a product of the interpersonal context in which it occurred."), and

(b) a check-list of counseling behaviors that includes five prescribed behaviors for an MI approach (e.g., "roll with resistance"), seven proscribed behaviors (e.g., "breakdown denial"), and three neutral behaviors that may be consistent with MI but are not considered central (e.g., "educate about risks"). Respondents to the checklist are asked to check all those behaviors that reflect core principles of an MI approach to dealing with substance use.

Procedure. Participants completed the MIKAT both immediately before and after a daylong (7-hour) introductory training workshop on MI. Participants were asked to anonymously complete the pretest upon arrival at the workshop, and the posttest at the end as part of the workshop evaluation.

MI Training Workshop. The workshop was led by the author, a psychologist with previous training and supervision in MI who became a member of the Motivational Interviewing Network of Trainers (MINT) during the course of the study. The workshop included both didactic and experiential components and was focused upon developing a basic understanding of the

MI model, spirit, and basic strategies (e.g., OARS, rolling with resistance, and eliciting change-talk). Participants rated the quality of the workshop highly, with a mean rating for the workshop overall of 3.74 on a 4-point scale (4 being "Excellent"). Each workshop had 12-20 participants in attendance (complete data was not available from all participants).

Results

Substance Use and Treatment Beliefs. Pre- to posttest changes demonstrate substantial improvements in correct responses for most items. Larger improvements are observed for items with the greatest room for improvement due to poor performance at pretest. To create a summary score for substance use myths and MI-consistent beliefs, a summary score for each set of items was calculated (# items correctly marked /total # of items) for each participant. An analysis of this summary score with a dependent t-test revealed statistically significant reductions in overall endorsement of substance use myths (pretest M=46.9%, posttest M=24.2%, t(63)= 7.73, $p < .001$, d=1.95), and significant increases in overall endorsement of MI-consistent beliefs (pretest M=63.7%, posttest M=82.0%, t(63)= -5.72, $p < .001$, d=1.44).

Counseling Behaviors Checklist. Pre- to posttest changes demonstrate substantial increases in rates of correct identification of MI prescribed behaviors and reductions in identification of MI proscribed and neutral behaviors. To create a summary score for each type of behavior, a summary score for each set of items was calculated (# items selected/total # of items) for each participant. An analysis of this summary score with a dependent t-test revealed statistically significant increases in overall correct identification of MI prescribed behaviors (pretest M=56.1%, posttest M=76.1%, t(70)= 5.72, $p < .001$, d=1.37), significant decreases in overall incorrect identification of MI proscribed behaviors (pretest M=30.0% , posttest M=17.1%, t(70)= -4.49, $p < .001$, d=1.07), and significant decreases in overall incorrect identification of MI neutral behaviors (pretest M=59.6% , posttest M=40.4%, t(70)= -4.13, $p < .001$, d=.99).

Discussion

The results of this pilot study are encouraging in regards to the validity of this simple test of knowledge and attitude change following MI training. As expected, pre- to posttest increases in MI-consistent beliefs and correct identification of MI prescribed behaviors was observed. Further, pre- to posttest decreases in MI-inconsistent beliefs and misidentification of MI proscribed behaviors were observed. Effect sizes (d) were large for both of these changes. Notably, one MI-consistent belief ("Resistance is best thought of as a product of the interpersonal context in which it is observed.") that is central to the MI model was highly endorsed by the participants at pretest. It must be noted that these participants had little or no prior training or experience in substance use treatment. Because this belief is so inconsistent with prevailing models of resistance in substance use treatment settings (as a characteristic of the disease or the client), different scores on this item might be expected with a different audience.

While causal inferences about training effects are not possible for this simple pre-post design, the results are encouraging. The new measure developed in this study should be further investigated as a tool for evaluating changes in knowledge and beliefs due to professional training. Future studies evaluating training should investigate whether the changes in beliefs and knowledge demonstrated on this measure correlate with actual behavior changes in counseling style or with self-reported perceptions of amount learned during training. Finally, future research should investigate whether changes in knowledge and attitudes are maintained over time or if they drift back to pre-training levels.

Note: The MIKAT with correct answers, as well as tables describing beliefs and attitudes measure items and counseling behaviors checklist items with pretest, posttest, and change scores, can be accessed by MINTies in the Member section of the MINT website.

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What the Research Says . . .

. . . About MI Training

Grant Corbett

Expectations may be the greatest barrier to MI competence. "Recipe" thinking, economics and outcomes are three reasons why.

Years ago an article in *Synthese* suggested that people think in "recipes". We want to know what to do and when, and how complicated can recipes be? Thus, should training not be achievable in a few hours or days? Then there is economics. Even where there is interest in improving staff competence in new clinical styles, limited continuing-education budgets can mean brief trainings. Most importantly, over-burdened health professionals, accountable organizations and funding bodies want training that will improve health and financial outcomes with the least expenditure of time and dollars.

So, requests for one-hour or half-day "trainings" are not uncommon, with typical workshop lengths being two to three days. What does this mean for what the research says about training professionals in MI?

First, it means that the number of training days evaluated by research programs may be restricted by what can be demanded of health professionals and by financial factors unrelated to what may be necessary to achieve skill competence. Thus, what you will read in this column will be the evidence for formats that have been studied.

Second, clinician behavior change is about more than the number of training hours or days needed. Program content is critical. The latter involves two questions: 1) what do we want practitioners to achieve, and 2) what do we know about the best way to change clinician behaviors in a given learning format?

For example, for a person to commit to a treatment outcome, they need to trust that the change will do them more good than harm. This can entail perceived risk. If this is the case, what then motivates risk-taking?

One answer comes from the emerging field of social cognitive neuroscience. Fehr and colleagues (2005) show that increased levels of oxytocin (OT) in the brain make people more willing to take risks. What increases OT? The answer is that "any tangible and honest signal by the clinician that 'values' the patient can provoke OT release in the patient." (Paul Zak, personal communication, January 24, 2006; see also Zak et al, 2005)

Can MI training help develop these trust signals? We could take the behavioral route and have practitioners role-play and get feedback from peers on how valued they feel and how they engender trust (or not). However, could competence be achieved more quickly if we targeted a change in beliefs (Gysels, Richardson & Higginson, 2004)?

As Bill Miller & Theresa Moyers (in press) propose, the first stage in MI training is to communicate

> *that people possess substantial personal expertise and wisdom regarding themselves, and tend to develop in a positive direction, given the proper conditions of support.*

This describes the MI Spirit which, I believe, sets the conditions for clients to see that we intend to trust them. Miller and Moyers' (in press) research validates this:

> *Our own process research indicates that the therapist's ability to convey this spirit is a powerful predictor of using other behaviors central to MI as well as a predictor of increased client responsiveness during MI sessions.*

Thus, if a willingness to consider this patient-centered perspective is a starting point in learning MI, how do we present and engage this Spirit in training?

Trust is one of several neuropsychosocial changes I believe that we are targeting with MI. What these may be, and what counsellor behaviors and training experiences can support desired outcomes, becomes our next question. These will be the focus of the next column.

In this issue we will provide an overview of best evidence and practice for MI and related training formats.

Best Evidence

Best evidence can come from meta-analytic reviews, and in their absence, well-designed randomized controlled trials (RCTs; studies where subjects are assigned randomly to treatment and control groups). One source of the former is the Cochrane Collaboration (http://www.cochrane.org/index0.htm). For example, Thomson-O'Brien and colleagues (2005) looked at randomized controlled trials of continuing-education meetings and workshops and found that:

> *Interactive workshops can result in moderately large changes in professional practice. Didactic sessions alone are unlikely to change professional practice*. (p. 1)

The authors defined interactive workshops as "sessions that involved some type of interaction amongst participants in small (<10 participants), moderate (10-19 participants), or large (>19 participants) groups. The interaction may have included role-play, case discussion, or opportunity to practise skills." (p. 3)

Thus, presentations *about* MI would be didactic and unlikely to

change clinician behavior. Unfortunately Thomson-O'Brien and her co-reviewers could not conclude from available studies what the optimal length of training should be. However, most protocols involved between two half-day to two-day trainings.

MINTies Scott Walters and John Baer, along with Sarah Matson and Doug Ziedonis, published a systematic review of the effectiveness of workshop training for psychosocial alcohol and other drug treatments (2005). Eight of the 17 studies meeting their criteria involved MI. The number of hours of training in all but one study ranged from 10-15 hours, with additional follow-up in several. Their review concludes:

In general, training tends to improve attendees' knowledge, attitudes, and confidence in working with clients who have substance abuse problems. Some skill improvements, when measured, are usually seen immediately after training but are less often maintained over a longer time. Extended contact, through follow-up consultation, supervision, or feedback, appears to be necessary for the long-term adoption of skills. There are also a number of institutional factors that may influence the extent to which providers adopt new practices. (Abstract)

MINTies John Baer, Chris Dunn, Bryan Hartzler and David Rosengren, along with Betsy Wells, have been engaged in a stepwise process to evaluate MI training methods. Specifically, they did a pilot study to establish effect sizes for a standard workshop. Then they developed a measure to assess training effects (VASE-R). Most relevant to this column is that they have just completed two pilot tests for a SPICE style training method, which they are calling context-tailored training (CTT). For this they have written and refined a training manual. The group is in the process of doing a randomized controlled trial where they will compare CTT vs. standard 2-day workshops. (Personal communication from David Rosengren, October 26, 2005)

Best Practice

In summary of his meta-analytic review, Scott Walters offers the following best-practice recommendations:

I think we can say that, for most practitioners, a discrete 2-day training is not enough to change long-term practice. Except in rare instances when the protocol was very simple (screening and advice in primary care settings), you need ongoing contact with a trainer. In addition, as trainers we often forget the many other institutional factors that may affect the extent to which an intervention gets adopted into practice. Even if the practitioner wants to use the new skills, the organization may not adequately support it. Most of the other questions we just could not answer based on the available literature. (Personal communication, October 23, 2005).

MINTie Carolina Yahne was co-investigator, along with Bill Miller and Theresa Moyers, on the Evaluating Methods for Motivational Enhancement Education (EMMEE) research (Miller et al., 2004). Carolina offers the following:

I strongly recommend that trainees audiotape sessions with the written permission of their clients. The tapes should be coded by expert coders and written feedback sent to the trainees. Also, telephone coaching is extremely useful, especially if both the trainee and the coach have a copy of the written feedback in front of them. Each telephone coaching session should include at least one role-play, focused on the issue that most needs work. Feedback and coaching after a basic training usually lead to proficiency." (Personal communication, October 17, 2005)

MINTie Carl Farbring makes a similar best-practice recommendation based on training virtually all client-related corrections staff in Sweden over 2001 -2003:

[MI training] was extremely well received and people were rating high on all feedback. However nothing really changed, people were not using MI. That is not to say that they had not learned anything or that they were not proficient. I really don't know, but my guess is that since they did not start to practice MI immediately after the training whatever they had learned withered rather soon. (Personal communication, October 16, 2005).

Carl suggests that practice and feedback is what is needed.

Both Carolina and Carl's comments align with meta-analytic reviews of continuing-education studies. A current challenge is to find available dollars and expertise to code tapes and provide feedback.

Bill Miller offers his thoughts on the following questions I posed to him:

1. How likely is it that a clinician will achieve proficiency after a standard two-day initial training?
2. How much additional training (i.e., feedback and coaching) is a clinician likely to need after a "standard" two-day initial training?
3. What about effects of massed vs. distributed training (e.g., three consecutive days vs. three days separated by two-week periods)?
4. What does the research say about multiple learning modalities (e.g., watching demonstrations, hearing lectures, practicing skills)?
5. What factors lead to maintenance of skills over time?

In general, I'd say we have very little information to address these questions with regard to MI, although there is extensive learning literature on some of them (e.g., massed versus spaced practice).

'How likely is it that a clinician will achieve proficiency after a standard 2-day initial training?' Any generalized answer to this question will be misleading. In the EMMEE study (Miller et al., 2004), we got 50% hitting proficiency criterion after the stan-

dard workshop alone. But that doesn't consider important factors like who's being trained, who's doing the training, and what constitutes a 'standard' workshop. In EMMEE we were working with people who wanted to learn MI and traveled at some distance and expense to get the training. Roughly 25% of them met proficiency criteria at baseline, before any (further) training. In my experience it makes a big difference how much of a 'headstart' the trainee has on learning MI. In the COMBINE study (http://www.cscc.unc.edu/combine/) we pre-selected therapists who were already good at reflective listening, and it was far easier to teach them MI/MET than when starting from scratch.

Same thing with the question about how much additional training is needed. The point is to train TO CRITERION. Some trainees will get there quickly, if they weren't already there. Some never get there. When we added six half-hour follow-up individual coaching consults, we increased proficiency from 50% to 75%—a 50% gain.

How good is good enough? Again, it depends. What level of proficiency on what measure is sufficient to produce what increment on what client outcome? We just don't have those data yet.

To end, MINTie Jacki Hecht reports having had an MI working group to standardize approaches to training, supervision of intervention staff and efforts to maintain treatment fidelity across the Behavior Change Consortium (BCC) Studies (Personal communication, October 26, 2005; see http://www1.od.nih.gov/behaviorchange/ for information on the BCC). Details can be found in her paper with colleagues in the *Annals of Behavioral Medicine* (Hecht et al., 2005).

Conclusions

In summary, I propose that best evidence and practice indicates that:

1. MI training involve a minimum of two-three days of practice with feedback, followed by six half-hour individual coaching sessions in follow-up. Each telephone coaching session should include at least one role-play, focused on the issue that most needs work.

2. Participants have the opportunity to practice, tape and receive feedback immediately after training. This may require negotiating institutional support for trainees.

3. Assessment of MI skills pre-workshop would allow for customized training and re-evaluation at the end of core training would allow for training to criterion.

As noted, the next column (Part II) will look at what the research can tell us about what client changes we are targeting, and how MI training can evoke clinician knowledge, skill, attitude and behavior change to achieve these outcomes.

Endnote: Thank you to all MINTies who contributed to this column through their contributions of questions and comments.

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Editors Note: Recent readers of the MINT Bulletin may wish to review previous editions of Grant Corbett's *What the research says...about* columns:

MI Skills: Issue 11.2, 6-9.

Change Talk- Part 1: Issue 11.3, 9-10.

Change Talk- Part 2: Issue 12.1, 7-8.

Change Talk- Part 3: Issue 12.2, 4-7.

You will also find MI-related research referenced in the bibliography maintained on the www.motivationalinterview.org site at:

http://motivationalinterview.org/library/biblio.html.

"Salsa Dancing"

An Exercise to Demonstrate the Spirit of MI

Claudia Salazar

This exercise is part of the introductory session to the motivational interviewing skills training course described in MINUET 11.2 (MacRae, 2004).

The Exercise (20-30 minutes)

After the introduction of the session, we say that we are going to do an exercise to demonstrate the spirit of MI. The trainees are taken by the facilitator to an empty room with a CD player and told that they will be doing some salsa dancing. The facilitator then elicits feelings from trainees about the exercise, and usually there is a mixture of views: from those who feel very excited, to those who feel embarrassed or panic because they feel they cannot dance. Trainees are invited to take part but also given the choice not to. In our experience even those who are embarrassed take part as long as they have had an opportunity to express how they feel about the exercise.

The facilitator then asks the trainees to stand behind her (it is usually me). They are shown one of the basic salsa steps without music and then the music is introduced when they have practised this for a while. Then they are shown how to take this basic step backwards and forwards.

In the next part of the exercise, the facilitator asks for a volunteer to show the trainees how to dance in a couple and to combine the forward and backward steps. The music continues, and the trainees are encouraged to co-ordinate their steps with their dance partners. Usually there is great laughter and energy and if there is time then we suggest a change of partner or that they make up their own steps together in rhythm to the music.

Discussion

The trainees are then taken back to the training room, and the facilitator usually starts the discussion by mentioning the analogy of dancing versus wrestling. This usually enables trainees to discuss their thoughts about this and the following points generally arise:

- Doing something new may elicit difficult feelings if you feel very uncomfortable about the situation. Is this how clients may feel coming to their first appointment?
- It is important not to step on each other's toes.
- Everyone dances differently with different confidence and skill levels. You need to adapt your steps depending on whom you are dancing with, and the dance may improve as you practice the steps together.
- In salsa the "man" always leads the direction, but it is the "woman" who does most of the 'Twirling'. This touches on the counsellor's role in directing the session while the client's material is the most important.
- Dancing with someone new requires some getting used to, however experienced you are.
- Being a successful dancer is more than just being good at learning the technical steps; it is also about having a feel for the music.

Reflections on the Exercise

On evaluating the module over the last three years several trainees have mentioned how the salsa exercise helped them understand the spirit of MI and that it is a useful analogy in their work.

I think that this exercise could be done with any other type of music that requires people to dance with partners. Even if facilitators do not feel skilled to teach basic steps it is worth enlisting the help of a colleague or a dancer to assist in the teaching of steps. However, it is worth saying that I am not an expert salsa dancer and have no experience in teaching salsa. The technical aspects are not as important as is the experience of attempting to move to the rhythm of the music in co-ordination with someone else (the crucial part).

It is also great fun and really raises the energy level!!!!

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State of the Art and Science of Motivational Interviewing

Bill Miller

Projecting the Adoption Curve for MI

The work of my late colleague, Everett Rogers (Rogers, 2003) on the *Diffusion of Innovations* suggests that the adoption of a new approach or technology follows an S-shaped curve whereby earliest adopters are few, then adoption increases into a steep climb as the innovation takes hold, perhaps becoming normative. The curve begins to flatten out as the late adopters come on board, until finally it reaches maximum saturation. Whatever proportion of the population will ultimately adopt the innovation has done so, and from there on the curve levels off at cruising altitude.

One index of this curve for MI that I have been following over the years is the number of publications on MI, most readily accessible from the bibliography on the MI website. With the volume of publications doubling every three years for some time now, the curve is climbing steeply. Fitting this pattern to Rogers' prototypic curve, I estimate that in the UK and US at least, we're around 30% dissemination; that is, about three out of ten of those who will eventually adopt MI have now done so. Many caveats are in order: publications imperfectly reflect adoption in practice, and the meaning of "adoption" is less clear with a behavioral intervention than with hardware. These data also do not represent the picture outside English-speaking nations. For the UK and US, however, 30% feels about right to me, which means that the lion's share of the demand for training lies ahead of us, and will increase sharply.

Recent Controversies

Just before the MINT Forum there was a flurry of concern regarding publication of a null trial for MI with pregnant smokers (Tappin et al., 2005). The study was very well done, with excellent training and fidelity monitoring, and if there was any glimmer of advantage it was that MI, relative to treatment as usual, inspired fewer women to *increase* their smoking. This is not the only null finding for MI with smokers (Hettema, Steele, & Miller, 2005), and perhaps we ought to be puzzling why smoking seems to be less responsive to MI than are other addictive behaviors. Are we down to a committed remnant of smokers who have not responded to the many social sanctions against smoking, particularly for pregnant women? Is it that the outcome measure used (total abstinence) is less sensitive or forgiving than percent days abstinent?

Another interesting study appeared just before the Forum, in which 32 practitioners entering an MI workshop were randomly assigned to interact with simulated patient-actors role playing either high or low levels of resistance to stopping smoking (Francis et al., 2005). The brief consultations were taped and coded, with the result that practitioners interacting with high-resistance actors were rated as confronting significantly more (2 versus 0 on a 0-7 scale). The authors concluded that "This challenges important assumptions about the influence of practitioner behaviour on patient behaviour and subsequent health-related outcomes" (p. 1175). In other words, maybe patient resistance causes clinicians to confront and not the other way around. There is still good between-group (Miller, Benefield, & Tonigan, 1993) and within-group experimental evidence (Patterson & Forgatch, 1985), however, that therapist style can dramatically increase or decrease client resistance. Paul Amrhein's psycholinguistic analyses also show a remarkable shift in client language during MI, from resistance to commitment to change, the magnitude of which is rarely observed in natural discourse (Amrhein et al., 2003).

We have evidence, then, that causality can flow both ways, like chicken and egg. Client resistance and clinician confrontation are complementary behaviors that elicit and reinforce each other, much like the cycle of aggression and retaliation between nations. Client resistance *can* evoke practitioner confrontation. The question is whether it *should*. To interrupt a cyclic pattern of behavior, at least one party must not reciprocate. I believe it still makes sense to teach clinicians how to respond to resistance in a way that diminishes rather than reinforces it.

What's New?

The Guiding Style. Steve and I are working with Chris Butler on a new book, *Motivational Interviewing in Health Care*. When Steve wrote *Health Behavior Change* we were being careful not to call these applications MI, and a variety of alternative names arose: brief negotiation, brief MI, behavior change counseling, and such. This also relegated them to a kind of second-class status, as if they were somehow less skillful than "real" MI. Now we are reconceptualizing these health care applications within the overall spirit and method of MI.

Along the way we are conceptualizing a continuum of interpersonal communication styles that describe approaches not only to health care consultations, but to parenting, education, and psychotherapy as well. At one end is expert-driven Directing, the most authoritarian doctor-patient style. At the other is Following, in which the provider is mostly listening and passively following what the patient offers. In between is Guiding, of which MI is a refined form. A guide is someone who helps you get to where you want to do. The guide doesn't dictate where or when you will travel. Neither does the guide just follow along at the back. The guide uses expertise to help you reach your destination safely and enjoyably.

Each of these three styles makes use of three basic communication tools: asking, informing, and listening. The function of these tools is different depending on the style. Within a directing style, for example, the function of asking is to gather information that the director needs in order to make a decision and provide a solution.

The Personal Nurse Program. Another important development this year was the development and testing of the Personal Nurse Program (PNP) by Humana, under the direction of MINTy Vaughan Keller. Humana, a large insurer of health care, hired more than a hundred nurses, trained in MI and stationed in Florida, to counsel plan members by telephone. A computerized system identifies plan members with chronic diseases or who otherwise are high-cost service users. A nurse signs on to the system and is given the contact information for such a patient. Telephoning the patient, she identifies herself as a personal nurse assigned by Humana to keep in touch and talk about health. The nurse asks about and reinforces what health-promoting behaviors the patient is already doing, and asks what changes the patient may have considered to further promote health. The patient can call back and reach his or her personal nurse, and also the nurse stays in touch over subsequent months with brief MI-focused phone visits.

The program started out in Humana's innovation center, and obviously involved a significant investment of resources. Note that Humana is not itself the health care provider; this is the insurer. Within one year of operation, I am told, Humana had saved so much in health care costs for diabetes patients alone, that they institutionalized the PNP, moving it into central operations.

Mandated MI. Another development that is emerging rapidly, and one that worries me, is the mandating by governmental and regulatory agencies of the use of evidence-based treatments for substance use disorders. (Mental health counseling services in general cannot be far behind.) MI is now on just about everyone's list of evidence-based treatments, and it is also appealing to funders because of its low relative cost. As a consequence, treatment programs are being mandated to learn and deliver MI *whether they like it or not.* Now that's worrying enough, because like AA, MI was designed to diffuse by attraction, not coercion. It's a trainer's nightmare to face a room full of counselors who have been ordered to learn MI against their better judgment. The results of forcing people to attend AA have not been particularly encouraging thus far (Miller, Wilbourne, & Hettema, 2003), contrary to a generally positive albeit modest correlation between attendance and sobriety in the general AA population (Tonigan, Connors, & Miller, 2003). What, then, can we expect from the delivery of "MI" by providers required to use it (or say they are doing so) whether or not they share the basic spirit of MI?

There are also the familiar problems of training. The requirement to use evidence-based treatment can be an unfunded mandate. Some states are wisely phasing in the desired treatment methods by providing training for clinicians, usually in the form of one-shot workshops, and support for ongoing feedback, coaching, and supervision is often sparse to none. A workshop is rarely enough even for experienced providers who are ready, willing and eager to learn MI (Miller et al., 2004). If so, what can we expect from such training for coerced, unenthusiastic counselors?

Then there is the problem of quality assurance. Once a state or program mandates that its providers *shall* deliver MI, how does it ensure that MI is in fact being provided competently? There are no pharmacy records to check to show that it was delivered. If counselors' self-report of their own competence in delivering MI is at best weakly related to actual proficiency (Miller & Mount, 2001), surely case notes will be of little value in quality assurance audits. Having counselors provide periodic sample practice tapes (Miller et al., 2004) merely demonstrates that they can produce MI on demand, not that they are actually delivering it in routine care. That leaves routine taping of all sessions and random monitoring—a procedure typically used in controlled clinical trials (Miller et al., 2005)—and even if qualified moni-

tors were trained and available, this is likely to be expensive beyond the tolerance of most programs or regulatory authorities.

It seems likely that the principal outcome of requiring programs and providers to deliver MI will be increased self-report that they are doing so.

MI Training for Whole Programs and Systems. On the brighter side, but not entirely unrelated, we are receiving increasing requests to provide MI training for the staff of entire programs or systems. One of the more spectacular examples is the nationwide training within the Swedish correctional system, shepherded by Carl Åke Farbring. On a much smaller scale, I'm undertaking MI training for the whole staff of a residential treatment program in Albuquerque, from the counselors, physicians, and nurses to the people who answer the telephones and clean the floors. This means, of course, that we're bound to be training some folks who are unenthusiastic about being there, but at least it's a shot at system change. As we gain experience in working with entire programs and systems, this will be an interesting topic for sharing at future MINT meetings.

Spiritual Guiding. Returning to the topic of guiding, I'm bringing together two longstanding lines of work. As I approach retirement, this seems to be happening—a synthesis of what once seemed separate interests.

Among U.S. addiction treatment providers, at least, there is widespread agreement that spiritual growth is a key aspect of recovery. Yet many programs do little to address this issue directly, other than encouraging attendance at 12 Step meetings. That's entirely understandable. There are often more acute, pressing problems to address, and clients themselves may not exactly be clamoring for spiritual guidance. By the time people hit the bottom of alcohol/drug dependence, they are usually quite alienated from religion (and from any other prior social networks), and spiritual growth tends to be pretty low on their priority list. It could take some motivating for them to spend time on spiritual formation. In addiction treatment, of course, we're already accustomed to encouraging people to do things they are not initially enthusiastic about doing, but it would have to be on the staff's radar screen to focus on spiritual growth. (And it may not be as hard as we imagine; in a recent Gallup poll, 82% of Americans endorsed a need for personal spiritual growth.)

So suppose that we took seriously the importance of spiritual growth as part of the treatment and recovery process. What would we do differently in treatment? I was inspired by a visit to the Na'nizhoozhi Center, one of our Clinical Trials Network research partners, in Gallup, New Mexico. They have incorporated evidence-based treatment methods into their program, which treats primarily Native Americans from the Navajo Nation and other regional tribes. Motivational interviewing and the community reinforcement approach are on the menu. Also out back of the Center is a ceremonial compound complete with teepee, sweat lodges, drums and dance grounds. On their staff are traditional medicine men. They have incorporated evidence-based treatment with traditional Native spirituality.

So I came back thinking, "How might we do this in our own treatment system?" It doesn't make much sense (to me, at least) to put white folks in teepees, sweat lodges, and dance moccasins. Most of our clients come from families with Judeo-Christian heritage. What would be the parallel to what Na'nizhoozhi is doing with Navajo spirituality?

The answer, I think, lies in spiritual disciplines that have been around for thousands of years, the traditional paths through which people have sought conscious contact with the sacred. Most of these—like prayer, meditation, fasting, study, service to others—are not at all unique to Judaism and Christianity, but are shared by the world's religions. If these are the paths that have been used for so many centuries, perhaps there is something to them.

Thus we combined the guiding style of MI with a menu of spiritual disciplines that clients may choose to try. The combination is not unlike that in the Combined Behavioral Intervention developed for the COMBINE trial (Miller, 2004). It begins with MI (no MET feedback this time), exploring the person's own motivations for spiritual growth. In our first study, the spiritual guidance counseling was delivered by professional, certified spiritual directors. It turned out to be very easy to teach them MI, because they were already doing about 90% of it—excellent OARS skills, a collaborative approach, and a profound respect for the client's own journey. We have recruited 60 participants from a residential treatment center, and randomized them to treatment as usual with or without the spiritual guidance intervention (up to 12 visits, begun during the inpatient stay and continued afterward). We're still collecting follow-up data (up to 12 months) and I don't yet know the results. Meanwhile we're setting up a second randomized trial in which we will deliver spiritual guidance more intensively during residential treatment, this time delivered by program staff particularly interested in this aspect of care. Clients consent to participate, of course, knowing what they are getting into. Some want nothing to do with spirituality and decline, but many are eager to find out more. The spiritual directors, too, who never worked with alcohol/drug dependence before, have found this a rewarding experience.

Coming Soon to a Journal Near

You. There are also some exciting publications to appear this year. The first results of the U.K. Alcohol Treatment Trial just appeared (UKATT Research Team, 2005a, 2005b) and would be stimulating material for another virtual symposium. The Clinical Trials Network of the National Institute on Drug Abuse also has devoted substantial attention to MI and MET, with four national multisite trials underway. Two of these, headed by Kathy Carroll, have been completed and should be publishing results very soon—both with adult drug abusers, one with MI and the other with MET. Kathy is also directing a Spanish-language MET trial, and Theresa Winhusen is PI for a randomized trial of MET with pregnant drug users. Our paper describing eight stages in learning MI, which we have used as a guiding format for TNT workshops in the past two years, is now in press and will appear in early 2006 (Miller & Moyers, in press).

Some Things that Concern Me

Let me comment briefly on a few issues that worry me as MI develops and diffuses, and then conclude with some things that I think we need to know about MI.

Continuing Entanglement with the Transtheoretical Model. Throughout its history, MI has often been associated and confused with the transtheoretical model (TTM) in general, and in particular with its stages of change. I'm clearly responsible in part for this, having included the TTM stages in many publications and presentations on MI. The two grew up together in the early 80s, and MI is a good example of an approach to help clients who are not yet "ready" for change. ICTAB-3 was an early introduction of TTM to the addiction field (Miller & Heather, 1986) and was also the first ICTAB at which MI was discussed.

However, MI is explicitly not predicated on or derived from TTM. MI does not propose a comprehensive theory of behavior change, nor indeed until recently was there much theory underlying MI. It arose from practice, developed through the accumulation of empirical process and outcome data, and is now maturing to the point where formal theory can be explicated and tested. Theory did not precede MI, but rather has followed from it. When Steve and I prepared the second edition of MI (Miller & Rollnick, 2002) we consciously avoided TTM in the front section of the book, and invited Carlo DiClemente and Jim Prochaska to contribute a separate chapter in the back half on the overlap of MI and TTM.

Over the past decade, the TTM has come under increasingly vigorous attack. Nick Heather and I addressed this in the second edition of the book that came from ICTAB-3 (Miller & Heather, 1998), with Chapter 2 summarizing the emerging concerns (Davidson, 1998) and then a chance for Jim and Carlo to respond in Chapter 3. A lead article in the journal *Addiction* was devoted to renewed critiques, going so far as to say that it is time to "put the transtheoretical model to rest" for lack of supporting data (West, 2005). I have not participated in this debate, and am not weighing here the pros and cons. My concern is that we continue to be clear about the different histories, theories, and empirical data bases for MI and TTM. My concern continues to be aroused by quotes like this one from the *British Medical Journal:*

> *Motivational interviewing is a one to one counseling method designed for treating addictions. Its "stages of change" model is widely taught on smoking cessation training courses.* (BMJ 2005, 331:374)

and this one from *Drug and Alcohol Dependence*:

> *The transtheoretical rationale for MET . . (also known as readiness for change) is detailed in the Transtheoretical Model (TTM) for stages of change (Prochaska & DiClemente, 1992) and formed the basis of Motivational Interviewing (Miller & Rollnick, 2002) and MET.* (DAD 2005, 80:92)

MI did not invent the stages of change, nor is MI rooted in the TTM.

Using MI to Modify Questionnaire Responses. I am also concerned to see studies of MI where the outcome measure is limited to responses to a questionnaire; for example: does MI increase motivation for change as measured by Questionnaire X? Most questionnaire items are far removed from spontaneous speech, and are also highly susceptible to contextual demand. If a counselor has just spent an hour trying to elicit motivation and then administers a motivation questionnaire, it's not difficult to discern the desired responses. Tick marks on a questionnaire are likely to bear little or no relationship to subsequent behavior change, though they can be interesting mediational markers when given along with behavioral outcome assessment.

Mandated MI. My concerns in this regard are outlined above. MI was never designed to be a treatment that clinicians would be forced to learn, and I'm concerned what impact such coercion will have on the quality of understanding, attitudes, and practice of MI.

Certification. MINT as an organization remains profoundly ambivalent about certifying practitioners, let alone trainers, and understandably so. As the movement toward requiring evidence-based treatment progresses, there is bound to be increasing demand for some authority to certify competence in MI and other approaches. I believe that we do know enough now to evaluate a provider's proficiency in delivering MI. I'm not as sure we know enough to certify trainers yet, but at a minimum one would hope that a trainer would be proficient in delivering MI. There is still nowhere

to go for certification of proficiency in MI. It's just a matter of time until someone begins providing certification.

Rapid Diffusion. Relatedly, I continue to be concerned with how rapidly MI is diffusing (in both senses of the word) in practice. On one hand, it's encouraging that there is so much interest in learning this approach, but demand easily outstrips quality. I am not arguing for policing MI practice or training. I am calling for creative thinking about how to help people get it right as MI spreads so rapidly, lest this become a diffuse approach. There are already published descriptions of MI that depart substantially from what we regard to be the essentials. Consider this quote from the *American Journal of Health-Systems Pharmacy* (2005, 62:1313) describing how to use Steve's elicit-provide-elicit method:

> *Start by asking the patient general questions to build rapport and obtain pertinent information related to therapy... Next, specific information should be given to patients, who should be asked if they have any new concerns. Throughout the process the provider may offer a new perspective and solution... A skilled provider can use motivational interviewing for 5-10 minutes per session per patient.*

I don't think that's much like what Steve had in mind as a way for incorporating the provision of information in an MI-consistent manner. If misunderstandings are cropping up in published and peer-reviewed descriptions of MI, what's happening out there in routine training?

Things We Still Need to Know

Why Does MI Work? This is still the central puzzle for me. What is going on here, when a session or two of talk leads to a person turning a corner on an engrained behavior that has a decade or more of inertia behind it? I'm not particular fond of the idea of "critical ingredients" (like looking under the hood of a car and asking which part makes it run), or of the deterministic tone of "mechanisms of action," but we do need to understand what is essential for MI to work. That's key information for guiding training and quality assurance monitoring. All therapies pick up superstitious components over the years, and it would be nice to know which aspects of MI can be "re-invented" and adapted without compromising the core.

When and Why Does MI Not Work? It is already clear that the efficacy of MI varies across sites, problems, counselors, and clients. Why is it, for example, that MI seems to have less effect on tobacco smoking? When there are site differences in a multisite trial of MI, what may account for them? What accounts for therapist effects in MI outcomes?

A Theory of MI. That leads to the development of a coherent and testable theory of MI. It need not be a comprehensive theory of human behavior, just a specification of processes, mediators and moderators of efficacy. There are some closely-related theories around that could be explored and integrated into our conceptions of MI, including self-determination theory (Deci & Ryan, 1985), theory of reasoned action (Ajzen, Brown, & Carvajal, 2004), implementation intentions (Gollwitzer, 1999), crystallization of discontent (Baumeister, 2005), and theory of positive disintegration (Dabrowski, 1976). We need better linkage to mainstream psychological theory and research.

Groups. Then there is the enduring question of how to deliver MI in groups. It comes up in virtually every training workshop, and we still don't have a good data-based answer. How do group vs. individual MI compare in efficacy? Do the same processes lead to outcomes in group as in individual MI?

Who Does (and Doesn't) Learn MI Well? Experience in training suggests that there are individual differences in whether and how quickly clinicians learn MI. What accounts for this? Are there measurable attributes that predict preparedness to learn MI?

Diffusion. MI has diffused rapidly and is likely to continue doing so for some time, but how does diffusion happen? How do practitioners learn about MI in the first place, and what motivates them to learn and adopt it?

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Similarities and Differences between Cognitive Therapy and MI

Peter Prescott

I've met therapists of the cognitive persuasion who venture the viewpoint that Motivational Interviewing (MI) is a form of Cognitive Therapy (CT). My usual answer has been: *"Yes. I guess. They're sort of like cousins".* As I hear myself speak, however, I feel uncomfortable and perhaps a little resistant. As we all know, discomfort is one of the mothers of motivation. I've therefore tried to unravel some of the similarities and differences between CT and MI.

CT and MI have unique strengths and seem to complement each other. Treatment of most psychological or behavioural problems would probably profit if therapists were proficient in both approaches. Both approaches should import and export impulses to each other, but should in my opinion be developed separately.

Systematic comparison of CT and MI may result in a more precise understanding of both treatments.

A Few Similarities

Both CT and MI are reactions to earlier forms of treatment. Beck and Ellis were unhappy with the passive role of the therapist in psychoanalysis. They were also troubled by its lack of effectiveness in treating depression and anxiety. One impetus for MI was Bill's discomfort with the ethics of confrontative treatment of substance abuse. He also questioned its effectiveness.

Some of the present central concerns in CT and MI may reflect their respective historical roots. An ongoing reaction to psychoanalysis can perhaps be seen in CT's preoccupation with effectiveness and structure of treatment, and (until fairly recently) downplaying the role of relationship. MI's focus on the importance of empathy and acceptance, along with dilemmas connected to client autonomy vs. therapist influence, seem to be an ongoing reaction to confrontative therapy.

Both MI and CT value phenomenological aspects of the patient's experience. Treatment is grounded on the patient's own understanding of her situation, behaviour and emotion. Both approaches stipulate an active patient as a necessary condition for change: The

patient has to exert conscious effort to change and is not a passive recipient of therapy. In CT the patient must often learn skills to modify dysfunctional thinking and change behaviour. In MI, active participation is seen in repeated decision-making, along with mobilizing and utilizing existing competence strategies.

Both approaches contain interventions with that result in unpleasantness for the patient. Exposure—behavioural (situations), physiological (body sensations), cognitive (thoughts), and affect (emotion)—is an important intervention in CT. In MI, exploration of ambivalence and negative consequences is a form of self-confrontation and often results in internal tension and emotions like guilt, fear, and shame.

Both are directive treatments, can be manualized, and have well-defined concepts that encourage clinical research.

Motivational Interviewing

MI is influenced by humanistic psychology (people have inherent resources to change) and existentialism (we choose, are autonomous, and responsible for own behaviour). Furthermore, MI views people as complex, driven by competing motives and in conflict with themselves. This complexity is noticeable in motivational conflict (ambivalence) and fluctuating levels of self-efficacy (both optimism and doubts about being able to change grow and fade).

Learning theory is also an influence. Behavioural self-control training has demonstrated that people are able to change addictive behaviour. On a different level, principles of operant reinforcement can be recognised in MI's selective reflection and summarization of patient change talk. Although this technical way of looking is in conflict with the spirit of MI, it is clearly one relevant viewpoint.

MI is especially useful early in the process of change. By exploring ambivalence, eliciting existing motivational and self-efficacy resources, and highlighting decision-making, it helps clients make up their minds about changing. The starting point of MI is a person with some sort of problem with intentional behaviour.

In contrast to many psychological therapies, MI isn't guided by an *explicit* theory about the causes of problems and mechanisms that maintain them. This is a complex issue that includes classical and operant conditioning, expectancies, neurobiological adaptation, reduced self-efficacy, diminished effects of negative consequences, and conflicting motivation. Bill's article, "Toward a Motivational Definition and Understanding of Addiction" (Miller, 1998) could be a starting point for a theoretical model of intentional behaviour with reinforcing properties gone wrong. Descriptions of the characteristics of problem behaviours (eating, smoking, gambling, exercise, substance use) could possible result in different MI-treatments for different behaviors.

One of the most interesting ongoing developments in MI is the clinical use and adaptation of theory and research from social psychology (Baumeister – crystallization of discontent; Bem – self perception; Festinger – cognitive dissonance; Brehm – reactance; Deci - self-determination theory).

Another potentially productive development is the recent psycholinguistic research on the predictive value of client statements. It is hypothesized that change talk increases the likelihood of behaviour change, while resistance statements reduce it. These findings emphasize the importance of being acutely attuned to ongoing interaction with the patient and modifying interventions dependent on patient reactions. This understanding of the complexity of patient-therapist interaction is reflected in recent discussions about the limitations of manualized treatment.

Cognitive Therapy

CT is influenced by humanism (people can develop the skills necessary for change) and empiricism (people can be hypothesis-testing scientists in everyday life). CT holds the view that people would be happier and have fewer problems if they became more adept in evaluating their thinking. You can't really trust your thoughts, so you should think logically and carry out behavioural experiments to see if they are valid and useful. CT is also influenced by learning theory (for example positive and negative reinforcement, avoidance behavior and shaping). While behaviour therapy postulates that exposure works through extinction or habituation, the assumption in CT is that exposure is a behavioural experiment in which a patient can test the validity of thoughts and expectancies. For example, the treatment of PTSD with repeated exposure to traumatic memories results in reappraisal of danger. Interestingly, it is thought that exposure in PTSD treatment also works by changing information processing. By talking through traumatic experiences, memories are transferred from perceptual to symbolic representation (which has less potential to activate affect).

CT focuses on *how* you think. Cognitive processes like attention, perception, memory, association, attribution, logic, and rational analysis are important. This focus on the process of cognition gives CT a certain mechanical flavour. CT also focuses on *what* you think. The content of your thoughts differs quite a bit depending on if you have anger problems, anxiety, depression, shyness, gambling problems, or drug abuse. Although there is a certain amount of overlap, different disorders are characterized by distinct thoughts, assumptions and beliefs. (In the concept of schema we see similar processes and con-

tent of cognition. A schema contains characteristic thoughts and also guides attention, perception and memory.) CT focuses on conscious and intentional processing of information (viewpoints, beliefs and opinions), but habitual and automatic processing (automatic thoughts and schema activation) seems to be more important.

A major premise in CT is the hypothesis that relationships exist between affect, behavior, body reactions and cognition. Different behaviour/emotional problems are caused and maintained by characteristic patterns in thinking, emotions, actions and physiological responses.

CT can be seen as a "psychological medical model": The therapist attempts to find out what causes and maintains the patient's problems (diagnose) and to fix it (treat) in co-operation with the client. CT assumes that changes in thinking can result in changes in emotions, actions and bodily responses.

Unlike MI, CT can be done in a number of different ways and styles. Ellis' Rational Emotive Therapy is characterized by logical argumentation and persuasion. Guided discovery is Beck's approach. I have also seen videos of Christina Padesky's therapy that bears resemblance MI's eliciting style. These three ways of doing CT represent fundamental differences as to whether and how much patients have to conform to the treatment model versus treatment that is flexibly modified to accommodate the individual patient.

The ideal for therapy is an expert therapist who teaches the informed and co-operative patient self-help skills that can improve functioning and reduce emotional, interpersonal, and behavioural problems.

Although CT attempts to elicit intrinsic patient resources, the main focus is on helping the client to a cognitive understanding of his or her problem (psychoeducation), along with teaching skills to change it (cognitive restructuring, mindfulness, self soothing, positive self-talk, problem solving, relapse prevention, social behaviour training).

Sometimes patients change thinking just by talking with a (cognitive) therapist. They identify and evaluate dysfunctional thinking and generate more functional alternatives, which results in changed behaviour or emotions. The usual case, however, is that behaviour change needs long-term effort from the patient.

While MI focuses on preparing people for change (and motivation for maintaining change), CT is geared towards helping people with methods of change and maintenance.

More Specific Similarities and Differences between MI and CT

Negative automatic thoughts (NAT) and change talk. CT is interested in *how* and *what* patients think, while MI focuses on *what* patients say and to a certain degree *when* patients say it.

CT's concept of negative automatic thoughts and MI's change talk are in many ways similar.

Negative automatic thoughts are communicated through patient speech and are considered to be contributing causes of problems. One goal of treatment is to identify, elicit, and reduce the frequency and importance of NATs while generating more functional alternatives. Alternatives to NATs that are produced by the patient herself can be viewed as change talk.

Change talk is probably an expression of underlying "change thoughts". It is likely that the activating of "change thoughts", rather than verbal communication in itself, causes behaviour change. While NATs maintain problem behaviour, change talk is seen to be a contributing cause of change. One goal of MI treatment is to identify, elicit, and increase the frequency and salience of change talk. Change talk that is explored and summarized may result in decision-making.

Negative automatic thoughts (NAT) and change talk seem to be two sides of the same matter. For example, when we explore ambivalence, change talk constitutes the "pros" for behaviour change, while NATs represent the "cons".

Schemas and values. In CT, schemas are considered to be stable mental structures that contain core beliefs about the self, the world, other people, right and wrong. When a schema is activated the patient has a strong tendency to process information in a predetermined and idiosyncratic way. Schemas guide perception and colour interpretation of events and situations. They influence behaviour and emotions. In therapy, inflexible and rigid schemas are seen as dysfunctional and therefore should be modified. Schema change can result in large changes in behaviour

In MI, values are seen as broad behavioural ideals—judgments about what is good/bad behaviour and prescriptions for behaving consistent with values (Wagner & Sanchez 2002). They often give direction to the kind of life one wants to lead and define the type of person one wants to be. Like schema, they can be more or less conscious viewpoints and influence perception and preferences for experiences. In MI they are seen as being a resource for motivation for change. Evaluation of behaviour in light of values can lead to dissonance, emotional activation, and large changes in behaviour

Like change talk and NATs, schemas and values may be seen as flip sides of the coin: One side representing resources for change and the other for status quo.

Providing information. Providing or exchanging information have different flavours and functions in MI and CT.

In MI, the goal of exchanging information about negative consequences is to increase motivation for change. Offering information

about ways to change in the form of a menu fosters client choice and increases acceptability of chosen method, commitment, and probability of change. MI has specified a procedure for information exchange (elicit-provide-elicit) that counteracts patient passiveness and maximizes active and meaningful processing of information.

In CT, the therapist gives information in the form of a cognitive formulation of problem. This is a coherent and rational explanation that can lead to patient feelings of control and hope. Information about the structure and methods of therapy is also given. The objective of giving information is to generate a shared understanding that increases collaboration and motivation for cognitive therapy.

Relationship, working alliance and ongoing process. Both MI and CT focus on "the problem". Ongoing process between therapist and client is usually not an explicit theme in treatment. In both types of treatment therapists give affirmation and positive feedback, but otherwise do not usually comment on patient's actions or characteristics. (One exception is empathic confrontation found in some forms of CT with personality disorders.)

The relationship and working alliance between therapist and patient in CT is shaped by several factors. The patient is given information about role expectations. An explicit contract for the methods and content of treatment is formulated. Therapy sessions follow a predetermined structure and an agenda is set at the beginning of every session. Client viewpoints about session content are elicited at the end of every session.

In MI, the relationship and working alliance is initially addressed by discussing the background for contact and the patient's ambivalence about being in treatment. This is because many patients are referred to treatment under some sort of pressure. Through negotiation and agenda-setting the therapist attempts to create a working alliance that permits constructive patient participation. The skilled MI therapist is extremely attuned to interaction with the client. Different responses to change talk and resistance demonstrate MI-practitioners' preoccupation with the ongoing process of treatment.

Communication skills. In CT Socratic dialogue is the ideal for communication. Socratic dialogue has several aspects, one of these being a therapeutic stance of curiosity, interest and discovery. The goal of Socratic dialogue is to explore the patient's ideas and understanding of behaviour, feelings, other people, the world, the future, etc. It can also be seen as a therapeutic intervention in itself, because examining and evaluating thoughts can result in modification of behaviour and emotion.

In a Socratic dialogue the therapist uses exploratory questions, reflections, and summary statements. Exploratory questions can be both open and closed. Reflections can be questions. This is a substantial difference from MI-communication.

MI-communication is an exercise in balancing contradictions. It is a combination of technique and spirit and it is patient-centred and directive. Classification and the exact use of open questions, summaries, reflections and affirmation are technical aspects of MI-communication. High quality empathic listening skills represent the spirit. Patient-centeredness can be recognized in the exploration of underlying meaning in the patient's thoughts, viewpoints and experiences. Direction is seen in the selective use of micro-skills to reinforce change talk and "diffuse" resistance. This directiveness is a rather unique characteristic of MI.

Importing and Exporting Impulses and Ideas

I believe that treatment would be enhanced if techniques from MI were adopted to CT and vice versa. Here are a few elements in CT that perhaps could be transformed and integrated in MI:

- Teaching client self-help strategies.
- Behavioural change strategies and techniques
- Adaptation of cognitive restructuring
- Problem solving
- Skills training (maintenance of motivation)
- Empathic confrontation

Here are a few elements in MI that perhaps could be integrated in CT and result in "Client-centred Cognitive Therapy":

- Spirit, reflective listening, and operationalization of empathy and general therapeutic factors
- Selective use of communication micro-skills
- Understanding and working with ambivalence
- Understanding and working with resistance
- Repeated decision making and commitment
- Focus on eliciting client's existing resources

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'Whole Systems' Approach to Organizational Change

Denise Ernst and Mary Velasquez, Facilitators
Transcribed by Lynn Williams
Summarized by Kelli Drenner

Introduction

Many trainers have been asked to help intervene in whole systems and to help move this 'whole systems' approach to organizational change into practice. It would be very useful to share models of what is working, how people are able to do it, what kinds of successes they have had, and the multitudinous barriers that there are to working within systems.

A recent example is a group of state-funded programs in the US wanting to develop a model for moving evidence-based practice into actual practice. The state was putting tremendous pressure on the system to 'get this into practice' within a year. The goal was that within that year everyone in the whole state who was doing substance abuse work would be practicing MI. They asked to have the trainer (Denise) come out and train 40 practitioners to become trainers who would then go out and train everybody else in the system. Eventually, they were reluctantly convinced that it was a stepwise, time-intensive process which ended up being a two year contract. Denise and Mary did an introductory training.

Initially, 80 people in the state were trained. This was then followed by an advanced training attended by approximately half of the original 80. All of these were people who were enthusiastic about the advanced training. About half of the 40 people went to the advanced training went on to turn in tapes and got feedback and coaching. In the end, only roughly 20% of the original group of 80 got the free coaching and feedback that the state was paying for and putting resources into. Six of these went on to the TNT.

So from starting out from this huge base where they wanted all these people trained, only a core few were really well trained.

Several, related questions that came out of that experience:

1. How to negotiate what seems to be the most reasonable approach for the organization?

2. How can you help these people change their system and how can you help them understand what it really takes?

3. How can you help organizations understand what the steps are and keep them from trying to push too fast and expect too much?

4. How do we handle the issue of organizations trying to force their staff to attend Motivational Interviewing training?

Getting People to Think about Organizational Change – A Stage-based Approach

Like many individuals we see in treatment, organizations' motivation for change may range from not being ready to change, to being ready to change.

Recently, Mary had a call from a supervisor with the federal prison bureau at Tuscadero, the largest forensic hospital in the US. They have been mandated to use Motivational Interviewing and were unsure of how to proceed. Also, they were not really sure they wanted to change. They like their current 12-step oriented program and had confidence that it was working.

Another example is the State of Florida. There is some block grant money for treatment centers, but the centers can only continue to get this funding if they do MI. So they set out this whole elaborate system to train peers to go in and evaluate different agencies. As a result, Mary has been involved with them, working with the individuals who will be doing the evaluation of whether or not these centers are using 'evidenced-based treatments'. Some of the strategies she has used in assisting them with these evaluations are:

- Scaling rulers: On a scale of 0-10, how ready is your organization (or are the stakeholders) to use MI? You're an 8, why an 8 not a 6?
- Use stages of change for both the individuals within the organization and the organization.

This motivates these groups to have helpful discussions about their setting.

The Colorado Prison Bureau—which has units where people are put in isolation for 23 hours a day (i.e. terrorists) and have one hour interacting with the staff at the prison—wanted MI training. How do you work with these prisoners within this system? Interestingly, after training they report that MI is really helpful and that there are big reductions in disciplinary incidents when using MI.

Reports from the Field: Experiences Integrating New Things into Established Organizations

Work with a municipality to reduce assaults around drinking by training beverage providers (bars and other like organizations) to serve responsibly: what started as a small training issue turned into an organizational change issue. Having stakeholders and early adopters, or bar owners willing to engage in the process, was critical to making it work.

Prisons and probation: even with enthusiastic trainees, quality training is not all that helpful if the organization is unwilling to provide new routines and possibilities to do MI. We provided a manual, monitoring, peer review, and some things like that, and then MI exploded almost within the prison system. We trained the counseling staff and the correctional staff, using the "3 styles" concept Steve Rollnick came up with.

Systems with heavy assessment components: negotiating the incorporation of an anti-MI assessment battery into an MI-style session when the higher-ups are unwilling to change or bend when it comes to the assessments. Finding tools that you can use to fit around the assessment to engage clients in the process, without it becoming just a fact finding and research gathering sort of exercise, is one approach. Using some of the simple tools like the readiness ruler can help to "soften" the assessment.

Mental health systems: another example is a county-wide addiction service in Scotland. The clinical director and the manager are members of MINT and have asked another trainer to come in and work once a month with their clinical staff. The organization has given clinical staff time and space, given them cover for their work, and yet most of the staff just refuse to play ball. Staff are ambivalent and find every single reason for not getting involved.

Another idea is to focus on identifying a "clinical champion"—someone within an organization who may not be the most senior or the person with the most power, but is looked to by the most practitioners as someone that they respect and maybe aspire. That person could be a mentor. Having this champion engaged in the change process then increases the likelihood of the change spreading throughout the organization.

Handling those Organizations that Just Want the "Techniques" of MI

There is a conflict between MI style and bureaucratic style. This is the crux of a problem for trainers: resolving the conflict between these two styles so that MI can work in the system. The challenge is to keep the tools and techniques of MI from substituting for the enduring style and spirit of MI. One approach is to get agencies to take ownership—not just bringing us in as an outside consultant to but figuring out their own way to integrate it into their system. We had a discussion that went something like this: 'At the end of this, what this, what do you want to be able to do?' 'We want them to be able to do MI'. 'And what would you hope the outcome would be with the clients that they are working with?' The organization then began to understand what a tall order they were asking for from a two day training. By asking open-ended questions and getting them to think in that way, you are not in the position of needing to sell MI or to sell your services. There are a number of things that need to come together. While all involved do not necessarily have to agree on every part, they have to agree on what it is they are trying to achieve. A stepped approach may be useful with some organizations—making small changes over time.

Do Trainers Need to be Part of the Revolution for Some in Some Settings?

It requires a substantial investment of time, energy, and resources to facilitate a revolution within a system. It is really a consultancy role. One of the challenges would be figuring out what kind of budget would be necessary for that kind of work; a contract in these situations may be especially helpful.

Some suggest that it is important to develop a standard for how MINTies respond to these organizations. This, once again, brings up the question of regulating training. Perhaps some kind of position paper or consensus paper could be posted on the website as some kind of guidance for these organizations on what MINTies have learned. This paper might even outline the different training outcomes for different types/lengths of training rather than just one big training package that the organizations may not be able to afford.

Some of this work has already been done. Bill drafted an outline which is posted on the website which indicates what you can expect. Consulting the literature on organizational change would also benefit the process. The 'Change Book' from the Addiction Technology Transfer Center website (free of charge) goes through several different steps about how you integrate organizations. It includes the things to consider, questions for evaluating an organization, different levels evaluating, and gives you some ideas on how you can elicit the barriers and how to go about solving them.

With all of our enthusiasm for longer term contextualized training, there will always be a necessity or a role for short term training. It is our responsibility to find out how to maximize the impact in return.

MI Coaching

Denise Ernst

Research on learning MI (EMMEE) has shown that the addition of post-training coaching and feedback enhances the learning and facilitates integration of MI into practice. This workshop featured a demonstration of the coaching technique used in EMMEE. Participants in the workshop observed the presenter conducting a simulated telephone coaching session with a volunteer from the group. The volunteer played a newly trained MI practitioner. A basic telephone coaching process form was used and the demonstration included both discussion of a particular case and practice with a particular skill (deepening reflections). Following the demonstration, the workshop participants chose a partner and practiced telephone coaching. To make this more realistic, the participants did not face each other during the practice. Following the practice, the activity was debriefed and included a lively discussion about the use of telephone coaching in training new practitioners.

Making Ambivalence Complicated

Tom Barth & Christina Näsholm

Since the very beginning, the understanding of ambivalence, and the strategies for resolving ambivalence, have had a central position in Motivational Interviewing.

And lately, there have been discussions about the relative importance of ambivalence and change talk in facilitating change.

In the workshop, Christina and Tom shared their reflections, focusing mostly on their understanding of ambivalence, and its role in MI.

They started by reminding participants that human culture itself has always been ambivalent about mind-altering drugs. One has been aware of the bad effects, but also seen intoxication as a god-sent gift, a privilege. In Greek mythology, Bacchus, the god of wine, is also god of creativity—successful in love and in life, and able to handle his drinking. Whereas drunkenness had its own god, Silenus, who confronts us with the other side of drinking. Paintings by Munch, Degas and Rubens were shown, illustrating the ambivalent stance.

Ambivalence: what *is* it?

The experience of containing incompatible thoughts feelings and attitudes towards something.

It is more specific than pure uncertainty, puts a structure to uncertainty, as if it has only two sides. Introducing the concept of ambivalence to clients is offering a model for simplifying uncertainty—to make it easier to work with.

When we invite our clients to look at "the one side" we are inviting them into a contemplative state, a state with some degree of distance from the self and the problem. A position, or a space of reflection, where the helper/therapist/counsellor is willing to participate in exploring the conflicting thoughts and emotions connected to a "problem", and perhaps the possibility of change. A reflective perspective, where both self-observation and self-reflection is possible.

We could understand ambivalence as a *state,* rather than a *stage* in a change process.

A natural human state with possibilities for understanding and action. A state that permits us to test out different behaviours, in order to gain experience with ourselves in relation to the world. Perhaps even a state of openness and opportunity.

MI as a treatment is often about linking the state of ambivalence to a change process. Links that are easily made, since people can feel the discomfort of ambivalence, and seek different ways of avoiding it. The easiest way, of course, is to "stop thinking about it". But the empathic atmosphere in the MI relation can encourage clients to explore and perhaps resolve ambivalence by way of a choice or a decision. The exploring of ambivalence does not lock clients in their dilemmas, inconsistencies, or discrepancies. Exploring ambivalence is a reflecting, contemplative, and supportive strategy that can help a client discover, understand, accept, and resolve ambivalence—perhaps by choosing to make changes in behaviour. We have evidence from clinical experience and research showing that this is an effective way of helping people make changes.

Early in a change process we look for a "preconscious ambivalence". A readiness to understand oneself in terms of ambivalence before the thoughts have actually been formulated. How do helpers use "the third ear" to hear the seeds of ambivalence, and to know when it will be helpful pose the question: "What are the good sides of....?" If the client then grasps the model, the change process is moved forward.

What is the relationship between ambivalence and change talk? Are there times when exploring ambivalence can move clients away from change? One way of thinking is that the selective reinforcement of change talk belongs in a later stage of a change process. First the client is introduced to the concept of ambivalence, then needs some time to explore it and finally to focus more on change as a solution.

Or one could think of exploring ambivalence and reinforcing change talk as two different lanes, or ways to go when working with clients. Each lane might have advantages and disadvantages. It may be, for example, that the ambivalence lane is slower in some cases because it keeps reactivating doubt and uncertainty. And it may be that a decision based on a thorough exploration of ambivalence has a more secure foundation than a solution-focused change talk strategy. For the time being, it is a strength for the MI-community that we have different styles of practising motivational interviewing, and that we have meeting places where the differences can be described, demonstrated and compared.

Can we do harm by exploring ambivalence at the wrong time?

Certainly, we will put a strain on the therapeutic relationship if we keep trying to push matters that our client is not interested in. Inviting them to explore ambivalence before they feel ready for it, or fussing about "the one side and the other" when they have started to move on. But we can trust clients to tell us when this happens. After all, MI is not "human engineering," where the treatment result depends on the expertise of the therapist/counsellor. MI is about listening, and eliciting, and carefully providing clients with ideas or models of understanding that they may find helpful.

Towards the end of the workshop, Christina and Tom ran the group through a short version of the "cross-roads exercise"—a structured strategy for exploring different focal-points of ambivalence:

- ambivalence about the problem (good and not-so-good things)
- ambivalence about a possible solution (good and not-so-good things about changing)
- and ambivalence about choosing not to change.

Training Across Cultures in the Asia-Pacific Region

Suzanne Habib & Joel Porter

We have developed the Pacific Centre for Motivation and Change, and together we provide training in MI throughout Australia, New Zealand and Asia. The aim of the workshop was to focus on both theoretical and practical applications of providing training in MI in the Asia-Pacific region. The workshop and ensuing discussion explored the nature of culture, how our current methods of training in MI fits with Eastern and indigenous philosophies and practice, and a number of practical ideas of how to adapt MI training for use in cultures other than our own. The following is an overview and integration of the presentation and handout material.

Interest in MI is extending from the Western populations where it was developed and is widely used, to Eastern and indigenous populations where much less is known about how this approach can fit with these cultures and philosophies. Despite a lack of research (and therefore, empirical evidence to support its efficacy), organizations and individuals in many Asian countries are moving towards training and supervision in MI in a range of settings. Given that the majority of these countries have no MINT trainers, organizations are seeking training from overseas trainers who belong to the MINT network.

Most of these workshops are conducted in English, where trainees have English as a second language and/or a translator is used. It is easy to assume, therefore, that language will be the major challenge facing trainers in these situations. Although language can pose difficulties, a number of other powerful cultural dimensions have the potential to impact the delivery and efficacy of training in MI to a greater extent.

In describing the culture of a nation as a whole, Hofstede, Pedersen & Hofstede (2002) have identified five National Cultural Value Dimensions. These dimensions influence social organizations such as school and legal systems within a country, and provide an overarching structure for the sub-cultures to which individuals belong. The five national cultural value dimensions are:

- Identity- Collectivism/Individualism
- Hierarchy- High/low power distance
- Truth- Strong /weak uncertainty avoidance
- Gender- Masculinity/femininity
- Virtue- Long/short term orientation

These cultural dimensions are obviously generalizations, and there will clearly be individual personality differences within groups and cultures. In addition, it is helpful to think of these dimensions as continua rather than in either/or terms. However, overall, we have found them to be a useful guide when planning training in countries other than our own.

Of the five national cultural value dimensions, the three below are perhaps most salient to consider in terms of adapting MI training for use in non-western countries.

In considering the national cultural value dimensions above, clearly MI training in Western countries is oriented towards trainees who tend towards individualism, low power status, and uncertainty-tolerance. Generally, MI training is delivered with an emphasis on collaboration and autonomy in an eliciting style where the trainer is seen as a facilitator of trainee discovery and self-learning and is flexible and congruent to the needs of trainees. In many respects, 'good' MI trainers in a Western training setting are those who rely less on lecturing about MI and more on facilitating experiential exercises where trainees are actively involved and participating verbally. The 'success' of an MI training in a Western setting is often gauged as much by the extent to which trainees

Identity	
Collectivism	**Individualism**
• Behaviour is explained as reflecting norms • Focus on co-operation, need of the group, obligations to the group, self-control. • Success is attributed to help from others • Common themes are reciprocity, other-directedness, maintenance of harmony	• Behaviour is explained in terms of traits, personality, principles and attitudes • Focus on the independent self • Focus on needs and rights • Value concepts such as pleasure, competition, "doing your own thing" • Debate and confrontation are acceptable and sometimes valued

Hierarchy	
High Power Distance	**Low Power Distance**
• Respect for status • Titles very important • Teacher/Trainer is the expert • Teacher/Trainer informs	• Equality between people • Titles not often used • Teacher/Trainer may be challenged • Teacher/Trainer facilitates trainee self-learning

Truth	
Uncertainty Avoidance	**Uncertainty Tolerance**
• Familiar risks are accepted; however, ambiguous situations and unfamiliar risks are feared • Rules, structure, order, predictability and certainty are valued	• What is different creates curiosity • Creativity, spontaneity, tolerance and exploration are valued

became involved in discussion, exercises and role plays as it is by formal written trainee evaluation and feedback.

In contrast, consider the following (mostly) fictitious training scenario.

Lisa is a Caucasian, middle class, English speaking MI trainer conducting introductory MI training in a South East Asian Country. Lisa is a Psychologist and her trainees are to be mainly practitioners working in the addiction field.

Lisa is an experienced trainer who prides herself on her interactive, participative workshop style. She always projects an informal, easy-going style in which she is more of an equal of her trainees rather than their superior. Lisa's main concern about the upcoming training was around the language barrier, as she was told that most of the trainees couldn't speak much English. Fortunately, she was able to enlist the assistance of an excellent translator who also had a good understanding of MI and she had 4 days to deliver the training, so she became more confident that with this problem dealt with she could conduct a training of a similar standard and format to those she conducts at home. Lisa arrived the day before the training and spent the afternoon looking around and doing some final preparation for her workshop the following day. She woke several times during the night due to jet lag and in the morning was feeling a bit disoriented and not her usual sharp self; however, after her third cup of coffee she felt alert and anxious to start the training. Lisa opened the training with her usual introduction, including her professional background and experience, and invited everyone to address her by her first name. The trainees introduced themselves by name but were reluctant to share any additional information.

With the assistance of a translator and the intention of getting a better feel for her trainee's experiences with their clients, Lisa started off her training with a three-in a row exercise. When she asked the trainees to call out their feelings about having three difficult clients in a row she is met with dead silence. No matter what she tried, the trainees refused to answer, and Lisa became flustered and was unsure whether to keep trying or abandon the exercise and try something else. After a few minutes of silence, Lisa, who very much wanted to provide a training that met the needs of the group, asked them what they would like to get out of the workshop—what would their objectives be? Again there was silence and blank expressions from the group. Finally, an older male member of the group responded by saying, "We want to learn how to do Motivational Interviewing". While this was not really the response that Lisa had hoped for, she thanked the trainee for his contribution and decided to move on.

For fear of further uncomfortable silences, Lisa decided to spend the rest of the morning presenting in a didactic style and using a PowerPoint presentation. The trainees seemed to be taking notice of what she was saying and many took notes during her presentation. When describing the spirit of MI Lisa decided that the Horse Whisperer analogy would be too far removed from the experiences of the trainees, and instead decided to use the Dancing/Wrestling metaphor and showed a picture of two people ballroom dancing in perfect unison. Again she was met with blank looks and the translator quietly whispered to her that in their country there is no public touching between the sexes, so people don't do that kind of dancing! Lisa asked the trainees and the translator if there was another more culturally appropriate metaphor but again she was met with silence and decided to move on, in the hope that over the 4 days of training she could model the spirit of MI if not actually explain it!

Although she was relieved to have actually got the training started, Lisa was dismayed at the realization that all of the usual interactive exercises she normally used in her workshops were not going to work in that setting. She spent the morning coffee break adjusting some of her exercises so that the verbal interactive exercises could be converted to written responses. Between the morning coffee break and lunch that approach seemed to work better, with trainees writing their responses and examples rather than discussing in the large group, and Lisa was pleased that at least something was going okay.

The afternoon session seemed slightly better, and Lisa found that the trainees were happy to role play in groups of 2 or 3. Though the observers were not good at giving objective feedback to each other, the trainees seemed to like her moving quietly around the room with the translator giving feedback and assistance as they were practicing.

By the afternoon tea break Lisa was starting to feel the effects of jet lag, and by the end of the day she was exhausted and was looking forward to having an early night after rethinking how she could present the next three days of the workshop in a style that could suit the needs of the group. However, as she was packing up at the end of the day the organizers ask her to join them for dinner that evening.....

Although Lisa had attended to the language barrier in her training, she had not taken into account the national cultural value dimensions. In this training, the trainees tended more towards collectivism, high power-distance and uncertainty avoidance, and Lisa's style at the beginning of the workshop may have been perceived by the trainees as confronting, confusing and anxiety provoking.

Clearly, training in these different cultural contexts can be challenging and requires flexibility and the ability to adapt our training format to better suit the national cultural dimensions. This may mean that we provide more structure, are more formal in our interactions, and can develop and facilitate training with less interactive exercises, yet still maintain fidelity to the philosophy and principles of MI.

Our MI training in Asian and indigenous cultures so far has created many more questions than answers for us regarding the applicability of MI in these contexts. In particular it is interesting to consider how cultures that value high power-distance can resonate with the spirit of MI, whose three main components are evocation, collaboration and autonomy. In addition, how might a practitioner explore and increase discrepancy with a client in a culture that is uncertainty-avoidant? How might a 'high status' practitioner who elicits the perspective of the client be viewed by peers (and patients)?

Our early experience (and feedback) in introducing MI to indigenous people such as the Maori of New Zealand and the Aborginal people of Australia, as well as in Asian cultures (i.e., Singaporians, Hong Kong Chinese and Burmese), is that the spirit of MI resonates with their natural way of being. These groups of people appreciate the gentle, respectful approach and the responsibility and choice being placed back with the client rather than being shouldered by the practitioner. Discussion with trainees subsequent to MI training leads us to believe that collaboration, evocation, and autonomy can and does occur to varying degrees within these cultures, however they look quite different and are probably less overt than in a Western setting. Perhaps it is helpful to think of these elements as being on a continuum and to learn to recognize them in their own cultural form.

Training in countries whose cultural value dimensions are at the opposite end of the continuum to one's own can be challenging, while at the same time it is also an enriching, rewarding, and exciting experience that ignites creativity and extends us out of our training comfort zone. Below is an overview of some of the practical ideas that have helped to make our training successful in cultures other than our own.

Preparation

- Read and find out about the place you are going to. Understand the history and the political, religious, legal and social aspects around the training issue.
- Be aware of the national cultural value dimensions that may be relevant to the country you will be visiting.
- If you are using translators, try and get to know them and help them understand MI well in advance of the training.
- Allow twice as long as usual for training if you have translator.
- Send pre-reading material for trainees if possible. Many Asian trainees can read and understand English but are reluctant to speak English for fear of making mistakes. Pre-reading can be done at trainees' own pace, give a good grounding in the philosophy and principles of MI prior to the training, and increase trainee confidence during the training.
- If you plan to use videos, find out in advance about technology available and whether your training aids will work. Be open to the idea that even if the technology works these aids may not be helpful, and have a range of other options for demonstrating strategies.
- Have an understanding of local etiquette, particularly with regards to status, gender specific behaviour, greetings, and dress.
- Allow time to overcome jet lag and your own culture shock. Training in other cultures can be exhausting and overwhelming both emotionally and physically.
- Be aware that your country's code of ethics or best practices may not apply (or even make sense) in other countries.
- Try to have a co-trainer if possible.
- Do not underestimate the importance and value of establishing relationships based on respect, sincerity, and genuineness.

Training

- Try to be aware of ALL cultural aspects that may impact on training: national cultural dimensions, ethnicity, language, religion, gender, political. affiliation/climate socio-economic status, education, profession, age, etc.
- Speak slowly.
- Expect a lower rate of interaction and participation. Particularly in some parts of Asia, trainees will be expecting an 'expert' PowerPoint presentation and a didactic style.
- Start didactic and prepare trainees for the idea that the workshop will gradually become more interactive; start with pairs then gradually increase the size of the groups.
- Let trainees choose their own group members.
- Do lots of demonstrations and ask trainees to write down their observations rather than verbalizing them.
- Take care with humor.
- Take care with analogies and metaphor; these are very difficult to translate and can be misunderstood and misleading. Ask the translator to help you think of some culturally relevant examples before the training.
- Try to adapt your exercises to be less verbal (e.g., holding up different colored cards to indicate recognition of resistance, ambivalence and change talk).
- Rather than asking for people to volunteer or call out, have them work in small groups and elect a spokesperson to speak on behalf of the group (allow them to elect

the spokesperson, it will generally be the person with the most status in the group).
- Have written exercises so people can record their responses privately. Debrief the written exercises with the whole group and provide examples of MI congruent responses yourself, but avoid asking trainees to share their answers in front of the group.
- Take care with exercises that involve verbalizing personal reflection and any type of criticism of the 'system' within which trainees work.
- Allow trainees to practice in their own language.
- Give feedback in small group work (e.g., 2 or 3).

Evaluation

In parts of Asia, "yes" does not always mean "yes" and smiling faces do not always mean everyone is happy!

- Evaluate frequently; daily evaluation works well; trainees will give written anonymous feedback but not verbal feedback.
- Ask your translator to gather informal verbal feedback and let you know how trainees (and you) are doing.
- Allow time for trainees to approach you during the breaks or at the end of the day to ask questions or ask for feedback on their own, away from the group.

Building Rapport

- Compliment hosts and trainees on their country.
- Try to learn and use some simple words and greetings in their language, e.g., Good morning/afternoon, goodbye, please, thank you.
- Be respectful of etiquette and traditions (e.g. dress, time, deferring etc.).
- Take care not to jump to conclusions about trainee behaviour.
- Stay calm and quiet in Asia; you may need to be flexible with time, and other organizational details.
- Show an interest in local area and customs.
- Try the food.
- Join in local festivities, entertainment, and celebrations when invited.

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MI in Corrections

C. Å. Farbring, L. Forsberg & Steve Rollnick in PART 2

PART 1.

A little more than 20 years ago, Canadian researchers pioneered in studying correlates for offending and what—if any—were the most effective treatment interventions to reduce relapse in crime. Today more than 50 meta-analyses have been published and criminal justice systems in many countries have adopted a strategy, based on the knowledge from these findings, specifically focusing on reducing re-offending. This "What Works"-strategy has been implemented to its best extreme in the U.K., where it is funded and supported by generous government subsidies aiming at reducing recidivism by 10% by the end of the decade; Canada, Sweden and other Scandinavian and European countries have emulated the U.K. implementation, but with more modest funding.

The main intervention in What Works is based on evidence-based manualized programmes written by the best known researchers in the field, and a new category of criminal justice professionals—tutors—have been hired and trained exclusively to present these programmes to clients. Independent scientific accreditation panels scrutinize the scientific contents of these programs and approve or disapprove of all treatment interventions (U.K, Canada and Sweden) that are supposed to be used with clients. Therapeutic communities and cognitive behavioral programs, delivering social, problem-solving, and cognitive skills, have been best supported by empirical data so far, but the effects are small; programs have sometimes shown an improvement by 10% compared to controls, but in many cases showed no effects at all. Focus is shifting now to implemention issues, but in Sweden, specifically since 2001, also to the concept of motivation to change and clients wanting to use the skills that they are learning.

Twenty-four hundred Swedish prison and probation officers (nearly everyone working with clients) were trained in MI during the years 2001-2003 in 3-day workshops. The training was overwhelmingly well-received, but still there was not much evidence that probation officers really started to use MI in their practical work with their clients. At the same time the Swedish government launched a strategy against the increasing drug problem and funded corrections by 100 million SEK and later 110 million more to motivate and treat drug-using offenders.

Based on the modest results from the national training, I (C. Å. Farbring) authored a five session semi-structured motivational program with two objectives: 1) helping probation officers to enhance their skills in MI by practicing the program, and 2) motivating clients to change and to go into more treatment. The program (a manual and a workbook) was presented in March 2003, and by the end of 2004 it already represented 36% of the total program volume in corrections, with a completion rate of 79%. The program has been extremely well received by clients and MI counselors.

The implementation is built on about 40 supervisors (trained as MI trainers) all over the country who monitor and give feedback on tapes every five weeks (using Resnicow's content-related ONE PASS) in peer review groups; the supervisors, who meet about 4 times a year in central two-day meetings to practice feedback and calibrate ONE PASS evaluations, also render individual feedback and certify counselors after they have met criteria for MI skills. The program specifically attempts to avoid the pitfalls noted by Amrhein (2003; he was here in 2002 helping me to get started on a Swedish taxonomy for change talk) and lately also by Hettema, Steele & Miller (2005): e.g., the deciles where the issues of feedback and change plan are raised. We do not know anything of the outcome in client behaviour so far; it is still open for research. However, client attitudes from pre- to post-tests in the 2004 population have changed significantly on a number of variables: Problem Recognition and Taking Steps (SOCRATES D: $p < .02$ and $p < .005$) and also perceived desire, self-efficacy, priority, and internal vs. external motivation to change ($p < .0001$). Clients are also estimating that they are thinking more about change after the program than they did before. Of course the real question is: *does it really work?*

The government has ordered the National Crime Prevention Council to evaluate if the money has been used effectively overall, focusing on reducing drug use. Separately the Karolinska Institute (L. Forsberg) has been asked and funded to perform randomized trials on the MI program intervention and a number of connected variables as well. Clients have been randomized to three categories: 1) program with feedback; 2) program without feedback; and 3) treatment as usual supported by a protocol (could be MI but without the support of the MI manual). The coordinators of the three categories have been coached regularly by telephone meetings led by Forsberg. This RCT is one of the first ever done in Swedish corrections. Furthermore, the study is carried out with ordinary staff delivering the interventions and the interventions are delivered under normal, natural conditions. Consequently, not surprisingly we have encountered lots of obstacles. One is a major reorganization of corrections, which affects almost everyone involved and making a randomized clinical trial a minor priority. There have been many other practical problems: insufficient support from heads and executives, other priorities, funding etc. The collection of data will end by the end of 2005; however at a central meeting just recently the situation looked a little brighter.

A coding laboratory with 8 coders has been set up at the Karolinska Institute by Forsberg to analyze session tapes and this work is going extremely well. Preliminary data shows that the interrater reliability is good. Here MITI is being used as a treatment integrity check. A much appreciated 3-day workshop about MITI and "getting it right" was recently given by Terri Moyers and Denise Ernst on an invitation from the Karolinska Institute. Correctional staff practically involved in the research attended the workshop, which boosted their efforts to successfully meet the challenges and complete the study.

Some of the research questions are:

1. Does MI decrease drug use and relapse in crime compared to counselling as usual?
2. Does systematic feedback based on taped MI sessions enhance MI skills?
3. Are more skilful MI sessions related to increasingly stronger commitments from clients to give up drugs and criminal behaviour?
4. Is client commitment during MI sessions related to reduction of drugs and crime after release from prison?

Primary outcome measures are Addiction Severity Index points in the alcohol/drugs scale and the criminality scale. Future plans are also to divide sessions into deciles and to replicate the Amrhein et al. (2003) study with respect to change talk.

PART 2.

Here Steve Rollnick helped to present an interactive CD containing three styles of communication, developed by Steve, aiming at helping prison officers to handle stressful situations more adequately. A doctoral dissertation about 15 years ago on the health of prison officers showed that the level of their stress cortisol was twice as high compared to similar professionals, which constituted a danger to their health. The CD has been developed in collaboration between Steve's university in Wales and the Swedish National Prison and Probation Administration (Farbring). There is an English version of the CD and a Swedish one. Steve showed and explained the English version ("Talking Sense") to interested participants in the workshop. Also in Sweden the CD, currently being implemented in the research project, has already generated interest from the police organization, mental health, and juvenile institutions.

The rationale is that being able to distinguish between and blending the three styles will help prison officers to handle difficult and stressful situations more confidently. Hopefully it will decrease stress cortisol, and increased levels of listening skills will improve on the atmosphere between clients and staff and make treatment a more credible option. Prison officers at thirteen wards in seven "heavy" prisons have been randomized to go through the intervention: the CD and a tutor-led presentation of the three styles. There are also exercises to accompany the presentation to verify if they have understood

and learned how to handle situations better.

Pre- and post assessment of burnout syndromes and other work stress and health-related dimensions are being used. Also, several medical tests are sampled by an independent medical partner organization and sent to the laboratory of the Karolinska Hospital for analysis. Stress cortisol levels are analyzed by an expert in the field, Professor Töres Theorell at the Karolinska Institute for Psychosocial Medicine. The research design is a singe case format. Thus, the pre- and post-assessments are completed with monthly assessments of the most crucial stress measures.

The randomized intervention is currently introduced at the different prisons and will go on until May 2006. The feedback on the intervention is very positive from prison officers so far. They seem to recognize the need for handling difficult and stressful situations better. The interest for this study even outside of corrections is large.

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MI for Anxiety

Hiroaki Harai & Henny Westra

MI for Anxiety

Hiroaki Harai

Background

The basic concepts and treatment strategies for anxiety described here are basically derived from my private clinical and research experiences for two decades at mental hospitals. My own background as a psychiatrist trained as a behavior therapist since 1985 is instrumental to shaping my view. However, I have been experiencing large changes in my view about anxiety disorders during the past couple of years. There are two factors: one is MI, and the other is Steve Hayes' Acceptance and Commitment Therapy and the theory about rule governance. My views and methods described here are largely half-baked and have not been empirically scrutinized yet. Please take this workshop as a preliminary and experimental venture.

Why I Find an MI-informed Interview Method Useful to Treat Clients with Anxiety Disorder

Therapist background

I have been treating anxiety disorder clients who are referred from local mental health professionals. More than half are OCD clients, and I have been treating them by ERP (Exposure and Ritual Prevention.) The real-life problem of deploying ERP is not ERP per se, but the treatment planning. Most of the clients avoid discussing their obsessional thoughts. Some clients are very talkative, but what they are saying is all about their rituals. Some give me large pages of written report of their rituals and press me, "Please understand how bad these rituals are, and tell me how to control these rituals by your behavior therapy." Some keep silent, just tremble. After a series of intensive interviews what they say is, "My head is full. It is so bad. Somebody has touched some part of my body; I don't know what it is. I am so anxious. Doc, just take them out, now, please. I want to die." In both cases, they are avoiding thinking, uttering, and describing their obsessional thoughts. And if the therapist does not know what obsessions the client has, it is impossible to build a hierarchy for exposure.

Some times I put them into an ERP situation in a blind manner. Some times I can get results, but in most of the cases, it is a futile effort. I am running a support group for OCD clients. Some OCD clients refuse to participate in the meeting. Their unanimous reason is, "I don't want to hear others talk about their obsession. I worry that I will acquire new obsessional thoughts." They avoid words. I call this "cognitive avoidance," and this avoidance and related problems also occur in other anxiety disorders including social phobia, panic disorder, and generalized anxiety disorder.

Recent Addition of Theory of Treating Emotional Disorders

Recently I have become familiar with the theories of thought action fusion (Shafran & Rachman, 2004) and stimulus equivalence (Augustson & Dougher, 1997). As these theories suggest, anxious clients avoid not only real materials but also images and words. I must know their obsessions before starting ERP. What I can do for these thought avoiders? They are not mute. They keep speaking, asking how to get rid of obsessions, for professional advice from me. Some are wise enough to tickle me to say, "You are the best, most knowledgeable therapist, please give me advice." How can I avoid these demands and let the client utter their fearful words?

I have found MI useful here. The five principles, OARS, and avoidance of advice-giving are the same as with MI in the substance abuse field. The change talk is different Clients with clinical anxiety disorders are very much ready to take something. Advice about how to avoid obsessional thoughts or anxiety is eagerly adopted. They are motivated to change their physicians if the physicians seem not to understand their pain. Thus sometimes, the goal of the interview in those cases is,

"Don't change, stay still." Still, the whole concept and strategy of MI fits in the treatment planning process and during treatment for those anxious clients.

Clinical Interview for Anxiety

Goals in the clinical interview for anxiety vary, but let me summarize them as a working hypothesis.

Assessing the Nature of the Problem

During the treatment planning process, decision-making about the treatment focus is the vital part. As anxiety and worry are basically motivational for the clients to seek treatment, understanding the content of worry and developing treatment focus from the view point of the clients is the goal. I list several components considered as important.

1. Client's perception: How does the client perceive his / her problem?

(a) Awareness: ego-syntonic or dystonic, disability, How the client perceive his/her anxiety.

(b) Attribution: Does the client attribute the reasons or causes of discomfort, responsibility to change to him/her self or to others?

(c) Avoidance: Does client think avoidance is the easier option? How much does avoidance affect the client's values? Avoidance includes not only overt behaviors but also covert behaviors. Thought suppression (blocking) is considered as avoidance here. These avoidance behaviors take various forms such as "safety behaviors", "cognitive avoidance", "defense mechanisms", "compulsive rituals", "prn use of benzodiazepines", etc. All of these behaviors serve the same purpose,, "instant and accessible measure to decrease or control uncomfortable emotion." These are not necessarily maladaptive.

(d) Persistence, Chronicity: Does the worry or related problem persist for many months? / Several days? / Just at this moment?

(e) Help-seeking behavior: Does the client visit various health care providers to get help to control anxiety?

(f) Influence of anxiety in the client's life: Family entanglement. Some family members are involved in the process of avoidance, and some ridicule the clients. The quality of work and leisure are influenced. Some receive disability benefits.

2. Resistance to change in the context of Anxiety disorder

(a) Rationalization

(b) Blame others

(c) Optimism for future solution (time would solve this)

(d) Rule seeking and following

(e) Any avoidance behavior

Typical Example of Worry which Should be Targeted for this Interview

Although the utility of MI in treating anxiety disorders does not seem to be dependent on diagnostic categories, it is useful to know what is typically avoided in clinical interviews. And making differential diagnosis among typical anxiety disorders is relatively easy. I list the most typical anxiety-provoking scenarios, which are most avoided during interviews for each anxiety disorder.

Tentative Goal of the Clinical Interview for Clients with Anxiety Disorders

After assessing the client's perceptions, there are several changes for clinicians to have in mind.

1. *Problem of cognitive avoidance resulted from stimulus equivalence.*The treatment planning process itself is a therapeutic process. Therapists intentionally repeat to verbalize the most feared word or scenarios to the clients. This process called as "imaginal exposure", "imaginal flooding." The repeating process causes a decrement of the anxiety-provoking nature of the feared words or scenarios. Theoretically it is explained as "habituation" or "cognitive defusion."

2. *Problem orientation: Alleviating discomfort, removal of triggers from environment, asking help from others.* This behavior should be

	Most feared scenario and typical Example of imagery exposure, words which are avoided	Not so feared situation (there may be concerns at normal level.)
Panic Disorder	Sudden death, unexpected death, heart attack, asphyxia, choking, suffocation, fatal arrhythmia, situation where you can not call emergency services on the verge imminent death	Natural disaster, chronic disease (cancer, diabetes, infectious disease), interpersonal relationship. Any problem which would get serious in the remote future.
Obsessive Compulsive Disorder	Unrecoverable damage to descendant, tragedy in the remote future, future disaster through minor carelessness. Responsibility, "If you had been just a bit more cautious, this tragedy to your children would have not happened."	Physical illness (except the obsession related to specific body conditions), interpersonal relationship, tragedy to spouse or partner
Social Phobia (social anxiety disorder)	Social failure in terms of reputation in peer relationship. Others consider you are ordinary, mediocre, bland, no point to socialize with you. Others pretend to be friendly to you, but it is a performance. All others in the room share the same thought: "Poor (your name), he tries so hard to be popular among us in vain." You are considered as a pitiful "social phobic" and you don't know it as others pretend to be friendly.	Education, social status, overall evaluation of human value (generosity, honesty, open-mindedness, dignity, love, social contribution), physical illness
Generalized Anxiety Disorder	Imminent danger caused by outside reasons. "The reason for your worry will never change, you will not be free from the annoyance ever." Social responsibility which disables you to avoid feared situations.	Tragedy or disaster in the remote future, social status. Being ridiculed for your nervousness by others.

changed to “acceptance, choose, taking action for their values”.

3. *Irrational optimism in the natural outcome of their anxiety.* Except the cases which have comorbid depression, many clients are optimistic. They think after waiting for a while, circumstances will get better and the anxiety will go away. Their strategy is, “Just avoid bad thing. Time will solve it.” This is a common sense type of coping strategy; however, an anxiety disorder is a special case in which this coping does not work. “Creative hopelessness” is necessary to make them to stop unsuccessful avoidance behavior.

Open question

“Suppose you fear would be real one. You have not taken any avoidance measures. What would happen to you? How would your anxiety or worry change?”

“Then suppose the most feared situation, the tragedy you just mentioned, would have taken place. What would you do?”

“Would you tell me more about your worry in your mind?”

In most cases, the client avoids to answer these questions and tries to divert to other topics. Simple reflection of the original worry works in this situation. The counselor should not follow the diversion led by the client.

Affirm

Affirm can be made with exposure: “You have been tolerating the fear of a heart attack for many years.”

Reflection (simple, amplified, elaboration)

Functions as exposure (“worry exposure”, “verbal exposure”). In some cases, the same word is repeated until the client can utter the feared word voluntarily.

Summarizing

In most cases, anxiety disorders are chronic conditions. Avoidance behaviors, treatment seeking, and prn use of anxiolytics serve to control temporal emotional experiences, however they are also the reasons why the phobia and the rituals persist. Summarizing the course of illness, efforts on the patients’ side, the treatments they received and the outcome is motivating for patients to change the orientation of their problem-solving efforts.

Developing discrepancies

Evocative statements:

“You have been worrying and asking for help for years. Nothing has changed for years. At the same time you still wish that some expert’s opinion will help in the future.”

“You have been working on solving this problem for years. How does your effort pay off?”

DARN-C for anxiety

D: Description: concrete and precise description of feared objects which pass the Stranger Test (see below).

A: Acceptance: acknowledging that experiential avoidance is no longer a valid strategy to avoid discomfort.

R: Responsibility: acknowledging that action must taken by the clients themselves.

N: “No, I don’t worry about this” statements. Fearful and avoiding clients can not differentiate between what they fear and what they do not. By increasing the statement, “I do not worry / fear this,” the client and therapist can go the real core of the unspoken fear.

C: Commitment to goals that pass the Dead Man’s Test (see below). Behavior change of the client.

Roadblocks to MI-style Counseling

Shared worry

Some worries are shared between clients and counselors. Seemingly natural / normal worries are hard to examine for counselors.

Advice giving (rule offering and reinforcement of rule following behavior)

It is often the case that clients ask for solutions, and this behavior takes various forms. It is hard to resist giving solutions, once you have started. The client says, “In the previous session, you advised me to do this. It half worked and half not. Tell me a better way to manage the problem, I am pretty sure your next advice will give me the final and durable solution.” One GAD client now asks me to copy her whole medical record for the purpose of gathering advice from what I said to her. I am pretty sure that during more than 24 sessions, I gave her some advice.

Two Tests to Verify if the Goals of the Treatment are Sound or Not

I put some tests to help to build appropriateness of the clients’ statements.

The Stranger Test & The Dead Man's Test

The Stranger Test

The Stranger Test refers to goals and objectives for clients that are described so that a person unfamiliar with the client could read the description and understand it. Because anxious or phobic clients avoid describing their worry or fear precisely, and clear description of the feared objects are mandatory for developing a hierarchy for exposure therapy or other type of behavior therapy, it is necessary to describe the thoughts and objects which elicit anxious responses in the manner that would pass the Stranger Test. For example, if a client's goal was to decrease "obsession about the wash room," a stranger might interpret “wash room” in various ways. There are numerous objects in the wash room, and there are numbers of different types of wash rooms: public, hotel, private, male, female, Japanese / Western style. If the therapist had defined "obsession about wash room” as "Obsession provoked after each instance of wiping your anus after defecation by sheets of paper” it means that it was not the door knob, urine, or the sink that triggers obsession, and it passes the stranger test.

In most cases, our culture defines dirty things, hazards, or dangers to avoid, as a very large class. Examples are “feces”, “contamination”, “corpse”, “accident”, “illness”, “abuse”, and the therapists do not try to examine the nature of those things as a source of fear. Everybody is considered to have the same disgust to those things. These words function as motivational triggers to

avoidance behavior before conducting precise examination of the nature of the threat. It is generally correct in the circumstances of real threatening situations like natural disaster. You do not have the luxury to examine the nature of the source of fear. However, what if the source of the fear is inside of yourself?

The Dead Man's Test

The question posed by the dead man's test is: Can a dead man do it? If the answer is yes, it doesn't pass the dead man's test and it isn't a sound goal; if the answer is no, you have a good goal. For example, suppose that you acknowledged a problem in taking anxiolytics too often when experiencing anticipatory anxiety. Let's say that you came up with the target behavior, "does not take anxiolytics." Does this pass the dead man's test? No. A dead man could refrain from taking pills. What would be better? How about, "take pills at a fixed schedule"? This passes the dead man's test because a dead man does not follow a schedule.

The End Note

I myself prefer to call this method "de-motivational interviewing." The aim of the interview I described is to stop patients' futile avoidance behaviors. It is a matter of course that there should be a motivational side, and I call it "value building." This needs further discussion.

I hope this small article will open a new field to apply MI principles.

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MI Adapted for Anxiety

Henny Westra

This workshop focused on exposing participants to how MI could be applied to the treatment of common anxiety disorders to increase motivation for change and engagement with subsequent treatment procedures such as those in Cognitive Behavioural Therapy (CBT). The major rationale for adapting MI for anxiety includes frequently encountered ambivalence about change and engaging with methods of change (such as exposure to feared stimuli). Individuals commonly express reluctance to utilize methods of change based on fears of increased anxiety, failure, provoking dreaded events (e.g., humiliation, jeopardizing their safety or the safety of others), and invoking uncertainty that goes along with change. While CBT, the dominant treatment for anxiety, is effective, response rates are far from ideal. Moreover, resistance (e.g., treatment refusal, homework noncompliance) is frequently encountered in CBT, and there is a paucity of methods within CBT for managing these impasses effectively. Thus, MI may hold particular promise in this population when used as a catalyst or preparatory intervention for engaging individuals with change methods. From this perspective, the proximal goal of MI would be to increase motivation for change and engage the individual with more action-based methods.

Various points of integration of MI with more action-based methods for anxiety treatment could be envisioned, including MI as a prelude to CBT, for example. Or additionally, MI principles could be integrated into the action phase of treatment, such as rolling with resistance at whatever point ambivalence is encountered, or presenting CBT techniques in an elicit/provide/elicit style which preserves the client's autonomy.

A number of challenges in adapting MI for anxiety were identified, such as establishing a focus for MI. In anxiety, comorbidity is the rule, not the exception. Where is the best place to focus MI in a population with multiple possible issues? Also, identifying 'good things' about anxiety or depression seems tricky. That is, it requires some significant clinical skillfulness to cultivate and maintain a fundamental attitude toward the client as attempting to achieve good things, when they themselves are frustrated with their avoidance or depression. Clients often freely discuss the downsides of avoidance for example, but seem to struggle more with recognizing and 'appreciating' the drives or needs behind behaviour patterns (e.g. worry) that they wish to eliminate. Finally, identifying who needs MI appears to be an important question for future study. That is, what are the markers of a shift from phase 1 to phase 2?

The bulk of the workshop was spent listening to and processing excerpts from an audiotape of MI with a client with generalized anxiety disorder and agoraphobia who was nonresponsive to previous CBT for anxiety. I have reproduced a few of these excerpts here to illustrate different aspects of MI as they pertain to work with anxiety. *(Note: The client has provided written permission to reproduce these transcript segments.)*

"Good Things about Anxiety"

T: I'd like us just to spend a bit of time, just looking first a bit at some of the advantages. So it may sound like a strange question, but what are some of the good things about avoiding, about not traveling, about thinking about death and worrying?

C: Well I guess if I stay at home I always have everything I need, u know?

T: Sounds like staying at home - it's sort of like a sense of control over the situation. Would that fit? Would those words fit?

C: Ya. I don't' see myself as wanting to control everything or wanting to be in charge or the boss, but it is kinda a control thing. I mean I think that by staying home I can control that no is going to get sick, no one is going to die or....

T: So you're not looking at it like being a control freak or being bossy, you want to control that other people aren't hurt - that you don't lose somebody important to you. And everybody wants control whether they say it or not, right?

Control is something that human beings want! We want to feel like we have some control over things, especially things dear to us."

"Not So Good Things about Anxiety"

T: As much as there's been some good things about staying close to home...I see there's a lot of pain as well for you. What are the downsides....to staying close to home, avoiding traveling, worrying about death?

C: That I might pass this onto my kids....and that's something I don't want to do....(crying)

T: It's painful for you when you imagine your kids ending up with anxiety, depression...

C: Just knowing what I go through and um, thinking that they may have to do the same thing, and it just..... eats away at me, thinking oh, please don't let this happen to my kids.

(later in session)

C: I guess u know maybe it's been in the back of my mind but I've tried not think about it, and I, and it really came to light when I started to write those two letters that we talked about last week. Um, if I remained anxious, and then if I didn't remain anxious, and sort of a time line. But when I was writing that letter and what my life might be like if I remained anxious, I thought, I wonder what this must be like for Peter (begins to cry) and uh, ... U know I think as much as you love a person you can only take so much and I think that someday, he's gonna get tired of waiting around for me to decide that u know, 'hey, maybe I can go somewhere today'. And ... I know if I said that to him he'd probably be upset and say that's not true, but u know I'm sure that if I, if my anxiety stays the way it is at times, that he's going to have to be going places by himself, and I don't really think that's how he pictured his life.

T: So whether or not it means him actually leaving you, you really can see him being very hurt by not being able to do things with you ... if this were to go on. He's been pretty patient I think you said, pretty understanding so far, but... your worry is if this continued, this could really hurt him

Developing Discrepancy

T: When you talked about those advantages....they are coming out of that sense of caring for other people. A lot of this stuff, staying home, avoiding, was to care, and its sounds like now there's this feeling, that caring in that way can end up hurting, a lot of people. You were trying to do something very good...to not have people hurt, to not lose people ...and yet out of all that, there is this potential to hurt other people and yourself...What do you make of that?

C: I guess I'm just going about it all wrong way...showing people how I are about them...and yet, I need to take some risks, as scary as it might be...I guess if I knew for sure that maybe it might be the first step to learning how to manage my anxiety, and also that I want to do something about it before it does jeopardize my friendships and relationships and...I don't want it to get to that point where I feel so pressured to do it because something's at risk...

T: You don't want to wait till somebody's ready to end a friendship, or until Peter says 'that's it I've had enough', to do something about it. You really care a lot about people, that sounds like that's something that's really important to you - something that you really value. It sounds like when you look at it, it's sort of 'gosh, this anxiety had kind of misled me on how to show my caring for other people, for how to be a caring person..."

C: Well I think it's going to be a lot of work to change it too....but I'm prepared for that, I wanna do it...I just know that my life is going to be miserable if I don't do something about this, and I think at this point in time, where I don't have anything thing at risk, where I don't have anything or anyone pressuring me to do this, that this is a good time, and I think I'm ready..., I just need some help, I need some support, some ideas, some suggestions...

As these excerpts illustrate, particularly in a case where previous action-based treatment has failed, MI has significant potential to help clients move forward in processing and understanding their reluctance to change. This is consistent with our experience in other case studies using MI for anxiety. References to some of the work from our group in integrating MI and CBT are included below. We look forward to continuing to explore this application of MI in future as significant interest appears to be developing in MI among anxiety practitioners and researchers.

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The Delicate Endeavour of Promoting Change

An Audio Recording and Transcript

Jeff Allison

In this session, I presented a digital audio recording and transcript of a first interview, conducted by a community psychiatric nurse in a Scottish alcohol problem clinic. The 50-minute interview is an actual consultation, not a simulation. The recording was made in autumn 2004, for a monthly practice development group with which I had been working for the previous three years. My purpose in presenting it was to discuss its wider training potential, and to explain my intention to make an interactive CD-R with this interview at its core. The interview has been subjected to MITI assessment and found to be very competent MI. Most importantly, the outcome of treatment is known and, luckily, the patient agreed to be interviewed about what he found helpful in working with this practitioner. He also consented to the use of these materials for training purposes.

Demonstrations of MI have always played an essential part in training, whether they are conducted 'live' by a trainer, or pre-recorded on video or audio. Demonstrations have a number of prime purposes: to show what MI looks like, to enable learners to better understand the nature of MI and the consequences for process and outcome, and to enable learners to contrast their own practice with that of the demonstration, and in so doing, to consider the changes they might want or need to make to become more MI-consistent in their practice (assuming this is their goal).

No doubt we are all by now familiar with the 1998 Miller, Rollnick & Moyers videotape series, in which there are a number of longer simulations. I have used these since they were first published (although my preference these days is to demonstrate MI, if this is the wish of the trainees). While the videos have proved of great interest for learners, there are a number of minor problems, not least of which are the language, culture and fields of practice in which the demonstrations are set. Although it may not always be the case, it seems reasonable to assume that the nearer a demonstration is to the learner's own work setting, the more likely it is that the learner will be constructively engaged. This is not to ignore the transferability of any good demonstration, provided it is properly exploited.

Another limitation with the 1998 series is visual quality and stimulus. Through television and cinema we have all become so used to visual media being of such a high quality that a semi-professional recording, in which two people 'sit and talk', may cause those less enthralled by MI to lose attention and wander. Despite the various viewing tasks that trainers invite learners to undertake, many feel that 'watching a video' is far too passive. More importantly, perhaps, some aspects of the conversation's content are likely to be lost unless the learner is provided with a transcript of the video. When this is done the learner has a choice: watch and listen to the video, read the transcript and listen to the video, or jump between the two. In my experience as a trainer, learners report that having the transcript while they watch/listen to the video is far better in assisting them really to 'hear' what is going on. Certainly, without the transcript much is lost—especially by those who are not American or do not speak English as a first language. If the maximum benefit may be obtained from a video recording of a demonstration by access to three elements—visual (the protagonists), visual (the transcript), and auditory (the soundtrack), what might be gained and lost by removing the first element and enhancing the other two? This was one of the questions to be explored in the session.

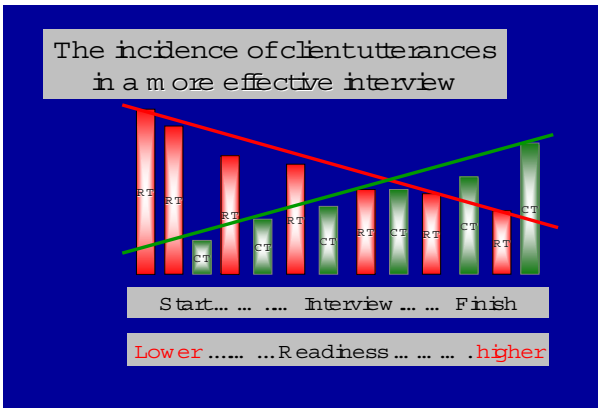
I started by explaining the context in which the recording came to be made. For three years I had been meeting once a month, for half a day, with a small multi-disciplinary group in a National Health Service alcohol problem service. For each session, one of the participants recorded an interview with a patient, transcribed a section, and sent both to me before we met, so that I could prepare a commentary. The purpose of the session was to discuss the interview, using MI as a reference point and, occasionally, to do exercises exploring issues arising. This type of training, when followed consistently over time, embeds learning more deeply and shifts practice competence in the desired direction. When the group and I first heard the recording we were all very impressed with the quality of the practitioner's work. From my particular perspective, I saw in this a potential demonstration of much wider application.

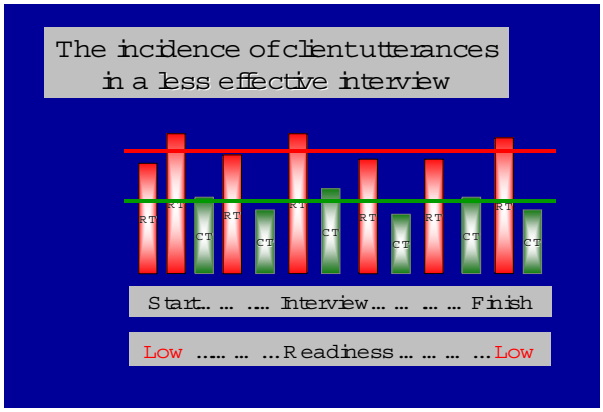
Some months later, I arranged to meet with the practitioner and the patient. We spent a day listening to the original recording, going through the full transcript, and recording our comments in digital audio. I also interviewed the patient, on his own, about his thoughts and feelings concerning the whole process of 'treatment'. By chance, the original recording is of the highest quality—you can clearly hear all that is spoken, the sighs, and the snuffles of the practitioner—she had hay-fever! The patient's initial stance was that he had no intention of doing anything about his drinking and had only come because his doctor and daughter insisted he attend the appointment. His professed objective was to drink himself to death. He was depressed, lonely, and felt that life had nothing to offer.

The interview follows what one might call a classic MI pathway. The practitioner demonstrates the

thoughtful and assiduous guiding spirit of MI and, in conjunction with the patient, identifies various things that he holds dearer than the prospect of death through excessive consumption. He becomes more aware of the discrepancies in his thoughts and feelings. Over the course of the 50 minutes one hears a diminution of 'Sustain Talk' and an amplification of 'Change Talk—his readiness to change is dramatically enhanced. There is a moment when his ambivalence becomes profound and is tearing him apart—he becomes tearful—but they get beyond this and it ends with him stating his clearly emphatic intention, "...to cut down." (The figures below illustrate client utterances in more and less effective interviews).

Indeed, he did cut down from between 100-150 units a week to around 6 units. His drinking at this lower level has remained stable for at least six months. He attributes this shift to his conversations over the months with the practitioner, the process being initiated in this first interview.





Having first used it in training workshops at the beginning of this year year, I showed the PowerPoint sequence with which I have introduced it and discussed how I integrate demonstrations in training. I also discussed the reactions of trainees to the experience, particularly my own interest—to better understand the learning potential of a projected transcript synchronised to the audio, but without the visual stimulus of the actual protagonists. We then listened to the first thirty minutes of the audio and watched the projected transcript. I think it fair to say that everyone present was touched both by the struggle of the patient and the competence of the practitioner. It was generally felt that having a very accurate transcription to follow while the audio is heard draws the listener deep inside the conversation. A number of people commented that, although they could not see the speakers, the fact that they were so involved in the conversation by virtue of the double stimulus (soundtrack/transcript), helped them paint a vibrant picture of the pair. The presence of a video camera may have changed the nature of the dialogue, while a small audio recorder is more easily ignored and forgotten. Clearly something is indeed lost without video, but more might be gained.

What do I intend to do with these materials? The first occasion on which I used the recording and transcript was when I was co-leading a workshop with Steve Rollnick. He was very impressed with the demonstration and encouraged me to think about how it could be used in a more creative way than simply 'playing and projecting'. Steve's own current interest and growing understanding of interactive learning materials helped me to formulate a plan for the development of a CD-R. After a couple of false starts—it's a complicated business—I am now working with a software developer to build a CD-R that will have a number of elements and interactive learning levels. At the moment our plan is as follows:

- Level 1: Listening & Watching.
  Option A (without content analysis): the recording plays and the transcript is read in a window. Two versions of the transcript will be available: Standard English or Scottish vernacular spellings.
  Option B (with content analysis): the recording plays and the transcript is read in a window. The transcript font is colour-coded for practitioner and/or patient utterance characteristics. This will allow the viewer better to recognise certain components in MI. A coding key will appear.
  With both of the above options it will be possible to 'jump out' of the recording to hear brief comments from the patient, the practitioner and myself as to what was 'going on' at a particular point in the original conversation.
  With both of the above options a smaller, separate box will appear intermittently to offer concise explanations/definitions of words in the text, e.g., Boak = retch.
  Option C: an interview with the patient about his experience of treatment.
- Level 2: Making Judgements.
  Option A: What is this?
  As for option A in Level 1 above, but at selected points, the recording and transcript stops and a section of speech is highlighted (it could be either the patient's or the practitioner's) and a flag appears with the question, 'What is this?' The practitioner decides and then clicks a button to get

the answer.

Option B: What would you say next?

As for option A in Level 1 above, but at selected points, just before the practitioner speaks, the recording stops without showing the next utterance of the practitioner, and a flag appears with the question, 'What would you say next?' The practitioner decides and clicks a button to hear what the practitioner actually says. The viewer then decides if what he/she would have said might have been more helpful, much the same or less helpful. The recording continues until the next stop point.

This is my first attempt at developing these type of materials. I don't know how the CD-R will be received by MINTies or practitioners or how useful folk will find it for group or individual training. It's very Scottish and may be too difficult to understand in, say, Vladivostok or Cape Town! It is anticipated that, if it works, its main value will be as a demonstration of one type of resource. It would be wonderful for MINT to develop a range of demonstrations from different countries and cultures, and in languages. I'm optimistic that, at least for English speakers, the CD-R will prove a little bit more interactive and exciting than just 'plain' video. Of course, it may all fall flat. We hope to have it available for sale by the spring of 2006.

I would like to sincerely thank all those people who have taken time to discuss my plans with me and especially the practitioner whose work forms the heart of the recording.

MI & Supervision Workshop

Brendan Murphy, Presenter
Note-taking by Lisa Ford

Note: Brendan, workshop presenter, has provided the reader with a factual account of the workshop content whilst Lisa, participant and note-taker, has included some of her thoughts about and experiences of the workshop in the article below. Initials have been used to distinguish between the two.

BM: I began the workshop by saying that I was both a supervisor and a supervisee, and that all that I was going to present was relevant to us as supervisors and as supervisees. This is an important place to start as I believe supervision is a process where both the supervisor and supervisee have specific roles and responsibilities that are crucial to making the relationship work.

I outlined the definition of supervision as...

a process in which one worker is given responsibility to work with another worker in order to achieve certain personal, professional, & organisational goals.

LF: Brendan then asked the workshop participants to comment on what they thought the goals of supervision were, which prompted a lively discussion and lots of ideas being forwarded, including...

- offering support
- educative guidance
- monitoring
- accountability
- acceptance
- creativity and innovation
- empowerment
- direction

The problems of having your line manager offering clinical and management supervision combined were mentioned. As was the importance of the supervisee's organisation/agency valuing supervision.

We then discussed some examples of poor supervision that the participants had experienced, including...

- When a supervisor off-loads onto the supervisee.
- When a supervisor is experienced as more needy that supervisee.
- When supervisor is unable to deal with the feelings a supervisee is experiencing and engages in avoidance behaviour.

Brendan went on to say that supervision has the potential to cause a lot of anxiety for the supervisee, and to outline some of the typical responses that a supervisee may consciously or unconsciously use to cope with this anxiety:

- Repression
  Uncomfortable feelings pushed into the unconscious, i.e., the supervisee might avoid working with certain client groups/issues.
- Projection
  Assigning own feelings to someone else: "My supervisor doubts my ability to work with this client."
- Denial
  External threats are cut off from consciousness, i.e., "forgetting" to do follow-up work or disagreeing with prior agreements.
- Displacement
  Redirecting unacceptable urges on to a substitute, i.e., blaming the supervisor for the client falling off the wagon.
- Sublimation
  Forbidden impulses become socially acceptable behaviours, i.e., the aggressive man becomes the "confrontational counsellor."

Brendan also noted that all these (and many other defensive postures) could just as easily be assumed by the supervisor as by the supervisee.

BM: Having looked at some of the issues that may negatively affect the supervision process I emphasised the need for the supervision relationship to always be...

1. Supportive (*of even greater importance* when things have gone badly wrong)

2. Educative (the supervisee must leave knowing more than when s/he came in)

3. About quality control (the supervisor and/or the agency, the supervisee and the client must be pro*tected by codes of best practice)*

I believe that a supervisor's previous experience of supervision is

usually the biggest determinant of his/her style in supervision. This can be positive or negative and includes more than our history of being supervisor or a supervisee in a work setting. It also usually includes others who have positively/negatively influenced us in our lives. For instance, our way of interacting in supervision may be influenced by how we were treated by a sports coach, or in school by certain teachers, and often bear traces of how we were parented as children.

I asked the group to think back over the people in their lives who had a supervisory role over them and got them to include current and past supervisors in their professional lives as well as other people in authority including parents, teachers, managers etc.

Following this I asked them to fill in a sheet about those people that included the following questions.

- What did he/she do that was helpful?
- What did he/she do that was unhelpful?
- Your response at the time?
- The influence that has on you now?

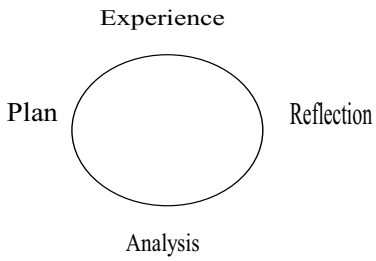
LF: As a participant in this exercise I found it to be thought and insight-provoking. I realized that I had never before reflected in a structured and thoughtful way upon what I had valued about and also found less helpful about the supervisor who I had worked with for 5 years, a long time. But perhaps most importantly this exercise led me down the path of appreciating the expectations I have on myself as a supervisor—the origins of these—and the opportunity to reflect on how helpful some of my expectations actually are.

My reflections upon what it was I was really looking for and needing from a supervisor lead me to further understand and conceptualize what I am aiming towards providing as a supervisor—the standards I set myself. I began to recognize my desire to be 'the perfect supervisor', shaped by my own needs professionally and otherwise throughout my life, and to appreciate that this very desire in itself was a 'roadblock' to being the 'good' and helpful supervisor I hope to be. There is some relief in me for that at least. The exercise also reminded me that to be an effective supervisor is hard work and can be uncomfortable in that it requires a full commitment to continual self exploration and self-awareness and cannot be a professional mask to be put on and taken off.

Following this exercise, Brendan outlined Kolb's learning cycle, which highlights how different people have a predisposition to learn in different ways.

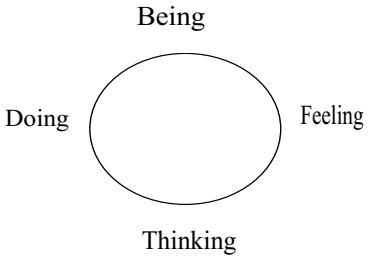
The theory is that people are often more comfortable with one particular learning style and don't tend to moving smoothly between the four. This is another one of those things that is as true for supervisors as supervisees.

Figure 1



BM: Following on from this I went on to say that we also have a predisposition to be a certain way in our approach to supervision.

Figure 2



Being: The person is full of description about what happened. Shares lots of factual data and details.

Feeling: The person mainly speaks about the emotional content and the effect of what has happened to them and to others.

Thinking: The person discusses what has happened from a theoretical point of view and has a penchant for looking at why things turned out as they did.

Doing: The person wants to know what to do next or how to respond to what has happened.

By now you may already be starting to recognize yourself or your supervisors / supervisees.

In supervision, ideally we should be able to discuss issues from all 4 points of view equally.

In reality, supervisors and supervisees have preferred ways of being, and this leads to all sorts of communication problems. Imagine a supervisor in "doing" mode while the supervisee is in "feeling" mode. The conversation would probably go something like...

Supervisee: I'm really stuck with this client.

Supervisor: What have you in mind to do about it?

Supervisee: I don't know, he makes me feel really de-skilled. I get a sinking feeling when I look in my diary and see his name.

Supervisor: Sounds like you don't get on with this guy, tell what you are going to do about it.

And so on...

This is not unlike how you might demonstrate the Cycle of Change in the Transtheoretical Model with the client being in pre-contemplation stage and the counsellor being in action stage.

Obviously the supervisor and supervisee need to be in the same stage to communicate well and to see the presenting issue from every angle.

LF: Brendan demonstrated to us how we move between each of the stages with the assistance of a volunteer.

He laid out four floor cards on the floor in a circle as in Figure 2 and walked her around each one, stopping at each to ask her the following questions

Being: Describe what you see in the room. What you can see?

Feeling: How do you feel about being here at this moment with everyone watching you?

Thinking: How do you think this training is going? Do you get the process I am explaining?

Doing: Imagine you have already

left this session today ....what do you plan to do with this?

As she answered each of his questions it became much clearer as to how we each have a preference for one of these particular stages. Brendan reminded us that ideally we would move towards giving equal focus on each aspect being/doing/thinking/feeling in the issues we work with in supervision whether we are a supervisor or a supervisee. He also said that it doesn't matter in what order we bounce back and forth between the four stages, as long as we cover each one.

One of the tips he gave us was to hold a picture of Figure 2 in our head while in supervision and be mindful of covering each part of it when discussing issues.

BM: In addition to being in the same "communication stage" I suggested the supervisor use the core skills of MI throughout the supervision process.

Express Empathy in supervision

- We all need it when doing this kind of work.
- Acceptance works better than judgment.
- Talk about your own struggles/successes.
- Understanding causes supervisees to change.

Develop Discrepancy

- Ask the supervisee: "What did you think you did well in the session?"
- "What would you do different next time?"
- The supervisee must provide arguments for change, not the supervisor.

Avoid Argumentation

- Avoid labeling your supervisee (difficult/resistant/distant etc).
- Don't argue with the supervisee. Explore instead.

Roll with Resistance

- Are you dancing or wrestling?
- It is the supervisor's job to keep supervisee resistance levels low.
- If you encounter resistance in supervision, name it and work through it.
- Supervisees have a reason for doing what they do. Discuss that rather than get caught up on the presenting issue – "Let's talk about what is it that stopped you from xxxxxxx?'

Support Self-efficacy

- Do not get caught up in a Parallel Process (the supervisor working vicariously through the supervisee) as the supervisee has to do the work, not the supervisor.
- Be openly affirming and encouraging.
- Use positive blame (hold them aaccountable for good practice, i.e., 'You did that well, how did you do that?')
- Get the supervisee to spend time looking for valuable lessons in the things that went wrong.

I finished by linking the FRAMES acronym that we are familiar with to the supervision process by saying that MI skills fit well with and supervision because...

- Feedback (This is two-way)
- Responsibility (Helps the supervisee to shoulder it)
- Advice (Ask the supervisee if they want it first!)
- Menu (A place to generate ideas)
- Empathy (Being with the supervisee through it all)
- Self-efficacy (Helps the supervisee learn & re-learn)

LF: I had been very keen to participate in this workshop, having supervised for a few years now with little reflective or educative input. I was not to be disappointed: the workshop was well presented, well delivered, and well timed. The presentation contained a good balance between the presentation of useful information and participant involvement with reflective exercises. I came away from the workshop feeling that I had learnt and as an added bonus that I also had material that I could appropriate for any future presentations that I may be required to make.

Brendan credited the sources that he drew on while preparing this workshop as...

Tony Morrison
Jacky Knapman
David Kolb
Jacque Elder

MI, Maintaining Change and Preventing Relapse

Peter Prescott

The first two editions of *Motivational Interviewing* have the subtitle, *"Preparing people for change".* Perhaps the third edition should include something about maintaining change in the subtitle.

Clients meet different challenges while going through the process of change, and maintaining behaviour change is an area of difficulty for most clients. This workshop presented ideas in progress and focused on exploring MI approaches to assisting the client with maintaining change and preventing relapse.

The workshop participants were asked to consider the following:

1. In what way do you use MI to assist the client with maintaining change & relapse prevention? Or how do you feel that could be done?

2. What would you like for a client to take away from an MI consultation that focuses on maintaining change & relapse prevention?

And most importantly:

3. Is it possible in an MI framework to teach clients to do this on their own?

Answers to 1.)

It seems that MI currently helps people stop relapses, by focusing on the initial skills & strategies that will trigger change, and reusing these in the hope that change eventually takes hold. When it comes to maintaining change MI tends to focus on eliciting and re-eliciting change talk and thereby existing client resources. Another

alternative is to do relapse prevention, CBT interventions, and Solution focused therapy in an MI-style.

Answers to 2.)

We would like a "maintaining" client to leave an MI session with renewed self-efficacy, motivation and commitment. This could be in the form of constructive self-talk or visualization.

Answers to 3.)

The workshop participants discussed if it was possible to teach the client MI self-help skills to maintain long-term motivation, or MI-tools to withstand sudden intense drops in motivation that lead to relapse episodes. One way of looking at MI does not give room for this approach: *"The client learns by counselling, but we don't teach, it's not a goal of MI." "We trigger change, hoping it will take hold."*

Relapse can be seen as being caused by attrition of long-term motivation or sudden intense drops in motivation. Changes in motivation, both slow and quick, are often caused, at least in part, by "negative" thoughts (i.e., "self-sabotage"). Is it possible within an MI framework to teach clients skills so that they can modify de-motivating thoughts? Could elicit – provide – elicit be such a framework?

The workshop participants received the following handout about different approaches to relapse prevention and maintenance:

- Relapse prevention – Focus on specific high-risk situations and general lifestyle imbalances.
  1. Identify and analyse the general and specific factors that lead to the relapse.
  2. Work with patient to prevent new relapses by
     i. eliciting the patient's own resources
     ii. teaching the patient specific cognitive and behavior skills that can be used in high risk situations
     iii. lifestyle counselling
- Solution focused therapy – Focus on solutions, not the relapse, by eliciting existing patient resources.
  1. Explore the answers to solution focused questions:
     i. How were you able to main tain change for so long?
     ii. How did you stop the relapse?
     iii. How will you go about main taining change?
- Cognitive behaviour therapy – Focus on specific factors that lead to relapse and on the more general relationship between substance use and emotional problems, deficits in social skills, and deficits in problem solving skills.
  1. Prevent new relapses by
     i. helping/teaching the patient to identify and modify thinking that can lead to relapse (per missive thoughts, positive expectations about effects of substance use, negative self-efficacy thoughts)
     ii. eliciting existing, and teach ing new, strategies to cope with high risk situations
     iii. teaching the patient cogni tive and behavioural skills that reduce emotional prob lems, enhance social func tioning and increase prob lem solving capacity

Acknowledgement: Thanks to Judy Carpenter for her assistance in the preparation and writing of this article.

Brief Intervention for Risk Drinking in General Practice in Sweden – A National Project

Astri Brandell Eklund & Peter Wirbing

The Risk Drinking Project within the National Institute of Family Medicine has the *aim* to *train doctors and nurses in general practice and occupational health to detect risky drinking early and use brief intervention.* One branch of this project concerns Adapted Motivational Interviewing (AMI). There is a lack of trainers in AMI in primary care in Sweden, and at the same time the demand for training of AMI is steadily increasing. Thus we have defined as one of our tasks to train new trainers in AMI.

The workshop presented thoughts on what to include in training our new trainers in AMI and how to do it. We did put the following items for discussion:

- What to include, what to leave out of the theoretical content?
- How to improve and maintain skills of new trainers?
- What pedagogical skills to train?
- What is a good enough outcome? When is MI diluted beyond recognition?
- Other thoughts and concerns?

The format we have used so far is a two-day workshop + booster training + one-day seminar on medical aspects of risk drinking. The participants are supposed to have good knowledge of MI and at least 1-2 years experience in using MI in clinical practice, but this has in fact varied quite a lot partly due to the facts mentioned above.

These were, in short, the comments that we were given during the workshop:

Focus on tasks, not on techniques! Tasks congruent with short GP consultations! For example: 1) Raising the subject, 2) "How do you feel?" 3) "Any information?" (Elicit-provide-elicit), 4) "Close". Chorus of the song: "Simple at the front, depth behind".

Focus on few skills. Elicit from the participants what they already do, i.e., how they raise the subject. Show the participants what the interventions should look like using video / tapes / transcripts.

Use pre-training measurement of competence! Discover Interviews versus practitioners after training. Support implementation by phone coaching.

Develop guidelines step-for-step for use of AMI for risk drinking and do the training based on these guidelines.

The comments were very useful for us and have in many parts already been put in practice. Thanks to all of you that participated in our workshop!

Rapid Communications

Ongoing MI Research

Jim McCambridge & Allan Zuckoff, co-chairs

A Pilot Study of MI for DWI Offenders

Maurice Dongier

Up to 50 % of DWI offenders never fully participate in remedial measures following conviction. This pilot study, conducted with colleagues Florence Chanut & Thomas G. Brown, was planned as piggybacking on an existing larger research project funded by the Société de l'Assurance Automobile du Québec (SAAQ). This governmental public institution has been inviting recidivist offenders arrested for driving while intoxicated to participate in an intensive study, carried out by our team. Participants were paid $160 to undergo a 6 hour multidimensional assessment (neuropsychological, psychosocial and biological), with a final brief feedback interview.

Hypothesis of the additional exploration: 30 minutes of MI will contribute to better outcomes at 3 and 6 months follow-up than "feedback as usual" with encouragement to change. *Methods*: 51 subjects were randomly assigned to one of the two interventions. Dependent variables measured at follow-up were number of days of hazardous drinking, AUDIT scores, psychosocial consequences, and services utilization. *Results:* Significant reduction in hazardous drinking was found at 6 month follow-up (p = .04). A trend in favour of MI in psychosocial consequences was also found at both 3 and 6 month follow-up. Impact on services utilization also favoured MI (p<0.01).

A larger study (projected n = 150 subjects) is currently under way.

London MI Drug Prevention Studies

Jim McCambridge

Our previous study of MI with at-risk youth with a twofold intervention rationale—immediate risk and problem reduction, and altering longer term drug use careers—demonstrated impressive short term benefits. We reviewed previously undertaken drug prevention efforts and judged the existing evidence-base not strong. We identified a need, therefore, to develop interventions beyond schools, particularly for secondary prevention, with a 'brief interventions' perspective promising.

Three Quasi-experimental pilot studies were briefly described. These took place in inner–city schools, with trained youth workers in colleges and in the form of a 'Let's Talk about Drugs' community-level intervention in a college. Two ongoing trials were then introduced.

The first was an exploratory study of universal prevention in Further Education colleges with 416 participants who were unsuccessful in schools. This comprises 3 trials in 1, with intervention objectives being specified for three groups: non-users of substances; users of drugs legal for adults to consume; and illegal drug users. MI is being compared with classroom-based drug awareness, with follow-up study after 3 and 12 months.

The second trial is a comparison of MI vs. standardised Drug Information and Advice-giving with 327 regular (weekly or more frequent) cannabis users aged 16-19. Topic-based MI with multiple drug targets has been implemented with >80% sessions audio-recorded, and >80% follow-up after 3 & 6 months.

A Transtheoretical Model Group Therapy for Cocaine

Mary Velasquez

We are conducting a number of studies using MI; these include:

- Project CHOICES Efficacy Study: A Fetal Alcohol Syndrome (FAS) Trial (CDC)
- Preventing Alcohol Exposed Pregnancy After a Jail Term (NIAAA)
- Screening in Young Women: A Stage-Based intervention (NIAID)
- Developing Alcohol-Related HIV Preventive Interventions (NIAAA)
- Efficacy of Motivational Enhancement and Physiologic Feedback for Prenatal Smoking Cessation: The Smoke Free Families II Study (RWJ)
- A Transtheoretical Model Group Therapy for Cocaine (NIDA)

The aims of this last project are to modify the *Group Treatment for Substance Abuse: A Stages-of-Change therapy manua*l to specifically target cocaine abuse, via a twelve-session, group intervention with six "early stage" sessions targeting the experiential processes of change, and six "later stage" sessions targeting the behavioral processes of change; to conduct a preliminary randomized trial comparing the TTM group to an education/advice comparison group; and to assess mechanisms of change.

There is emerging evidence that MI can be adapted, with a few critical modifications, to a group therapy format. Few published reports, however, have addressed the process of using MI in groups.

We use the acronym "OPEN" to characterize our use of MI in groups: *Open* with group purpose (to learn more about members' thoughts, concerns, and choices); *Personal* choice is emphasized; *Environment* is one of respect and encouragement for all members; *Non-confrontational* nature of the

group.

MITI coding (Global sccores) of initial group sessions show a high level of Empathy and MI Spirit being achieved by the group leaders, suggesting the feasibility of doing MI in a group format. Results will be reported at a later date.

Complicated Grief in Persons with Substance Use Disorders

Allan Zuckoff

This talk reviewed two recently completed, preliminary studies on the prevalence and treatment of complicated grief in substance-abusing populations. Complicated grief (Horowitz, Siegel, Holen, & Bonanno, (1997; Prigerson, et al., 1999) is a debilitating syndrome, distinct from bereavement-related depression and anxiety, characterized by separation distress, traumatic stress, and failure to adapt more than 6 months after the death of a loved one.

A recent report documented complicated grief in 33% of outpatient community psychiatric treatment seekers (Piper, Ogrodniczuk, Azim, & Weideman, 2001), but no information has been available regarding its prevalence in substance abuse treatment settings. To obtain an estimate of the prevalence of complicated grief in patients receiving methadone maintenance treatment (MMT), we conducted an anonymous, self-report survey in an MMT clinic associated with our large, urban psychiatric hospital. The survey consisted of demographic questions, a loss summary, questions about substance use in the context of the death that bothered participants the most, and the Inventory of Complicated Grief (ICG; Prigerson, et al., 1995), a reliable, 19-item self-report instrument querying grief symptoms. 188 clinic patients completed our survey (response rate=47%). During the previous 30 days, more than half of participants reported use of substances. We found prevalent loss and a high rate of complicated grief in MMT patients surveyed. We also found an association between presence of complicated grief and increased substance use following the death, and higher rates of recent drug use among those with complicated grief.

Empirically supported treatments for co-occurring substance use disorders and complicated grief are lacking. A targeted treatment for the syndrome has been developed (Shear, Zuckoff, Melhem, & Gorscak, in press) and tested (Shear, Frank, Houck, & Reynolds, 2005), but this treatment had not been tried with substance abusers. To assess the feasibility of conducting Complicated Grief Treatment with substance abusers, and to obtain a first estimate of an effect size for the treatment in this population, we conducted an open prospective pilot study of an outpatient, 24-session individual Complicated Grief and Substance Use Treatment in our University-based clinic and in a community clinic attended primarily by low-income African-American patients. This manual-guided psychotherapy integrates motivational interviewing and emotion-focused skills training to address substance abuse, into our existing treatment for complicated grief. Nine women and 7 men who were bereaved $\geq$6 months, scored $\geq$30 on the ICG, met DSM-IV criteria for an SUD (previous 6 months), and attended at least 1 therapy session were assessed pre- and posttreatment. Eight participants (5 men and 3 women) completed treatment, while 6 women and 2 men were noncompleters. Completer and intent-to-treat analyses showed large reductions in grief and depression symptoms and medium to large reductions in substance use outcomes. Details of this study are in press in the *Journal of Substance Abuse Treatment* (Zuckoff et al., in press).

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