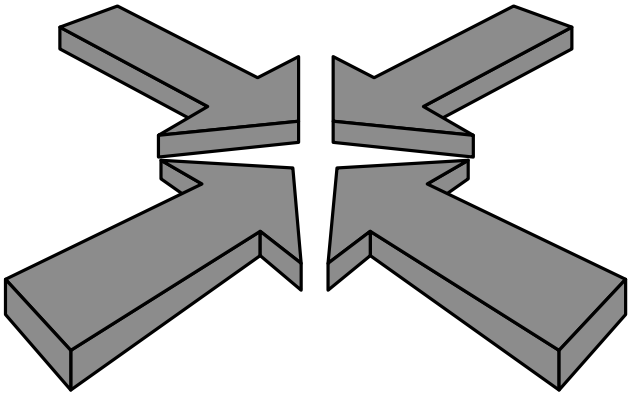
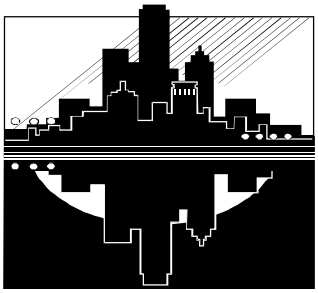
Motivational Interviewing Newsletter for Trainers

May 1, 1997, Volume 4, Issue 2



New Perspectives



MI in the Big Apple

Kathleen Sciacca

Training Update

Since the training program in Italy, I have provided Motivational Interviewing (MI) training workshops at a number of national conferences and training events. These usually last from one and a half to three hours. I have focused the content of these workshops on an overview of the philosophy, strategies and interventions of MI and always include some experiential skill building in reflective listening and responding. I will be presenting a three day MI training in Delaware. The first two days are in March and will include in-depth training, while the third day happens in May and is a follow up to provide feedback and supervision after participants have applied this approach. This seminar will also include the correlates between MI and dual diagnosis treatment and interventions.

MI and Dual Diagnosis

My primary field of work is dual diagnosis program development and training. I have introduced MI concepts into the curriculum for full day dual diagnosis seminars and institutes. I have also added a training segment into on-going program development seminars. I will be offering two day training workshops in New York City and in other areas of the country as opportunities present themselves.

MI and Dual Diagnosis

When I learned about motivational interviewing several years ago I was struck by the similarities and the departures from traditional substance abuse treatment by both MI and dual diagnosis treatment. These departures and the theoretical bases of each of the models emerged from two different systems of care. Dual diagnosis treatment emerged within the mental health system. Skills such as reflective listening integrate very well into the dual diagnosis treatment framework where clients are engaged at all levels of treatment readiness and motivation.

When I was invited to write a feature article for Professional Counselor, a magazine with both a substance abuse and mental health readership, I decided to write about the overlap between the MI and Dual Diagnosis model. It was a way to bridge the gap between the systems of mental health and substance abuse and their contrasting models. The theme of the issue, “Counseling Skills for the New Millennium”, provided an opportunity to discuss ways both models remove the barriers of outworn criteria and prejudice that have denied people appropriate treatment and the impact these models can have upon service in both fields in the new millennium. The article includes charts that are concise, detailed and easy to follow.

Training Wishes

I would like to attend an advanced training of trainers seminar in MI that would include both reinforcement of skills imparted at the initial training and provide an opportunity for exchanges

on planning and implementing lengthy MI training programs such as three consecutive days.

A Final Note
"Hello" to all of the MINTies who attended the training in Italy. If you visit the website (http://www.erols.com/ksciacca) please send me an e-mail and say hello.

From Across the Pond

Stephen Rollnick

Serious Networking
The next MINT workshop will be in Europe in October 1997. The European Addiction Training Institute in Amsterdam, The Netherlands, will be organizing it, under the professional eye of MINTie Rik Bes. A parallel meeting is also being organized, to be run by European MINTies Jeff Allison, Tore Bortveit and Peter Prescott. The idea is to bring trainers together to swap materials and ideas. European MINTies will be invited, although there is no desire to exclude North American and other colleagues. People will have to find their own travel expenses.

The Workshop from Hell
It happened. Tore Bortveit from Bergen, Norway asked me to tell you that he went all the way up to the North of the country, and ran a workshop in a place called Hell. The clients from Hell, the counselors from Hell...

MI Activity
I still hear from European MINTies running training in the fields of eating (Janet Treasure), addiction (Jeff Allison, Rhoda Emlyn Jones) and exercise (Tim "Norman" Anstiss). Norway is probably the most extensively covered country, with a very solid group of MINTies based in Bergen. If there's a village called Heaven, they will get there! Strong interest has emerged in France, Belgium and Spain in the form of participants at a workshop organized by Rik Bes which we ran in Portugal recently.

Videos
I don't particularly like using videos in training, but they can be useful. Tore Bortveit used one in Hell, which Jeff Allison and I had the privilege of viewing on a recent trip to Norway. Our immediate reaction was to want it dubbed into English. Bill and I are to make one in June this year, and Jeff Allison is seriously talking about a European venture. A Swedish training aid for the training of family practitioners is also being made. The delight for me will be that I can show other peoples' faces besides my own when training.

Advice-Giving and All That
I found some research on advice-giving. This reminds me of the debate I had with MINTie Geoff Williams in these columns some time ago. This research comes from the *conversation analysis* of consultations in health care settings. For example, the sociologist David Silverman has dissected the finely detailed dances that occur in consultations, by submitting transcripts of audiotaped sessions to *discourse* analysis. His conclusions are largely compatible with some of the strategies of brief motivational interviewing.

Resistance is a key concept in this analysis. It most commonly take the form of *unmarked acknowledgments* (e.g. "mm", or "hmm"). In the face of this resistance, practitioners tend to back off so as to avoid disagreement. Saving face is a high priority for both parties.

Whither advice-giving? Silverman's conclusions lie nicely between the two extreme views taken by Geoff (for advice-giving) and I (against it): "There is a very clear correlation between the way in which an advice sequence is set up and the response it elicits from the patient. In 32 cases where counselor delivers advice *without attempting to generate a perceived problem from the patient,* there are only 3 cases where the patient shows any sign of uptake. Conversely, in the other 18 cases, where the advice emerges either at the request of the patient or in a step-by-step sequence, there are only 4 cases where the patient does *not* show uptake" (Silverman, 1997, p127). It thus depends on how it is done. Unfortunately, Silverman's study, and another by

Heritage and Sefi (1992), point to the almost pervasive failure of practitioners to elicit the patients perspective prior to giving advice.

It is obviously time to move beyond the simple question of whether or not practitioners should be giving advice. Have we not started this process already, by suggesting that they *exchange information* in a particular way, and then try to elicit the implications for action from the patient? I hope Geoff agrees? Here is the reference: *Silverman, D. (1997) Discourses of Counseling: IV Counseling as Social Interaction. London: Sage Publications.* The Heritage and Sefi study is referenced in this book.

On Tip Toe Through the Consultation

I have been looking at transcripts of medical consultations about antibiotic prescribing. (Doctors in Europe are reluctant to prescribe them for upper respiratory tract infections, but feel under pressure to do so from patients.) Yesterday I thought of our work on resistance. It appears to be much less overt in medical consultations than in some addiction counseling sessions. There's less fighting, and more gentle avoidance of conflict.

This is what happened: A mother comes for the third time in a fortnight with a spluttering little boy, clearly wanting more action from the doctor (antibiotics, please). But the word is never mentioned. The doctor does not elicit her preferences. He examines the child, and tells her that he will get better "in a week or two" without any drastic medicine from the doctor. The mother reels a little (she is exhausted), but maintains a polite manner, displaying exactly the kind of resistance Silverman calls unmarked acknowledgment. She leaves. There was no overt disagreement. Who felt satisfied after that consultation?

Premature Behavior Change

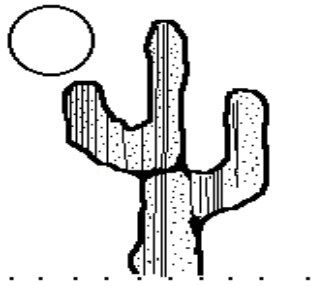
Two examples, one lesson: why focus on behavior change when other emotional matters are more important? How often do we and our services fall into the trap of premature focus on particular behavior changes? Is this what Jim Prochaska means when he says we need a paradigm shift away from action-oriented treatment?

I observed both of these scenarios. The staff are complaining about patients not complying with treatment. A group of men are in a spinal injuries rehabilitation ward. One is furiously pumping iron, strengthening his arm muscles from a wheelchair. The others are passive and noncompliant. I asked a colleague about the good patient. Why was he so different? She said, "It's just a honeymoon period. In a few weeks he'll be depressed like the others, and the staff will be complaining about him too." She is teaching them about readiness to change behaviors, and the relevance of their needs, like the need to come to terms with trauma before working on behavior change.

Second example: the staff are complaining about the patients not complying with treatment. Its a cardiac rehabilitation ward. They say patients resist looking at the need for lifestyle change. The physiotherapists are particularly frustrated. The nurse in charge tells me that patients frequently get depressed after a heart attack. It struck me that the use of a simple agenda-setting strategy would pinpoint the needs of patients, and avoid this kind of conflict of agendas. How often does this go on in addiction treatment?

Important MINT Dates

Submission	Publication
8/1/97	9/1/97
12/1/97	1/1/98
4/1/98	5/1/98



Notes From the Desert

Bill Miller

Editor's Note:
Bill was bogged down with grant-writing deadlines

and preparing to depart on sabbatical. He will return for the next issue.

Editor's Cup

David Rosengren

The MINT: What now?
After reviewing the results of the MINT survey and discussing the matter, Bill, Steve and myself have decided to go forward with a small subscription charge. The fee will be $5 (U.S.) for a one year subscription to cover the cost of copying and distribution. We will continue to publish three times a year. We appreciate your support of the MINT and hope you will continue to subscribe.

Bill is poised to leave on sabbatical, so the responsibility for copying and distributing the newsletter will move to Seattle. Since my administrative support (and time) are limited, I would appreciate your sending subscriptions without further solicitations. Enclosed you will find a form on which you may indicate if you do or do not wish to continue the newsletter. Please return that form — in either case — as soon as possible. If you are subscribing, please enclose your check.

The issue of whether to include non-MINTies was not clearly resolved by the survey. There were strong opinions expressed against wider distribution in a few quarters with the greater majority seemed to only slightly favor keeping the distribution smaller or having no strong opinion. There were only a few voices heard for including a broader group. Given this picture, and for the present, we will keep the distribution within the current boundaries.

News from You
Prior to the next newsletter, I intend to send out a few "biography questionnaires". This will be sent to only a few of the MINTies and your answers will be included in the following issue of the MINT. I see this as a cost effective way to more directly inquire about and include the readership in the MINT. This questionnaire is in direct response to the message you sent through the reader survey, "We want to hear more about what other trainers are doing!" Of course, you need not wait to receive a questionnaire to send something. Your thoughts, ideas or pieces are welcome at any time. Please feel free to send this via letter, email or on diskette.

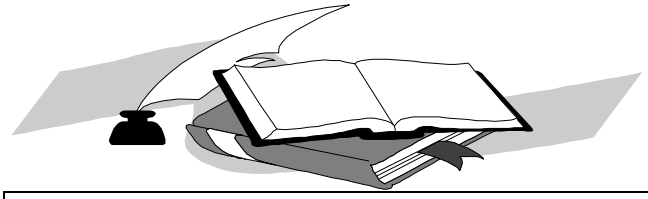
Training Thoughts
I just completed a fairly active training period where I've done several one day workshops and then some briefer 2 hour seminars. Although I love doing training, it also takes a lot of energy and preparation. I'm glad to have a little period of quiescence here.

I continue to find two hour presentations more professionally challenging than the day long workshops. The group is usually has a broad skill level and often arrives expecting to be taught MI in one easy lesson. My goal is to develop a "MI 101" which covers the basics and gives people a taste of MI, but doesn't try to cover all the concepts. To date, I stand firmly convinced that I have not succeeded.

We are back on line to do our Advance Care Planning workbook and intervention. I previously told you I was a bit challenged by what would need to be accomplished in a relatively brief period of time. I've decided to go with a three session sequence. The first session is entitled, (perhaps somewhat too boldly) How People Change. It will include three primary elements: Resistance versus Ambivalence; Stages of Change; and Five Principles of MI. The second session is entitled, Techniques for Enhancing Motivation. There are three primary elements in this session: OARS, Looking for Change Statements, and Managing Resistance. The third session is focused on the integration of these elements into the research intervention. This is an interesting challenge. Unlike other brief training where my goal is to create an interest in the attendee that leads to seeking more training, here the trainee will need to reach some level of competence after this sequence. I'm not sure it's possible, but I'll keep you posted on how it goes.

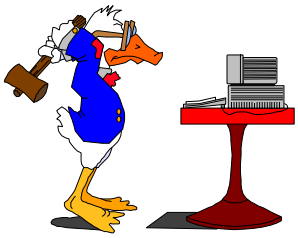
A Second Gathering
I read with great interest Stephen's discussion of the Trainer's ancillary meeting to be held by European MINTies Jeff Allison, Tore Bortveit and Peter Prescott. The idea is to bring trainers

together to swap materials and ideas. I'm not sure my travel budget will allow me to attend, but it would be great to hear what is being planned. It again raises the idea of a follow-up meeting here in North America. The last time I floated this idea, the response was under-whelming. A few strong affirmatives, but most folks did not respond. I am willing to do some planning, but only if there seems to be a ground swell for doing so.



Publications

Sciacca, K. (1997) Removing Barriers: dual diagnosis Treatment and Motivational Interviewing. Professional Counselor, 12, 41 - 46.



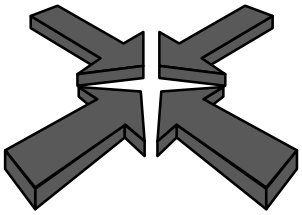
A Message from Cyberspace

Kathleen Sciacca included information about a **"Dual Diagnosis Website:** The URL is:

http://pobox.com/~dualdiagnosis or
http://www.erols.com/ksciacca
E-mail: ksciacca@pobox.com

The website includes complete articles, chapters, up-coming training events, a national and international directory for dual diagnosis programs, a credentialed listserv, and much more.

Kathleen asks that if you "stop by" the website, drop her an email to say "Hello!"



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