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From The Desert

Bill Miller

From Zero to One

If all learning is zero through ten, then the most important part of learning is zero through one.
Monty Roberts (2001)

For me, one of the enduring surprises of MI is how a rather small dose can sometimes exert a relatively large effect on behavior (Miller, 2000). The average effect of MI on behavior is significant but modest—meta analyses put it between .4 and .6; that is, between two and three fifths of a standard deviation (e.g., Hettema, Steele, & Miller, 2005). Individual responses, of course, are distributed around the mean effect, even for the most skilled MI practitioner. I am interested here in the upper tail of this distribution: those people who show substantial change with relatively brief exposure to MI. Is there something about these individuals that prepares them to respond so well to MI?

The first candidate that occurs to me is the person for whom the principal obstacle to change really is ambivalence, the lack of clear intention or commitment to change. In the transtheoretical model (Prochaska, 1994), these would be called later contemplators. They have been thinking about change and have a good mix of pros and cons. They have personal resources to succeed with change if they decided to do it. They just haven't decided. Action-oriented or pushy persuasive counseling could evoke resistance, whereas an approach focused on evoking personal motivation and commitment speaks to the key issue. For these folks, if MI can get them over the decisional hump, substantial change would follow. In contrast, for people who are "already ready" for change, little benefit from MI might be expected.

In other cases, MI may benefit from a contrast effect. A single person person-centered voice may have substantial impact when all other voices are punitive, controlling, shaming, and blaming. In one clinical trial, a single MI session was randomly offered (or not) at intake into a relatively didactic, confrontive disease-model inpatient substance abuse treatment program. Could one MI session possibly have any effect with so much counteracting interaction? In fact, post-discharge 3-month continuous abstinence was doubled in the MI condition (57%) compared to those receiving the same program without MI (29%) (Brown & Miller, 1993). In Carolina Yahne's Magdalena study with prostituted women (Yahne, Miller, Irvin-Vitela, & Tonigan, 2002), she was amazed that 25 of the 27 took initiative to return for the 4-month follow-up interview. The payment was modest, so she asked them

Editor's Choice

Forum Thoughts

Allan Zuckoff

Each year I have taken special pleasure in preparing the proceedings of our annual MINT Forum for publication in the MINT Bulletin. As a faithful attendee since 2000—after skipping the first meeting following my TNT in 1998, only to mentally kick myself as I read raves about the 1999 meeting posted on our listserv—I have felt it particularly important to preserve the wonderful presentations, discussions, and information exchanges that I've felt lucky to experience firsthand.

This year I have a new perspective on the Forum, and thus on these Proceedings. As a member of the planning committee, I had the opportunity to see the meeting come together, as people volunteered to facilitate sessions, demonstrate exercises, and otherwise play a role in the life of the Forum; I also found out, first hand, what a relatively small group of dedicated MINTies has done, year after year, to make these meetings possible. By the end of the final day, I was both exhausted and deeply appreciative of all MINT members who give of themselves at MINT Forums, and especially of those who work selflessly and (for the most part) behind the scenes to provide our otherwise virtual community its moment of face-to-face sharing.

In This Issue

***From the Desert,* Bill Miller** reflects on the surprising phenomenon of rapid change in some MI trainees in *From Zero to One.* This is followed by **David S. Prescott's** account of how MI can play a role in helping perpetrators of sex crimes, *Helping High-Risk Sexual Offenders Get Back on Track: Incorporating MI Principles in a Group Setting.*

The remainder of the issue is dedicated to the *Proceedings of MINT Forum 2006.* Contributers include **Rory Allott, Guy Azoulai, Stephanie Ballasiotes, Steven Malcolm Berg-Smith, Jim Blucher, Brad Bogue, Paul Burke, Marci Campbell, Ann Carden, Carol Carr, Judith Carpenter, Charlotte Chapman, Michael Chenkin, Cathy Cole, Frances Dannenberg, Carol DeFrancesco, Sandy Downey, Chris Dunn, Paul Earnshaw, Jacque Elder, Denise Ernst, Steven J. Feinstein, Heather A. Flynn, Michael Giantini, Tim Godden, Ali Hall, Denise Hall, Jacki Hecht, Jennifer Hettema, Karen Ingersoll, Jonathan Krejci, Claire Lane, Michael B. Madson, Bill Miller, Theresa Moyers, Christina Näsholm, David Prescott, Dee Ann Quintana, Carol Rankin, Kris Robins, Edy Rodewald, David Rosengren, Kathleen Sciacca, Dee-Dee Stout, Laura Travaglini, Deborah Van Horn, Chris Wagner, Henny Westra, Lyn Williams, Carolina Yahne,** and **Allan Zuckoff.** And the issue concludes with a very special contribution by **Harry Zerler.**

Looking Forward

Our next issue will be wholly dedicated to the *Festschrift* in honor of Bill Miller. The issue will feature, for the very first time, the publication of the original and uncut version of Bill's seminal 1983 article, *Motivational Interviewing for Problem Drinkers*, along with tributes and considerations from MINTies worldwide. Contributions are still being accepted to what will undoubtedly be a very special issue of the MINT Bulletin. MB

why they came back. The modal response was, "because you listened to me, and didn't call me a whore." Someone interested in a client's own perceptions and feelings may really stand out as an oasis in the desert. I wonder if this might be part of why MI seems to show larger effects with minority populations that historically have suffered generations of domination and abuse (Hettema et al., 2005). Differentially greater response in one group, of course, means that there are others showing less response. If a contrast effect of compassion is part of what makes for a marked response to MI, this would suggest possibly less response for more privileged individuals and populations.

In any event, I think there is much to learn from those who show the largest response to MI. The more common question has been, "For whom does MI not work?" That is a valid question, too, but I believe it would be worthwhile to devote some qualitative study to those in the upper tail of the response curve.

The same issue applies in training. On average, people receiving a 2-day MI workshop don't show large increases in proficiency. Some, however, do evidence significant skill gains. Of those who entered the EMMEE study with below-threshold, 29% of those in the workshop only group, and 17% of those in the self-directed group (manual plus videotapes) newly fell within the proficient range skills (95% MI-consistent responses on the MISC) at the 4-month follow-up. It has been my observation that some people just "get it" when exposed to MI, and something like a perceptual shift occurs. For some it may just be permission to be kind and compassionate, when their training and context have been otherwise. For others who have been trained in client-centered counseling, it may be the realization that one can do this with their population (or that they have forgotten to do so). There seems, in any event, to be a kind of "Aha!" experience for some when they read the MI book or attend a first training. It is as if they recognize the approach and its underlying spirit, and take to it naturally. I don't know how often this happens with MI training, but my sense is that it's not rare. Many have told me over the years, "You changed my life, and transformed the way I work with people." Usually they are not talking about me personally, for many of them told me this on first meeting, having read the MI book or received some training. It was encountering the ideas, the spirit of MI that was transformative. I expect that other MINTies have had similar experiences.

I hear my Euro-MINTy friends calling me back from the brink of grandiosity. Yes these are the exceptions, and my own research shows that most people attending a 2-day workshop with me do not make profound gains in skill level. For some, it was because they entered training already almost meeting our criteria for MI proficiency. I think it is true, though, that for others, initial exposure to MI takes them from zero to one, and that is a big perceptual shift. Perhaps it is just seeing with one's own eyes that it is possible, that there is a way to inspire rather than extract change. That was my entranced reaction the first time I saw Monty Roberts work--that the age-old violent method of breaking horses isn't the only way, isn't even necessary. There is a better way. Click. Zero to one. MB

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Helping High-Risk Sexual Offenders Get Back On Track

Incorporating MI Principles in a Group Setting

David S. Prescott

Introduction

Working with people who present barriers to meaningful engagement in treatment is a common experience among treatment providers working with sexual offenders. This article describes a method for clarifying and addressing factors that interfere with successful engagement in treatment (and attempts to change). It is oriented toward work with individuals who are of normal intelligence and who do not possess high levels of psychopathic traits, although with some accommodation, professionals can use elements of this method with these populations.

This approach has proven to be efficient with respect to staff resource allocation and the development of necessary skills for group participation. It has grown out of discussion and practice among the treatment team at Sand Ridge Secure Treatment Center (Wisconsin's civil commitment center for sex offenders determined by the courts to be at high risk for sexual re-offense). This team's review of the recent literature regarding the motivation and treatment of criminal offenders has also contributed to the development of this method. This overview is provided in the hopes that it may benefit others working to engage abusive individuals meaningfully in treatment. This chapter describes the problems that led to its development, a sequence for identifying and working through these treatment-interfering factors, and some guidelines for keeping the process focused.

Sand Ridge is a secure treatment center for adult male sex offenders who have completed their prison sentences, but whom the state has detained in order to provide treatment to reduce their risk of causing further harm in the community. While a discussion of the nature and controversies surrounding civil commitment is beyond the scope of this article, it is not surprising that many patients have difficulty engaging in treatment. Some patients participate primarily to gain benefits unrelated to change (e.g., the appearance of progress with attendant privileges). Others may have significant personality characteristics that nearly preclude participation in treatment. Many have simply developed tactics to avoid admitting responsibility, whether to others or themselves. In some cases, patients may have mental health problems or learning disabilities that require additional attention so they may acquire greater benefit from treatment. The patients at Sand Ridge receive a multi-disciplinary approach with close coordination of services.

Background

Researchers and practitioners alike have observed that sex offenders often have difficulty engaging in treatment (Blanchard, 1995; Proeve, 2003), and that elements of sexual aggression are deeply established in offenders' world views (Mann & Beech, 2003) and decision-making (Laws, 2003). Others (e.g., Ward & Hudson, 1998) have observed that some sex offenders do not want to change. Although sex offenders are a heterogeneous population, the patients at Sand Ridge typically display high levels of difficulty with respect to sexual deviance, self-management, socio-affective functioning, and attitudes that support diverse forms of misconduct including sexual aggression (Thornton, 2002). While these difficulties contribute to sexual aggression in general (Ward & Beech, 2004), they can also become barriers to engaging in treatment.

Patients often enter treatment shortly after admission to Sand Ridge. However, many have returned from later phases of the treatment program due to behaviors that interfere with their treatment progress (e.g., continued aggression towards facilitators or

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peers, extended periods of deception in treatment). Many have failed in other sex offender treatment programs. Some have previously declined to participate in treatment and often have additional backgrounds of failure in educational and counseling environments. Those entering treatment therefore face extensive challenges that interfere with their ability to engage in treatment. Often these have existed across most of their lives. Apart from substantial sexual and personality disorders, these include (but are not limited to):

- *Distrust of professionals and the legal system.* Beyond the grief and rage that patients can experience upon their civil commitment, many are mistrustful of all authorities, including treatment providers working in close contact with the courts or law enforcement. Some have expressed a belief that the very presence of treatment providers under such conditions confirms their belief that mental health professionals are corrupt or have no interest in them. Regardless of any possible justification for these concerns, this distrust can serve as a disincentive to treatment.
- *Denial and minimization.* Many patients enter treatment claiming that they did not commit some or all of the offenses of record. Many are unwilling to acknowledge the extent of harm in their actions or maintain attitudes tolerant of sexual abuse that fuel attempts to minimize their actions.
- *Extensive failure in both educational and treatment settings.* Patients often feel that not only are education and therapy venues for failure, shame, and humiliation, but even the prospect of having to reenter them is itself shameful and humiliating. Many have historically regarded sex offender treatment providers as harsh and punitive. Others express a strong belief that little, if any, change is possible in their lifetime, and that the chances are greater they will be incarcerated for life than enjoy the benefits of change.
- *Untreated disorders.* Many patients have histories of biologically based vulnerabilities that have rendered prior treatment experiences problematic. Unaddressed ADHD, learning disabilities, and comorbid psychiatric illnesses have often reduced their past ability to access treatment as easily as others.
- *Deficient skills for managing challenging interpersonal situations.* Dysfunctional coping styles, poor problem-solving skills, failure to manage impulses can prevent meaningful engagement in treatment.
- *Difficulty taking treatment seriously.* Many patients have life histories marked by general aggression and deception, and set out to "con" their way through treatment, taking only superficial responsibility for their actions. In many instances, this has gotten them to moderate and even advanced levels of treatment, whether at Sand Ridge or other settings. However, it has prevented their being able to integrate therapeutic progress into their daily lives.
- *Lack of motivation to reduce sexual deviance.* Many patients experience intensely arousing sexual deviance and are unwilling to let go of it, even upon entering treatment. Many also engage in ongoing sexual fantasy as one of their few coping skills, and are ambivalent about changing this. Even though sexual deviance becomes a treatment target later in the treatment sequence, many patients remain ambivalent about considering this change in the future.
- *Anti-change attitudes.* Many patients enter treatment with antisocial beliefs and attitudes specifically related to treatment. Some patients consider themselves political prisoners. Many explicitly endorse a "convict code," believing it is honorable for them to protect each others' secrets, even when this could harm themselves or others. Still others participate in treatment but are more interested in spending their time looking for legal loopholes to gain release than in making sustained changes to their lives.
- *A sense of powerlessness.* Many patients state they are powerless to change their own lives. While this may be a tactic for avoiding responsibility to some, others experience life as something that happens to them and believe that others have more control over their behavior than they do. Very often this is expressed in statements such as, "Go ahead and do what you're going to do; you're going to do it anyway." Others express a view that they have no real future and are unwilling to change except to realize some short-term personal gain, such as access to a job or unit change. These attitudes can reflect implicit theories that society is overly hostile, punitive, or out-of-control (Beck, 1999; Mann & Beech, 2003) and a resulting willingness to be opportunistic.

With its focus on treatment-interfering factors, as well as cognitive skills, the initial phase of treatment at Sand Ridge serves two functions. First, it directly addresses the thoughts and behaviors that contribute to irresponsibility and prevent full engagement in treatment. Second, it prepares patients to think differently about their prior concerns and revise their belief about the possibility of change. It begins this process through an engaging and encouraging provider style and the inclusion of program incentives to assist patient motivation.

Ultimately, a patient's consent to treatment means only that some unknown portion of them wants to make an unknown change. Upon entering the Sand Ridge treatment program, most patients possess a rudimentary willingness to spend at least a little time in treatment. However, they face considerable challenges before they can participate meaningfully in the treatment that will specifically address their individual needs.

Treatment Context

Therapist style is among the most fundamental elements of the treatment program. Studies (e.g., Marshall, Fernandez, Serran, Mulloy, Thornton, Mann, & Anderson, 2003) have shown that treatment providers for sexual offenders who possess a warm and

empathic style and whose actions are directive yet rewarding produce the best outcomes with respect to dynamic factors associated with sexual recidivism risk. Sand Ridge trains treatment providers to work in this fashion and to model the changes they expect patients to make. Given the preparatory nature of the early phase of treatment, facilitators should mentor their patients, and demonstrate a concern for their welfare while remaining firm around the values underlying sex offender treatment. This approach can alleviate the cynicism with which many patients approach treatment, while deflecting attempts at manipulation. Facilitators have received training in many of the techniques and spirit of motivational interviewing (Miller & Rollnick, 2002).

Group treatment is at the center of the program. While there is little research into the efficacy of group versus individual treatment, the literature on treatment of sexual offenders describes numerous advantages of group treatment (e.g., Marshall, Anderson, & Fernandez, 1999; Marshall, Marshall, Serran, & Fernandez, 2006; Frost, 2004; Jennings & Sawyer, 2003). A recent survey by the Safer Society Foundation (McGrath, Cumming, & Burchard, 2003) found that 99% of residential treatment programs and 90% of community programs for adults use group treatment, most often with adjunctive individual treatment. The authors note, "Sole reliance on individual treatment is often contraindicated. Individual treatment is more expensive and does not provide the same opportunities for peer support and social skill practice as group treatment" (P. 48).

To this end, the early stages involve group treatment to prepare patients for the more stringent demands that come later, when self-disclosure and the supportive challenges of teamwork become increasingly important. Treatment groups at Sand Ridge also use homework assignments and role plays. Unit staff and their supervisors are available to help with assignments for patients in earlier phases of treatment. Unit staff members also attend formal and informal case planning meetings, and contribute to the development of individualized treatment plans and goals. In many instances, individual therapy is used to address specific patient concerns. However, the primary emphasis is on group treatment wherever possible.

Beyond the advantages of group treatment, several other aspects are important to the long-term success of Sand Ridge patients. As noted above, an often unstated but significant challenge in treating high-risk offenders is that much of the work involves fostering success in those who have all too often been poor candidates for treatment.

Ultimately, to achieve the final goals of treatment, the early phases should help patients move closer to a lifestyle conducive to supervision in the community. Hanson and Harris (2001) noted that higher-risk offenders were often less cooperative with supervision requirements (including treatment) while Hanson and Bussiere (1998) speculated, "High risk offenders may be those most likely to quit, or be terminated, from treatment" (P. 358). Arkowitz and Vess (2003) noted that self-report of cognitive distortions collected via questionnaire "are too susceptible to a socially desirable response set to provide useful data with sex offenders who are involuntarily committed for treatment" (p. 237). Finally, Robinson (1995) observed that sex offenders appeared to benefit more than other types of offenders from a cognitive skills training program.

In summary, the early stages of the Sand Ridge treatment program invites patients whose offending has persisted, often despite detection, sanction, and prior treatment experience, to engage meaningfully in group treatment that will address their history of offending and the psychological factors that contributed to their offending. Very often, these patients enter treatment demonstrating impulsivity, irritability, and unwillingness to accept responsibility for their actions. The majority of patients have diagnosed sexual and/or personality disorders that require considerable personal effort (and external support) in order to change.

It would therefore be unfair to expect that these patients could immediately meet the challenges of entering treatment and quickly begin disclosing their offense histories. By addressing attitudes, thoughts, and behaviors that interfere with treatment, the early phase of the program can better prepare patients for the later phases of treatment. In many instances, patients are unable, unwilling, or simply not ready to engage meaningfully in treatment. For this reason, the treatment team established the "Individualized Treatment Group" (ITG), where patients directly address treatment-interfering factors within a group setting. This setting (which generally contains fewer patients than mainstream treatment groups) provides the benefits of feedback, questions, and discussion from other patients, and provides patients the opportunity to practice having challenging discussions within a group context before delving into more serious issues.

Putting the Group Together

The ITG is, at its core, remedial. Patients can join it because of issues such as those mentioned above or any challenging aspects of personality characteristics that prevent their benefiting from other groups. Placement in an ITG can occur on its own or in combination with a treatment group in order to prevent removal from that group. Individuals coming to this group possess distinctly different challenges; so the resulting diversity can form the basis of considerable discussion. Although uncommon, some patients may start treatment in an ITG. This has occurred when newly admitted patients have extensive histories of poor responses to treatment or when they have transferred from one treatment track to another (e.g., from the conventional track to one designed for patients with high levels of psychopathy).

The therapist's style is critical. Warmth, empathy, and acceptance combined with a directive approach will work best for the patients who have often failed in confrontational settings. A key task for group members is to determine for themselves

whether they are at a point where they can meaningfully commit themselves to personal change. Therefore, the task of the facilitator is not to advocate the merits of participation in treatment, but to remain open to ambivalence and supportive of any emerging commitment to change. Along the way, the patient can analyze the costs and benefits of the focus issue. Research demonstrates that people are more convinced by what they hear themselves say than what others say (Miller & Rollnick, 2002; Ryan & Deci, 2000) particularly when they experience having some choice in the matter (Bem, 1972).

A guiding value of the ITG is that patients gather to discuss and work on issues, not to debate them. Many who have experienced repeated contact with the law argue vigorously over fascinating but irrelevant aspects of their situations. Others are skilled at noticing the ironic qualities of treatment and those who provide it (e.g., noticing that treatment providers can also engage in irresponsible behaviors) without addressing larger issues (such as the role of irresponsible behavior in their sexual aggression). Many debates are worth having; the ITG is not the venue for them. By maintaining the relevance of the issue to the patients plan for change, patients can better progress.

Other guiding elements of the ITG come from the spirit and techniques of motivational interviewing (Miller & Rollnick, 2002).

Resistance has been the source of much discussion among sex offender treatment providers. This has included revelations that denial is not predictive of sexual recidivism (Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2004) but can be predictive of treatment participation (Levenson & McGowan, 2004) and therefore may indirectly influence treatment outcome and risk. Others, such as Blanchard (1995) and Jenkins (2006), have explored the therapeutic relationship within sexual offender treatment. Discussing research showing that client behavior can provoke clinician confrontation and vice versa, Miller (2006) observes, "Client resistance and clinician confrontation are complementary behaviors that elicit and reinforce each other, much like the cycle of aggression and retaliation between nations" (p. 16). For purposes of the ITG, facilitators must recognize that resistance enters the process naturally and inevitably. Facilitators are at their best when they welcome resistance, as it very often accompanies ambivalent statements containing the first indicators of a willingness to change.

For purposes of the ITG, developing discrepancy is the difference between where the patient is and where they want to be with respect to the focus topic. This simple difference is often how facilitators approach the challenges that patients face. By asking questions using this language ("Where would you like to be with this?"), they are able to prevent debate and maintain focus. Facilitators can reframe resistance such as blaming others for their actions (e.g., *I can't participate when all these other guys are so obviously sexually deviant and their crimes have been different from mine*) with statements such as, "This really shows how important their support and understanding is to you." Likewise, facilitators can reframe patients' complaints about the perceived arbitrariness of rules as a strong desire to understand the reasons that those rules exist. Discussions can then include the discrepancy between the patient's current functioning and the requirements for reentry to the main stream of their treatment track, with an emphasis on how decisions about their participation are between themselves and their future.

Preparing the Patient

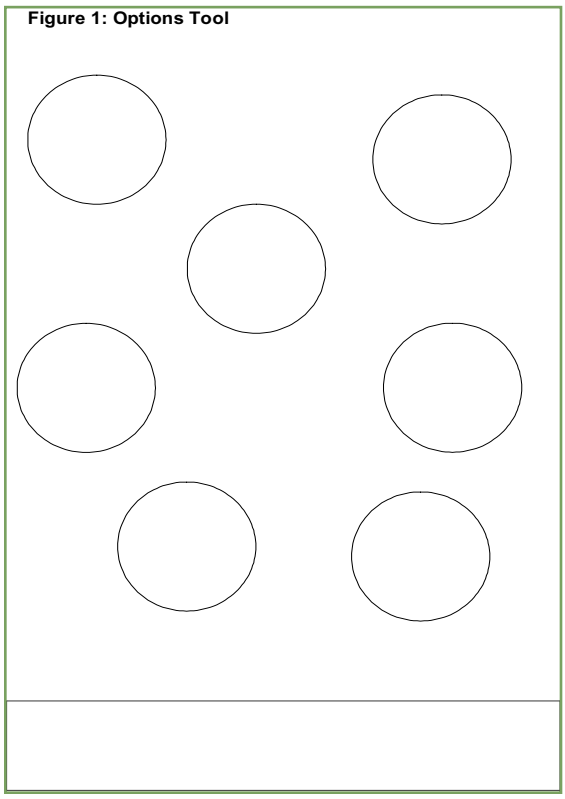
Throughout the treatment experience at Sand Ridge, patients and facilitators meet to discuss progress and the expectations of the program. Placement in an ITG follows a process in which the patient meets with staff members involved in his treatment. This can include a treatment team consisting of facilitators, unit staff, and health service staff. At Sand Ridge, the facilitators include one psychotherapist and one unit supervisor. This helps bring both perspectives into group and assures discussion of behaviors that occur on the living unit.

The team asks permission to discuss the individual's status in treatment and seeks his perspective on how he is doing. This can include discussion of prior attempts to engage the patient and agreements they may have made. A facilitator then outlines the treatment-interfering factors that have concerned the team. Although it is highly likely that various members of this team have discussed these issues with the patient prior to this meeting, it is helpful to have representatives from as many departments as possible in attendance to prevent unnecessary blame placed on absent team members (a device often referred to as "staff splitting").

It is most helpful when the team can focus on a small number of core elements of the treatment-interfering factors rather than a laundry list of irritating behaviors. Ideally, one to four goals for the ITG is optimal in order to maximize the patient's ability to stay focused on them. This may require team members to conceptualize single behaviors as part of larger areas of need.

Patients address diverse issues in ITGs. Beyond common issues such as pervasive disruption, attention-seeking behavior, or reluctance to pay attention, patients can address areas such as their reluctance to provide a comprehensive account of an offense or their sexual history. In some cases, patients have entered an ITG due to intense ambivalence about their relationships with other patients (and the affect of those relationships on their treatment progress). Other patients have entered in order to address their low motivation for treatment and persistent reluctance to apply treatment material to their daily lives. These issues are all ideally suited to an ITG situation, where other patients can provide support, thoughts, ideas, and feedback. For example, one patient struggled for months to address his history of bestiality. Another patient (who experienced different problems with respect to treatment) was able to relate that he had a similar history. This started a group discussion that resulted in the patient's eventual return to his original treatment group.

Figure 1: Options Tool



Once the team determines these areas of need, they can be written into an "options tool" (see figure 1; Berg-Smith, 2006). By writing the treatment-interfering factors into the circles, the patient then has:

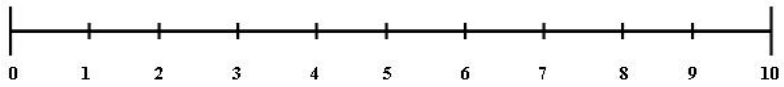
- a hand-crafted document different in appearance from the usual formatting of clinical paperwork, including treatment plans.
- a tangible, visual roadmap whose structure does not necessarily imply a specific sequence of tasks.
- a menu from which the patient can choose for himself which area he will address first. This emphasis on choice is fundamental to the patient's ability to make change for himself as well as to advance in treatment
- additional "circles" to which the patient can add goals of his own.

Facilitators can anticipate that the patient will not agree with some or all of the goals. This is to be expected; the team can note that the patient did not agree with all of the treatment team's concerns and recommendations. Likewise, the facilitators encourage the patient to add concerns of his own. The guiding value is that the process is collaborative but includes the treatment team's concerns. After all, left alone these treatment-interfering factors will prevent meaningful personal change. Facilitators can address the patient's strong resistance to addressing treatment-interfering factors during the course of the group.

Depending on the patient's circumstances, his placement will either occur in tandem with other treatment activities (signaling a last effort to maintain his placement in various groups) or as his sole treatment activity. Whatever the case, the team presents the ITG as a means to get the patient back on track. While many patients to date have expressed a desire to continue their participation, the ITG should last only as long as needed to return the patient to the rest of the treatment program.

Upon establishing the goals for the patient to work on in the ITG, facilitators can next use a "readiness ruler" (Miller & Rollnick, 2002, p. 183) to explore the patient's motivation further.

Figure 2: Readiness ruler



Despite its apparent simplicity, the use of this ruler can produce fruitful discussion as well as another tangible visual aid. The facilitator can ask, "On a scale of one to ten, how ready are you to consider addressing these areas?" When the patient offers only a "four," the facilitators can then ask why he didn't choose a one or a two. Whatever the patient's response, it will almost invariably involve some sort of strength, positive attribute, or belief in his ability to address the issue. The facilitators can then affirm and explore these areas before asking, "What would need to happen for you to move up one half-step to a four-and-a-half? The patient's answer will likely involve some sort of action that he and/or others can take and include what Miller and Rollnick (2002) call "change talk," invoking "the person's own reasons for and advantages of change" (p. 24). This can provide considerable insight and direction for patient and team members alike. It also helps that the patient who considers possibilities for change rather than others.

The Group Process

The ITG is open-ended, providing the opportunity for newer patients to receive feedback from more experienced ones. Once involved in the ITG, the patients receive the opportunity to review each of the issues outlined in their option tools, and discuss them with the group. The same process of assessing readiness with the readiness ruler is useful for exploring each area. In addition to eliciting "change talk," the process provides a forum for other patients to ask open, thought-provoking questions and to provide support.

Once the group begins exploring a relevant area, they next examine the costs and benefits of each issue. For a patient addressing disruptive group behavior, this involves discussing what he gets out of being disruptive along with the costs (e.g., continued failure to progress). Key questions for this discussion include:

- How has this issue played a role in your past behavior?
- How does this issue play a role in your current behavior?
- What kinds of payoffs do you get from this?
- And on the other hand, what kinds of difficulties is it bringing you?

Depending on circumstances, supplementary questions can include:

- What is happening when you decide to engage in this behavior?
- What do you want to happen and what do you get?
- How might this issue affect others?
- How might one approach situations where this issue might arise and get what you need without this issue happening?
- If you were in my (or someone else's) shoes, what might you

think about this issue? (other patients often have a number of contributions to add to this question)

By exploring the benefits as well as the costs, the patient can decide for himself how committed he is to making change in this area. It is important that he make these decisions free of coercion or the sales pitches of well-intentioned professionals. The patient will have only his own commitment to rely on in later stages of treatment.

A further area for exploration involves a "cognitive check-in" (Thornton, 2005). This assignment tasks patients with monitoring how their thoughts influence their behavior. As applied in the ITG, patients describe:

1. a situation in which they experienced strong emotions.
2. what went through their mind.
3. what they did/what skills they used.
4. what they could have done/what skills they could have used.

This sequence is deliberately kept simple in order to maximize the patients' use of it. They can then apply this series of questions to any area of focus.

Action Planning and Completing the Group

Facilitators and patients monitor the referral issues both on the unit and within the group. Together these players design formal and informal action plans that vary according to the issues. For some, it has involved a demonstrated and agreed-upon pattern of reducing disruption and for others the completion of some task, such as an assessment process. In some cases, patients can return for additional work to consolidate the gains they have made. Others must work further to address issues incrementally. When each patient is ready to leave, the group has a "send-off" discussion in which they review his strengths and accomplishments.

Potential Traps

Working with patients who have been unsuccessful in other treatment settings, often for decades, presents no shortage of challenges. There are many areas in which patient resistance to change can disrupt the process of the group. The following are some, but not all, potential difficulties that facilitators might experience:

- *Debate versus dialogue.* Patients often enter group with an intense sense of grievance towards the legal system and mental health professionals. Facilitators may sense that the patient has brought abusiveness with them into treatment. It can be productive to hear a patient out and encourage dialogue with other patients who have moved beyond similar concerns. However, facilitators should take care to maintain a focus on personal change.
- *Unrealistic expectations.* Facilitators and other members of the treatment team must guard against expecting too much too soon. The purpose of the ITG is to address issues so that the patient can re-join their treatment track. The treatment team can best prevent unrealistic expectations by outlining very clear goals upon referral.
- *Discrepancy hurdles.* Patients are sometimes ambivalent about discussing the discrepancies between their current and desired statuses. Under these conditions, facilitators are at risk to argue for change, often in the form of offering suggestions as to the advantages of change. Under these conditions, possible solutions include focusing on other patients and convening staffings to discuss alternatives.
- *Focusing on one patient to the exclusion of others.* Some patients seem to be the focus of attention more than others, while some patients actively avoid the scrutiny of others. It may be useful to develop and maintain a schedule of whose topics the group will discuss and when, ensuring that all patients contribute. Facilitators should also invite input from the less vocal group members.
- *The negative spotlight trap.* Professionals with experience in diverse inpatient settings can understand how problems command attention far more readily than successes do. In some cases, simply getting out of bed or maintaining a schedule represents success. Facilitators should remain active in their attempts to highlight even small successes while maintaining respect for the challenges that patients have yet to address. With no spotlight on success, patients have fewer avenues for exploring what has worked in their attempts to get back on track.
- *The expert trap.* Described first by Miller & Rollnick (2002), this is a familiar problem in which patients defer responsibility, asking (and in some bases, baiting) the facilitator with questions such as "you're the expert; you tell me what to do," or "What would you do in my shoes?" Very often, when facilitators enter the expert trap, patients will quickly write off their suggestions as meaningless or impossible, further strengthening their commitment not to change.
- *The urge to fix problems.* Miller & Rollnick (2002) refer to this as "the righting reflex" – a tendency among professionals to try to fix the problem instead of patiently allowing patients to arrive at solutions. This can combine with the expert trap to leave professionals with a crippling sense that although they desire to motivate group members, they must do so quickly in order to maintain a posture of authority. Very often, the best solution to the urge to fix is to maintain an active focus on remaining warm, empathic, rewarding, and directive.
- *The etiology trap.* Group members sometimes engage in lengthy discussions and other periods of reflection in which they explore how various issues in their lives came to be. Although there can be great merit in exploring one's life history and assembling an autobiography of one's life is an expectation within subsequent treatment phases, understanding the roots of a treatment need is not the same as making change. It can be very easy for group members

to substitute eloquent life narrative for acceptance of responsibility and demonstrated change. To prevent the etiology trap from taking time away from change, facilitators can remind patients that there will be more time to search out the causes of their behavior in other treatment venues.

Summary

There are compelling reasons to employ group therapy with persons who have sexually abused. At Sand Ridge, patients optimize their own treatment by using open questions, observations, and support within a treatment environment that is warm, empathic, rewarding, and directive by design. Those participating in treatment frequently experience diverse treatment-interfering factors. Due to the demands of group therapy, particularly in the later stages of treatment, it makes sense to address these treatment-interfering factors early to prepare patients for the challenges they face as they commit themselves to meaningful personal change. The framework described in this article has been one helpful aspect in this process.

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A Participatory Way of Being

Jacki Hecht on Behalf of the Planning Committee

The Miami MINT Forum, 2006, marked our 11th meeting as a MINT group. Starting off as an informal gathering of a handful of trained MINTies in Malta in 1997, the MINT has grown in membership and diversity over the past decade. And while the Miami Forum was our largest meeting ever, with over 130 attendees, the planning committee tried to preserve the spirit and mission of this very first meeting by creating numerous opportunities for interaction and sharing among members.

This emphasis on interaction among MINT members is becoming ever more important, as this year nearly 40 new MINTies stayed on after their TNT to join the MINT Forum. To facilitate member sharing and participation, this year's Forum kicked off with an opening exercise to help MINTies interact with one another, and reflect upon their own values as MINT members. Numerous breakout sessions followed, to accommodate the many ideas for sessions that members offered to facilitate. For the first time, MINT offered a poster session where nearly 20 members presented posters of their research and service programs, while inviting questions, comments, and discussion about their work. Allan Zuckoff's facilitation of a Festschrift session, in honor of Bill's retirement, was yet another way of inviting MINTies to contribute to this meeting. In addition, an entire day was dedicated to training, whereby we invited members to demonstrate and facilitate training exercises for us to experience and practice. Lastly, we ended by inviting volunteers to provide a brief description highlighting the various breakout and plenary sessions as another way to invite new members to get involved. As we look toward future MINT Forums and we continue to grow, my hope is that we continue to ground ourselves in our evolutionary history that stemmed from the desire to share ideas, test out new approaches, and inspire each other to strive toward enhancing our therapeutic way of being.

Opening Session

What Does it Mean to Be a MINTie?

Allan Zuckoff, Judith Carpenter, & Jacque Elder

Who Are We?

The first part of the opening session explored attendees responses to a Pre-Forum Questionnaire that Allan emailed to all who were registered. Respondents were asked to describe the work they do with MI, grouped into the categories of Training, Practice, Research, or Other; their most memorable training experiences, including the weirdest, most embarrassing, most profound or transcendent, and most inspiring or exciting things that had ever happened to them during a training; and their relationship to MINT, including which TNT they attended and why, whether they thought there are "MINT values" (and if so, what they are), and what they valued most about MINT.

Remarkably, 100 of the 134 MINTies registered for the Forum returned a questionnaire, for a reponse rate of 75%. Of those who responded, 77% indicated they were involved in direct practice, 61% indicated they were involved in research, while 100% indicated they were involved in some form of training, teaching, or supervision. Further, 71% of respondents described using MI in the context of counseling or therapy, 22% in the context of health behavior change, and 6% in the context of criminal justice. Almost all of the 71% who used MI in a counseling or therapy context worked with persons with substance use disorders, eirher alone or in the context of co-occurring psychiatric disorders.

After reviewing these desciptive statistics, Allan got to the really juicy part by reading select responses from participants about their weird, embarrassing, profound, and exciting training experiences, and then asking the ~~victim~~ respondent to elaborate for the group. Fortunately, MINTies are, as a rule, both playful and ~~shameless~~ humble enough to be good sports about the whole thing and provide entertainment for their peers in the process. In the interest of ~~not pushing it too far~~ respecting the privacy of those who responded, those descriptions will not be reproduced here.

Opening Session ¦ continued

Suffice it to say that a good time seemed to have been had by ~~Allan~~ all.

MINT Values

In the second half of the session Judith and Jacque conducted a values exercise that provoked much discussion and interaction. It was a great way for people to get to know one another, and share their thoughts and ideas about the values of MINT and what they valued most from being part of MINT.

A list of values suggested by those who completed the Pre-Forum Questionnaire was projected for all in attendance to see. (See Table, **MINT Values,** right). Participants were first asked to select the 3 values most important to them individually. They were then asked to confer with the others sitting at their (round) table and come to a consensus on the 3 values most important to them as a group. Each table then submitted its 3 chosen values to us.

The value cited most was the sharing of ideas, information, resources and experiences. Generosity of spirit in communications, lack of hierarchy, being part of a non-judgemental community, integrity, curiosity and humility of members were also cited as being high on peoples' agendas.

With regard to the practice of MI, people cited that the fidelity to empirically based practice, an evidence based approach, and having more than one way to do it as important to them.

In addition to this description, the values lists of each of the tables has been communicated to the Steering Committee.

MINT Values

Compiled from MINT Forum 2006 Pre-Forum Questionnaire

1. Sharing of ideas, information, resources, experiences
2. Respectful listening
3. Becoming a bee rather than a fly
4. Optimism about the capacity for people to change
5. Generosity of spirit in communications
6. Humor
7. Friendship
8. Kindness
9. Acceptance of others
10. Wonder
11. Developing new ideas
12. Putting aside self-centered motives
13. Lack of hierarchy
14. Openness
15. Trust
16. Applying client-centered values throughout our lives
17. Belief in shared values
18. Respect
19. Generosity
20. Cooperation
21. Diversity
22. Overcoming biases
23. Improving the world
24. Community
25. Collegiality
26. Egalitarianism
27. Caring
28. Inclusion
29. Gleaning truth from research
30. Integrity
31. Holding ourselves to high standards
32. Compassion
33. Fun-loving
34. Seeing the good in others
35. Cultural sensitivity
36. Empathy
37. Dislike of hard confrontation
38. Efficiency of treatment
39. Curiosity
40. Playfulness
41. Love of learning
42. Service to others
43. Evocation
44. Altruism
45. Humility
46. Tact
47. Give more than you receive
48. Improve the quality of training
49. Non-interference
50. Self-determination
51. Camaraderie
52. There is definitely more than one right way to do it
53. Hope
54. Inherent goodness of people
55. International exchange
56. Fascination with the complexities of the human spirit
57. Unconditional positive regard
58. Belief in the tendency of individuals to evolve in healthy directions
59. Deep understanding of clients
60. Silence
61. Being a practitioner before becoming a trainer
62. Modeling the spirit of MI while training MI
63. Experiential continuing education for trainers
64. Doing no harm
65. Appreciation of the difficulty of behavior change
66. Service before profit
67. Mentoring as a way of paying back
68. Empowerment
69. Love thy neighbor
70. Active participation in MINT through the listserv
71. Non-judgmentalism
72. Dedication to helping those whose needs have been ignored
73. Fidelity to empirically-based practices

Training and Treatment Fidelity in Motivational Interviewing

Jennifer Hettema

Motivational interviewing is a treatment approach that has a wide research base and is becoming increasingly popular in various contexts. However, little is known about the fidelity of motivational interviewing in clinical or research settings. This presentation focused on treatment fidelity in general and as it applies to MI.

Put simply, fidelity is the degree to which an intervention is implemented as intended. In our clinical contexts, we have all likely come across individuals whose conception of MI differs from what we have learned as part of the Motivational Interviewing Network of Trainers. One common example is the presentation of stages of change theory as motivational interviewing. When these two approaches are presented as the same construct, misconceptions can develop and fidelity in clinical practice can be compromised.

Whether we explicitly acknowledge it or not, perceptions of treatment fidelity influence our clinical decisions the following ways: (1) when evaluating ourselves to determine areas in need of improvement, (2) when seeking a therapist for referral or personal reasons, (3) when hiring individuals, (4) when providing supervision, coaching, or giving feedback, and (5) when making decision about trainings. During all of these activities we are attempting to gauge the degree to which individuals implement MI in a way that is consistent with our expectations.

In research there are also concerns about treatment fidelity and we find ourselves evaluating research in many of the same ways that we evaluate ourselves and our clinical colleagues. During this presentation we read some examples of peer reviewed published journal articles testing the efficacy of MI that were included in a recent meta-analysis on MI. Participants evaluated the fidelity practices identified in articles and concluded that studies varied widely in their descriptions of the administration of MI.

Discussion was then given to the recent meta-analysis, which included 72 outcome studies of MI (Hettema, Steele, and Miller, 2005). During this meta-analysis we tried to measure the concept of fidelity by generating a list of MI principles, techniques, and strategies that we thought did a good job of capturing the nature of MI, such as 'develop discrepancy,' 'roll with resistance,' and 'express empathy'. We then went through each article and coded whether the authors mentioned using these strategies, hoping that this would be a general measure of the "MInes" of the intervention. Results revealed high variability in studies with some studies failing to mention any of these strategies in their description of the intervention and others mentioning all 12. Overall, the mean was about 3.6 and when we tested to see if endorsement of these strategies was predictive of outcome we found no effect.

Another thing we noticed when trying to capture some of the treatment fidelity characteristics of the studies in our meta-analysis was that sometimes there were discrepancies between what was reported in the article and what we had first hand knowledge had actually occurred in the study. One of the authors served as a consultant on many studies and there were cases for example, when he had consulted with researchers on the development of a manual for their intervention and then no such manual was mentioned in the article. These discrepancies took the form of underreporting treatment fidelity practices. This seemed understandable to us given the page restrictions imposed by most peer reviewed journals and the enthusiasm about sharing of results versus methods.

Still wanting to know more about the fidelity characteristics of MI outcome trials that have contributed to the evidence-base, we sought to create an instrument that did not rely solely on published reports. We utilized a helpful framework put forth by Borrelli and colleagues (2005). The framework provides guidelines and recommendations for conducting sound treatment evaluation research. The first category of fidelity in their model involves the *design* of research, in which researchers are encouraged to engage in careful planning and documentation of the theoretical rationale, format, and content of treatment and the plan for ensuring the execution of these intentions through study therapists. The authors also address the concept of *training,* or the sound preparation, planning, and execution of hiring criteria, training procedures, measurement of skill acquisition, and maintenance of skill across time. *Treatment delivery* involves the verification that treatment content and dose were delivered as intended through the use of tools such as manuals, record keeping protocols, and the recording and evaluation of intervention sessions. *Treatment receipt* allows researchers to ensure that that the intervention was received as intended by study participants and not compromised by factors such as literacy, education, language proficiency, environmental constraints, or motivation. Lastly, *treatment enactment* refers

to processes that allow for the ongoing facilitation of treatment strategies and skills.

We sought to create a fidelity instrument based on Borrelli's framework, with a particular focus on design, training, and delivery strategies. We created two versions of the instrument, one that followed the tradition of being administered to published reports, and one that surveyed authors of published reports about their fidelity practices. Both versions had the same item content, but one was scored by researchers while reading the article and the other was sent to authors for them to complete. The item content of instruments can be found in the PowerPoint slides from this presentation posted in the members' section of the MINT website.

Using the same criteria we used in our meta-analysis we identified all randomized treatment outcome trials conducted through the year 2004. Of the 82 studies that met our inclusion criteria, 59 (72%) of authors responded to the survey. Significant discrepancies were found between published reports and author surveys, including the use of a manual (39% vs. 64%), formal training practices (53% vs. 98%), and recoding intervention sessions for quality assurance purposes (32% vs. 53%). Detailed findings can be viewed in the PowerPoint presentation.

The presentation concluded that treatment fidelity is a difficult construct to measure. Clinicians were encouraged to think objectively about fidelity when making clinical decisions and researchers were encouraged to explicitly define fidelity practices within their publications. Improved practice and reporting of treatment fidelity will ultimately improve treatment and outcomes within our field.

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MI in Clinical Supervision

Anne Carden

I have been facilitating MI workshops for the past seven years. The educational backgrounds and experiential histories of my workshop participants has varied widely, and opportunities to assess their pre-workshop skills have been limited. Mindful of findings that suggest relatively poor follow-through after clinical trainings in general, I bundle into my training packages a full day for supervisors (who are expected to have already participated in my two-day orientation to MI) and three follow-up phone consultations to support the ongoing integration of MI into their service settings. I also request (and usually get) a pre-training meeting with administrators and supervisors in order to (1) explore their concerns about, expectation of, and commitment to the incorporation of MI into their agency's approach to consumer services, and (2) get a sense of how the proposed changes will fit into the existing infra-structure of the agency and how I might best support this process.

I have used some variation of my presentation materials (posted in the members' section of the MINT website) given the particular strengths, requests, and challenges of each group of participants.

When I address these issues at a training, I first engage participants in an exercise (solitary, small group, dyad, large group, or some combination of these) to give them an opportunity to generate and "unpack" their own lists. Only then, do I present material, connecting it to the group's insights. I use real-play and role-play throughout my supervision workshops and have found participants highly receptive to and interested in learning this way.

I welcome your comments and questions at cardenann@aol.com

Clinical and Research Dialogue

Michael Chenkin

A small but hearty group of MINTies had a spirited discussion of several topics. Of particular concern was the challenge of meeting the increasing demand by funding sources to incorporate evidence-based practices in the delivery of clinical services without a willingness to support proper training and implementation. The fact that proficiency in MI requires a significant amount of training and supervision was identified as being a possible barrier to widespread inclusion in the practice setting. One researcher participant enlightened practitioners by sharing the pressure to develop an efficacious product that could be easily packaged and utilized by a wide range of providers. He likened such a product to an "inoculation" and added that it would be nice if such a thing were possible. There appeared to be consensus that there is a need for greater sharing of information between researchers and practitioners and that it would be desirable to work together such that decision makers would make better choices about substance abuse prevention and treatment policy. With respect to the latter, the facilitator lamented the fact that there are neither a large number of practitioners nor of decision makers who attend major conferences such as the International Conference on the Treatment of Addictive Behavior (ICTAB).

Cultural Valuing

Edy Rodewald

This session continued a conversation begun on the listserve about training cross-culturally, following mixed response to the Adan (Quiet Man) video, where Bill Miller illustrates the use of reflections. Some workshop participants had objected to this video portion because they perceived a Native American client being depicted in a negative, stereotypical way. The agenda included: workshop participant sharing of cross-cultural training experiences; cross-cultural term definitions; differences in non-Western world views (context) and the need for re-building trust; and MI manuals adapted for working specifically with Native Americans.

The presenter demonstrated cultural valuing by opening the session by introducing herself and sharing something about her family, cultural background, and first language. Participants introduced themselves and shared their rich and detailed stories of cross-cultural experiences and challenges.

Differences in how affirmations, reflections, and empathy are communicated in various cultures were noted. One participant noted that, in her culture, a subtle response like moving the tissues closer to a client would be more appropriate than acknowledging the pain or tears of the client. Another participant's culture was said to generally perceive affirmations to be phony. One participant discussed difficulty with training reflections in a cross-cultural setting, stating the group considered them to be mind-reading, an unacceptable cultural behavior.
Communicative competence requires arranging a situation so that the group will trust and respond openly. One person shared that she needed to train interested community members/leaders outside the target group before she could get acceptance into the target group and begin training.

The American Psychological Association unambiguously advises counselors to commit to introspective "cultural awareness and knowledge of self and others". The enculturated training and techniques of most counselors reinforce embedded ideas of wellness, distress, disorder, and healing and make them appear to be "natural" rather than cultural, and therefore universal rather than local in their application. The Western world view is culturally institutionalized and relies on cultural assumptions—some of which are based on a "deficit hypothesis" that assumes that members of minority groups, because of isolation, poverty and cultural deprivation, experience deficits in intellectual performance and personality functioning ("psychology of race differences").
Many non-Western cultures have a history of being hurt by the Western culture (including practices by researchers, practitioners, and clergy members). To overcome this historical trauma, clients and training participants must be helped to feel safe, valued, and honored. Negative stereotypes are to be avoided and positive cultural group image and strengths promoted in training materials and videos. One participant shared she is developing training videos using Hawaiian counselors. Depicting individuals from minority groups in the role of counselor may facilitate a role change from passive objects to collaborators in the training and healing process. Because the concept of MI already fits well with a non-dominant world view, positive change can be brought about by emphasizing existing humanistic beliefs, non-judgment, positive motivations, and positive community role models.

Assimilation was described as the result of uneven acculturation between two very different cultures, with one culture changing significantly more than the other and eventually coming to look very similar to the more dominant culture. Assimilation can happen by force (as with conquered peoples) or voluntarily and is complete when only the dominant culture's values and behaviors are embraced by the minority culture individual. This sparked enthusiastic discussion regarding the (normal) defensiveness that a dominant culture approach may engender in a minority group. The presenter emphasized the need for both parties to be willing to change as a result of the coming together of different world views. The ultimate goal is that all voices will be heard and valued equally, and people who think differently will be able to act together for the benefit of humanity.

A big difference in non-Western world views is that mental, emotional, and physical states are viewed not as isolated states, but as sharing a continuum with spirituality. Non-Western worldview healing involves achieving a higher level of functioning than previously experienced rather than a return to the previous level of functioning. The non-Western individual is not isolated from a community and family context. There is a collectivistic valuing of the community's best interests above an individual's, and an emphasis on contributing to future generations.

Asking about a person's community resources, cultural identity, and spirituality can be helpful. The community can be tapped as a potential resource to build motivation for change and strengthen a person's commitment to change. One may ask, "For many people, family and kinship ties and community connections are important. What is important for me to know about your community relationships?" Asking about experiences with racism, oppression and historical trauma can lead to needs, challenges and sources of strength. One may ask, "For many

Cultural Valuing ¦ continued

people, cultural identity is important and people have different levels of comfort and belonging with one or more cultures. What is important for me to know about your cultural identity as we begin to work together?" It is important to be ready with referrals whenever possible. Always approach spirituality with sensitivity and be careful not to ask specific questions about spiritual practices as many are private and sacred. Explore whether spirituality or religion is/was important. One may ask: "For many people, their spirituality and beliefs are an important part of who they are. What is important for me to understand about your beliefs as we work together?"

Much of the material for this workshop came from two recently developed manuals by Kamilla Venner and Kathyleen Tomlin, MINT members who were unable to attend the Miami MINT forum. These manuals may be downloaded from the following websites:

Motivational Interviewing: Enhancing Motivation for Change – a Learner's Manual for the American Indian/Alaska Native Counselor, available at: http://www.oneskycenter.org/education/documents/MotivationalInterviewing1.pdf

Native American Motivational Interviewing: Weaving Native American and Western Practices, available at: http://casaa.unm.edu/download/nami.pdf

Training Lay People in MI-Based Brief Interventions

Marci Campbell & Carol Carr

Recently the MINT listserv has reflected a growing interest in training lay people as peer counselors, and the potential difficulties in doing this. Questions raised included: what is it that we are teaching, who receives the training, what skills/background do they need, how to deliver training, how to follow-up to know how the training is being used, and what do we call it?

Body & Soul is a national program being disseminated by the National Cancer Institute (NCI) aimed at increasing fruit and vegetable intake among African American church members as one way to address health disparities. The current program is based on earlier work of Ken Resnicow's and Marci Campbell's. In the earlier pilot study, lay peer counselors were trained over several days, had professional trainers, and needed to produce a taped interview using the skills taught to be able to become a peer counselor at their church. In the national dissemination there were no funds or infrastructure for this type of training and testing; therefore, we created a DVD to provide the training with a talk show format interspersed with demonstrations of the skills being discussed followed by brief interactive exercises to teach the skills. A manual was created for creating the Peer Counselor program, for providing the training needed (initially and ongoing), and for adopting and maintaining the program post-training. A second manual is for the Peer Counselors. It follows the DVD training, reproduces the interactive exercises, and includes FAQs about issues such as confidentiality. Both manuals are included on the DVD as well as on the Body & Soul web site (http://www.bodyandsoul.nih.gov). The skills taught are: open ended questions, reflections, building motivation through values, importance and confidence, and summarizing. A decision was made early on with NCI to avoid discussing theory and use of professional terminology. Therefore, we stripped these concepts down to basics and made them easy to comprehend and master. However, we also built into the talk show discussion why use of these skills lead to better communication and opportunity for behavioral change.

With funding from the Centers for Disease Control (CDC) and some additional funding from NCI, we have been evaluating the adoption of the Peer Counselor program in African American churches across the country. With the NCI funding we looked at immediate responses post- training with 1) professional trainers using the DVD and 2) church lay people as trainers. No significant differences were found. In both groups confidence in using the skills taught increased significantly. We also followed up with these groups to measure adoption and use of Peer Counseling within a 2-3 month period post-training. Few churches had started making calls. However, plans were in place at most churches to do more training (in the lay trainer group churches typically did not complete the full DVD training at one time, but broke it up into several segments). Our time frame was set by the NCI funding available to us for adoption evaluation. However, with our CDC funding we are observing the Peer Counselor training at 16 African American churches across the country and following up with trainers and peer counselors about it s use and impact. In addition, in this study we are measuring fruit and vegetable intake changes in the early intervention group of 8 churches vs. the late intervention group of 8 churches. In the pilot study we found that participants had significantly higher FV intake if their peer counselors listened, did not provide unwanted advice, and did less talking than the participant. We are asking these same process measures in the current study to determine if this finding holds.

Discussion during the session was positive. People felt that the DVD explained the basic skills clearly and stated they were planning to use the skill training sections in their own trainings in the future.

More information about this work can be found in our PowerPoint slides posted in the members' section of the MINT website or by contacting us at 1-919-843-7830 or at marci_campbell@unc.edu or Carol_Carr@med.unc.edu.

Motivational Interviewing and 12-Step

Looking for the Similarities Rather than the Differences

Jacque Elder & Dee-Dee Stout

"What's the difference between a sponsor and a vulture? The vulture waits until you're dead to peck your eyes out."

Circa 1988 AA, Pacifica, CA

In our presentation on 12-Step and MI, we hoped to show how the original texts upon which AA was built are generally MI adherent. Part of the reason we became interested in this—beyond our own 'memberships' in each organization—was the discussion between ourselves and others through the MINT listserv that there seemed to be some challenges in trainings with 12-Step counselors when it came to how to utilize aspects of MI in 12-Step based treatment facilities. We wanted to show how these two seemingly (to some) different concepts were actually quite similar, especially in Spirit. We also wanted to open a dialogue about the 'real' AA and to show these similarities while recognizing that there are of course differences. We see this as also in keeping with the AA concept of 'looking for the similarities rather than the differences' of things as a way to connect with rather than disconnect as we often did while using alcohol or other drugs. Furthermore, we feel that the misunderstandings regarding using MI in 12-Step programs do not come from the actual AA texts but rather are *misinterpretations* of those texts. So we looked at both the book known as the *Big Book* (of AA) and the book known as the 12x12, *The Twelve Steps and Twelve Traditions*, to see what MI adherence we would find, line by line. During our presentation, we managed to cover each of the 12 Steps of AA but sadly never got to the *Big Book* due to the number and nature of the wonderful questions and conversation about the 12x12 (the entire presentation can be viewed and stolen from the members' section of the MINT website, thanks to Chris Wagner, naturally!). Since one of the trickiest AA steps is the 4th ("Made a searching and fearless moral inventory of ourselves."), let's revisit that one for a short discussion here:

Step 4 & MI Adherence

- AA member gets to decide when & if to do it.
- Every 4th Step is considered "perfect."
- The choice to do more than one is up to the member.

As you can see, it is always up to the individual to decide whether, and how, to do a Step, especially one as potentially challenging as the 4th (MI adherent). Let's remember that AA as a whole states it is a "program of *suggestions*," reminding us that there is no authority in AA except a Higher Power (and as the individual defines this concept). However, we need also to acknowledge there are *individuals* within AA who seem to believe that they are in charge and have the authority to tell people what to do and how to do it. Again, this is NOT in keeping with either AA's Traditions nor the original meaning and texts.

And what about MI Spirit? Well, here AA is truly in parallel, we think. MI Spirit is about recovery! That is, when recovery is not limited to 12-Step, abstinence, and alcohol or other drugs but inclusive of those behaviors and any others and ways to treat them (all determined by the individual, naturally). We have defined recovery as these three (3) things: mindfulness, connectedness, and inner growth. *Mindfulness* as in **developing discrepancy**—who are you now vs. who do you want to be, for instance. *Being connected,* as in being connected to others as well as yourself (vertical & horizontal connectedness) and **personal responsibility.** Lastly, *inner growth,* as in changing or growing. We see this as **working with ambivalence** either as a clinician or a client. All MI adherent, eh?

There is a lot of history to help understand how this shift in AA occurred, the results of this shift, and perhaps what to do). Please see the full presentation for some of this historical information but here is a bit of it to help us see what's gotten us where we are today.

It seems that the real trouble began not so much with the inclusion of treatment into AA (though this was another reason for the changes in AA) but rather with the inclusion of AA into *chemical dependency treatment* in about the 1980s, surprisingly against the explicit opinion of AA's co-founder, Bill Wilson. He even stated his concerns to Congress (which obviously did not listen), in spite of his previous support of designing a national policy of AA-based AOD treatment. And so, here we are!

We are hopeful that this conversation will continue to grow. As both of us have students in our respective AOD certification programs that come from 12-Step, we have seen the struggles these folks and others have who believe that we are speaking heresy when discussing MI and treatment. They tell us it is a real affront to their personal recoveries and their often-newfound way of life. In many ways, it is as if we are challenging their religion (and that's a whole other conversation, eh?!). In practicing what we preach (pardon the pun), rolling with the resistance, expressing empathy, encouraging autonomy of thought, conversation, and personal responsibility in the classroom and out, and listening, listening, & more listening, we find that not only are our students 'getting' MI better but so are we. And therein lies the true Spirit of MI: we are always 'recovering' if we are if we are 'doing' it right—mindfully, connectedly, and growing—with love (and a goal, of course)!

Client Experiences of Motivational Interviewing

Henny Westra

Little is known about how clients actually perceive MI and the current study was designed to address this gap in the psychotherapy practice and research literature. Prior to undergoing four sessions of MI for generalized anxiety (i.e., worry), clients were asked to complete a brief questionnaire that asked them to identify what they anticipated about the therapy. Shortly after completion of the MI intervention, clients met with an interviewer and reflected on their experiences of the MI sessions in terms of their perceived role, the role of the therapist, the process of the therapy, change, and helpful and unhelpful aspects of the sessions. Interviews were audio-recorded and then transcribed in preparation for an intensive, grounded theory analysis of properties, categories and core themes evidenced in the MI clients' post therapy accounts. Five transcripts were selected for analysis based on empirical data indicating significant change in either optimism about anxiety management or worry pre to post MI sessions. The MI sessions for these 5 clients all received ratings of at least 6 (out of 7) on MITI ratings of empathy and MI spirit.

Below, we offer one illustrative example of two major subcategories from the client post-therapy interviews. We also indicate the frequency of occurrence of each category among the 5 interviews.

Positive Changes as a Result of MI

Increased Awareness (N=5)

"I just never stopped to think about that—she totally opened my eyes. A lot of it was opening my eyes to things because I obviously don't think about my thoughts in so much depth. And looking at the positive and the negative of the worry—I never really looked at it (before)."

Increased Anxiety Management & Decreased Anxiety (N=4)

"Seeing other ways that I can cope with anxiety, different strategies that are involved in my daily life. I got some ideas about what I can do to help myself."

Positive Impact on Others / Relationships (N=4)

"Yeah, the role I used to play is not so strong. And I think that all this dishonesty that I had with myself, really influenced my relationships with other people. I have this hope, this belief, that I can be more honest with myself and others. My kids have noticed for the past few days that I am more relaxed and I want to go out and do things. I have some plans to enroll myself (in school). They didn't see my lying around and withdrawn or isolated."

Increased Motivation for Treatment; Optimism about Change and Treatment Benefit (N=3)

"I am looking forward to the other part. It really makes me feel interested in how...my therapist mentioned that it's gonna be more practical. I am really looking forward to not only talking about my thoughts and feelings but also implementing these new skills in my daily routine. I'm really, really curious about this and how it will help me."

Experience of the Process of MI

Experience of the Therapist / Relationship: i) Careful Listening / Synthesizing (N=5)

"She was really with me. I felt that she was really listening to what I am saying and what I am trying to say. I feel she really likes me, that she enjoys the time, and I felt very friendly with her. I just looked at her face and felt she really tried to feel what I wanted to say. I found her sincere, warm and very expert in what she is doing. I felt that she really feels me—what I'm going through. She really moved with me so I was able to continue; She helped me to move forward, (by) thoughts or questions, or just some idea, or giving an example."

Experience of the Therapist / Relationship: ii) Nonjudgement (N=2)

"The way she was talking to me—she makes sure she's not hurting when she talks with people—she's very careful about that."

Helpfulness of Emotional Expression (N=3)

"It made me curious though about 'oh! ok, so maybe this is how I should be thinking? Or maybe, this is how I should monitor myself?' And at the same time, once I started to discover things, it was like, 'wow!' Some things hurt, some things were more like, ah-ah 'wow!' But some others were more like, 'wow! but that hurts.'"

Interestingly, the experience of the therapist and core facilitative conditions emerged far more frequently in client accounts of MI than technical elements or comments on their own role in the therapy. All clients reported careful listening to be helpful in different ways such as making them aware of their own previously

unrecognized thoughts and feelings or hearing what the therapist 'added' or perceived in their statements. In fact, when explicitly asked what the most helpful aspect of the sessions was, four out of five clients identified therapist involvement, feedback, or connection as the most useful therapeutic element. It was also striking to see how rich and differentiated client articulations of their experience of listening were. For example, one client stated, "I saw her as a mirror. I found it helpful to both hear what I was saying to myself as well as to hear what she took away from what I was saying." Another stated, "She seemed to pulling out key things in what I said and drawing my attention to them. She was really able to capture and summarize the key things I was struggling with." This client was surprised at the value of this since she 'rambles on all the time to people and then I don't notice anything'.

These qualitative findings largely support what we hope to achieve in MI and offer an important supplement to adherence measures of MI such as the MITI. That is, it is one thing to know that the therapist is doing MI, quite another to know if that comes through in the experience of the client. These findings suggest that clients perceive listening, summarizing, abstracting as very helpful and are attentive to the intentions of the therapists (e.g., acceptance, trying to hear the client). Future work will focus on comparing good and not-so-good outcomes on client experiences as well as rating client accounts for depth of the experience of listening and relating these to outcomes as assessed by quantitative measures.

Whole Systems Organizational Change

Lyn Williams

This workshop was aimed at building on the foundations of the Amsterdam Forum workshop undertaken by Denise Ernst and Mary Velasquez, which had explored the area of 'whole systems organisational change'. The idea had evolved as a result of their experiences and that of other trainers who have been asked to get involved in interventions in whole systems when training in MI.

The outcome of the Amsterdam workshop from the participants was a desire to develop a standard protocol/guidance for those who had an interest in how we respond to organisations that are looking at larger scale change. Furthermore that there was a general sense that the development of some guidance would be helpful and that this could then be posted on the website for trainers.

The aim of this workshop was to further stimulate and develop the discussion by presenting current evidenced based approaches in organisational development and change. The approaches were chosen as they aligned themselves well to the spirit of MI. The next step would be to then ask for a group of MINT members to come together after the workshop via the medium of email to develop the dialogue and a paper on:

1. What works well in organisations in adopting MI as a counselling method for clients?
2. What do trainers need in the form of guidance in taking on larger scale change programmes?
3. What are some of the models for change, and how MI could be developed as a framework for organizational change?

Within the presentation thoughts were offered on how to approach 'whole systems organisational development', through dialogue and positive psychological applications. Rather than taking a problem solving approach to change, and making the assumption that an organisation is a problem to be solved, changing the focus to appreciating and valuing the best of what is. The basic assumption here is that an organisation is a mystery to be embraced.

Current practices on interventions were presented in a series of slides for participant's consideration and were focused into the notion of positive dialogue as a basis for change which sits well with Motivational Interviewing. The whole approach to 'Whole Systems Organisational Change' has the service user/client at the centre of the approach and engaged in dialogue.

Appreciative Inquiry

One of the approaches suggested was that of Cooperrider's 'Appreciative Inquiry' (AI). AI is a process that engages people across an organizational system in a dialogue around renewal, change and focused performance. The main intention is to build an organization around what works, rather than trying to fix what doesn't, which is akin to the spirit of MI. One of the main benefits of AI is that there is an acknowledgement of contribution at the individual level, which will in turn lead to developing trust and organizational alignment. AI offers a systematic approach which is strengths based and it is an affirmative approach and has many similarities in its ethos and approach to change as MI. Organisational development is moving away from a beaurocratic, hierarchical, command and control approaches towards a system which recognises that we are connected and therefore we need to consider systems as a whole.

Human Resource Management

Engaging staff through sound Human Resource Management is a well documented approach to developing practitioners in the field

of health behaviour change. In England Drug and Alcohol National Occupational Standards which is a comprehensive set of competency based modules that have been developed and include Motivational Interviewing as a key competency in practice. Professional development plans and appraisal processes also help focus practitioners strategically into enhancing their practice through developing learning plans. Engaging human resource senior managers in whole systems organisational change is an important consideration.

Organisational Learning and Reflective Practice

Organisational learning is a characteristic of an organisation that adapts to constant change, and that is able to sense changes in signals from its environment (both internal and external). Organisational Development practitioners aim to work alongside their clients to enable learning from experience and incorporate the learning as feedback into the planning of organizational process. This approach sits well with the idea that practice supervision provides space for reflection on working with clients, so organisational change programmes need to build in the same space to reflect on the outcome of organizational learning and change.

Key Themes Highlighted in the Workshop That were Discussed and Will Need Further Development

1. *How do we develop guidance around the contracting and engagement in whole systems organisational change and beyond?* It was agreed that this was an area that requires further exploration as actual contracting stage is critical in regards how the process is then moved forward.

2. *How do we assess organisations and their aims and measure the effectiveness of interventions?* The trans-theoretical model of change can provide a basis for assessing an organisation's readiness for change, which could be further explored.

3. *How can we improve the environment/climate?* There was discussion on how awareness could be raised with commissioning organisations on what an MI consistent culture looks like. The focus for this could be on the three key areas that would assist in developing an MI-conducive environment within services as highlighted by Dr Miller in his column in MINT Bulletin 13.2. (Client-centredness being the fourth area which would keep the service focused on their experience): Collaboration, Evocation, Autonomy Support, Client-Centred. Reflective organisational practice creates space for studying what has worked well and an opportunity to check out whether change interventions are being effective such as improving the environment of a service. A clear understanding to what the change intervention is actually aimed at is critical for those involved. Feedback and measurement on the experience of change interventions is important, and this can be facilitated through focus groups made up of service users, key stakeholders and senior management representation. Making small changes can often make the biggest differences, and be most effective by involving the staff and service users; they are the experts in their context. Re-visiting organisational values and mission statements often help develop discrepancy between what an organisation espouses that they do and what they are actually doing

4. *What do you teach non-therapists, e.g., receptionists?* Discuss and agree with commissioners how far you want the climate and approach to be MI congruent; whole systems approaches need to include the frontline staff. Identify champions who will lead the way within the organisation and developing practice communities.

5. *How do you roll out organisational change?* A Project-Managed approach was suggested, and bringing together a group of people who will champion the change intervention. There were further questions around how do we manage, the control and accountability issues. The focus here in an intervention is that the commissioner continues to own the change process. There was agreement that MI can contribute by enhancing competence and efficiency during a change process, in that a coaching rather than an instructing approach is proven to work. Clarification of the goals and change process from the senior managers in an organization is an important part of organisational change. How do you also know what has changed if you don't evaluate the process to see if it is working? Engagement of managers is essential; politics can be an issue, and this needs to be borne in mind.

6. *Relationship with the commissioner.* The development of positive interpersonal working relationships with the commissioners of programmes and walking alongside helps facilitate change. For example, 'Is there any other way that I can help you?' Change from the top can be a challenge.

7. *Motivational Interviewing spirit and skills 'Whole Systems Organizational change'.* Further discussion is needed in developing MI into an Organisational Development approach.

A group of MINTies from the workshop interested in 'Whole Systems Organisational Development and MI' have volunteered their time to take this forward to the next stage through email. And we will update the MINT Bulletin with our progress in due course.

MINT Bulletin *Festschrift* Session

The Evolution of Bill, The Evolution of MI

Allan Zuckoff

Good morning, everyone. Thank you very much for being here, first thing, and welcome to the MINT Bulletin *Festschrift* Session: The Evolution of Bill, the Evolution of MI. Each year since I've been editor, the MB has sponsored a Forum session. Typically it's been a symposium session in which a particular theme that has been published about in the MB is talked about live. But it occurred to me that this year, in light of Bill's retirement from the University of New Mexico, we ought to do something different, and so I decided to create a *Festschrift*, and from that grows the *Festschrift* Session. For those who've been wondering, *Festschrift* is a German word roughly meaning "celebration publication." It is a common word in academia in honor of a colleague who has achieved a great deal and who is moving towards retirement or coming to a culmination. In our case it's not going to be quite so stuffy; in keeping with the spirit of the MINT, for our *Festschrift* the call for papers or contributions asked for a number of things: it could be an academic consideration of the work of Bill on MI, it could be reflections on how MI has affected the work of an individual or a part of the field, a reflection on how Bill and his work has impacted the individual either personally or professionally, and even thoughts on where MI is going or thoughts on where people think MI should be going. So we have a little bit of each of those this morning in the panel—and also, it could be something more creative, shall we say, as a way of expressing something to Bill, and we have something for that, too.

David Rosengren: So *Festschrift* is not German for shred-fest?

It isn't, so we won't be shredding anything this morning! Here's the program. We're going to begin with Terri Moyers, who will show us an enlightening slide show about the evolution of Bill, followed by a few slides and a talk by our beloved Dee Ann Quintana, who has come back here through the snow and everything else to be with us. Then we're going to have Charlotte Chapman and company with a special event, and then the *Festschrift* panel, consisting of David Rosengren, Kathleen Sciacca, Claire Lane, Chris Dunn, Chris Wagner, and Sandy Downey—so now the panelists know what order they're going in—followed by a little bit of time, at least, for any of you that would like to share thoughts on any of the themes that I mentioned earlier to have your own say, and concluding with some words from the guest of honor himself with reflections of whatever kind he chooses to make. So Bill will have the final word this morning, as he usually does. *(laughter)* So with that I'm going to turn the floor over to Terri.

*[**Theresa Moyers** presented a slide show with commentary, featuring pictures of Bill through the years, followed by a series of slides sent by Bill's friends, colleagues, and fellow MINTies to thank and honor him.]*

Next we have Dee Ann Quintana, who will give us her thoughts on Bill's career. *(applause)*

Dee Ann Quintana

Oh wow, there's a lot of you here. Allan, I need a drink! [Allan brings her a beverage] *(laughter)* For those of you who don't know me, my name is Dee Ann Quintana and I'm a Senior Program Manager at CASAA. That doesn't really mean anything, I just like the way it sounds: Senior Program Manager *(laughter).*

Bill and I met each other in 1988. Prior to that I don't know what he was doing but he wasn't doing it with me *(laughter)*. I was looking for a part-time job and Bill was looking for a part-time assistant and it was a match made in heaven.

When I started working for Bill in May he was doing all the administrative work for his grants. It's a lot of work, I was truly impressed, but by August he was gone, for a year, on sabbatical to Australia, and he left me with six graduate trainees and Dr. Reid Hester. I like him, now *(laughter)*.

After Bill returned from the sabbatical he started writing grants in earnest. He had the Midas touch. It seemed that everything he submitted got funded. I've taken a page from Bill's book, and I've prepared a slide to show the grant funding graph. Here it is—oh wow, that's the wrong slide, that's my blood pressure slide *(laughter).* Here it is—oh, look what happens if you overlap the two, it creates an interreactional effect *(laughter).*

Every time Bill got a grant that was funded he took great delight in creating the acronym for the grant. My favorite one, for one we had for a few years, was CRAB. I was the head CRAB and he was the Director of CRAB, and CRAB was me basically. There were others but luckily we were able to talk him out of using them *(laughter at slide).*

As funding increased and grants multiplied, it was clear to me that Bill needed an assistant all his own, someone who would work directly with him on all administrative things that were not grant-related. Besides, people who know me know I only have an interest in

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things that have a dollar sign in front of it.

It took me three years to talk Bill into getting an assistant, and I did a lot of talking. I knew exactly who it would be, I had her lined up, and when he was ready Delilah joined the team, and we've worked together now for fifteen years, the three of us *(applause)*. We've worked hard together *(laughter at slides showing Dee Ann and Delilah at leisure).* And yes, we've lost patience with each other, but never respect.

Bill, what a career you've had. What an amazing time we've had getting there. You've traveled to far off places, seen unbelievable things, have met unforgettable people. It truly has been an incredible journey. Thank you for taking Delilah and I with you.

Bill, Delilah and I have discussed your retirement, and we've decided we're not sorry to see you go—oh wait a minute, that's not exactly what I meant to say *(laughter)*. What I mean to say is that we're not sad that you'll be leaving your academic career, we're not sad because we'll still see you every Tuesday and Thursday in the office. And we're very happy to see that you're ready to complete the working part of your life and start the next: retirement. This also opens the door for Delilah and myself to talk about retirement plans as well. We were starting to wonder, just how long is he going to work? We would never leave you as long as we know you needed us.

Over the years lots of people have asked me about Bill, have I ever seen him get angry? Lose his cool? What's it like working for him? As I prepared for this talk I thought about those two questions and I realized that I've enjoyed working with Bill so much that I cannot believe that eighteen years have passed. We've raised children, seen each other though adversities, have had our feet put to the fire on occasion, and other than being a little singed, Bill's made it, and there's no one more deserving to retire. As far as Delilah and I are concerned, we will always be Bill's assistants. As for Bill losing his cool, I've seen it personally once, but if you did not know him well, you would not have noticed the subtle change *(laughter at slide)*. But sorry, everyone, there was no yelling, no screaming no cursing. Congratulations Bill *(applause).*

Allan Zuckoff

Thank you, Dee Ann. Our next portion of the program will be the creative portion. So we have **Charlotte Chapman and Chorus** *(applause).* Charlotte and company are going to lead us in song. It would be lovely to have everyone join in.

Farewell Song for Bill Miller

(To the tune of "Let It Be"
With apologies to The Beatles)

When I find myself in trouble training
His voice always comes to me
Speaking words of wisdom
"Reflect with empathy"

And though I may be weary
His words are right inside of me
"Dancing not wrestling
Reflect with empathy"

Empathy, empathy, empathy, oh empathy
There will be no confronting, just empathy
Empathy, empathy, empathy, oh empathy
There will be no confronting, just empathy.

And now he is retiring
What are we to do
When caught in an expert trap
Or just feeling blue

When faced with doubting researchers
Or clients who won't change
Who will be the voice of ambivalence
Helping to explain

Empathy, empathy, empathy, oh empathy
MI spirit is the answer and empathy
Empathy, empathy, empathy, oh empathy
So we sing this fond farewell… with empathy.

(Applause and cheers for Chorus)

David Rosengren

For those of you who don't know me, I'm David Rosengren. So we've all been really nice to Bill, so far. I need to tell you about the other side of Bill *(laughter).* So you saw the Project Match PI's up there [during Terri's slide show], they're all looking young and… young. There were other people below the generals. I was one of those, I was one of the captains. I was a project director for the Seattle CRU of that little endeavor and for those of you who don't know it, it was this massive undertaking and we would have steering committee meetings that were about the size of this group. And we were about as effective as probably this group would be if we tried to decide something about one issue or another. Meanwhile, Bill was off in Australia doing some crazy thing, writing a book, who knows what that was, Motivational somethin' or other? And then Bill came back, and funny thing, they put him in charge of the steering committee meeting because they figured Bill could straighten this stuff up. So the first thing that Bill did was say that only PI's could come to the steering committee meeting, so we went from a cast of thousands to eleven or nine or however many there were. Unfortunately this group in the past had had a history of instead of making decisions, adding on new things to the study. And as one of the captains who were going to be responsible for making this thing actually happen in the next six months we had a lot of concerns as a group that they were going to continue adding things and not making decisions. So I talked to my PI, Dennis Donovan, and I said, "I think you guys need a project director there to kind of talk about the realities of what we need to make this thing happen." It seemed like a good idea at the time, and Dennis said, "Great! Come."

So I came down to Albuquerque. I had never met Bill before. And there's Carlo Di Clemente: "Hi Carlo," I had met him at a previous meeting; "Nice to see you, glad you're here." Gerard Connor: "Glad you're here," Kathy Carroll, and

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then I meet Bill: *"You didn't get the Memo?"* "Well, yeah, I did Bill but we think it's really kind of important to give you the message that we need some decisions at this meeting," and Bill said, "Message received. *You can leave now."* And I'd made it about this far into the room, and I'd met the bouncer *(laughter)*. And he wasn't kidding, and he just stood his ground with the same sort of resolved look you saw on some of those earlier pictures.

So I spent the next three days going around with Bob Myers seeing all there is to see of CASAA and Albuquerque, I think I went through the town twice. The funny thing is, after that, the PI's made a decision that we should have a project director at this meeting as a representative to help them get things going. So six months later there was a meeting back in Santa Fe, but we came to Albuquerque early.

So I came into Albuquerque, and I saw my buddy Bob Myers, he and I had gotten tight after spending three days together. And Bob said, "Hey, Bill's having a party at his house tonight, why don't you come?" *(laughter)* and I said, "No Way! *(laughter)* I've been bounced once, I'm not goin' twice!" He said, "No, no it'll be fine." I said, "No, no, you *call* Bill before I come *(Laughter)*. So Bob called, and the upshot of course was we went, and Bill came in and he was very welcoming, and he said, "*It's only business." (applause)*

Kathleen Sciacca

When Allan asked us for a tribute to Dr. Miller, I guess I'll be one of the more serious speakers here, I took the opportunity to detail the immense contribution he has made to the field of dual disorders. I work very intently in that field. I've worked in that field for more than twenty-two years. I'm not sure how many people are aware of just how important Motivational Interviewing has been to the client population that includes severely mentally ill chemical abusers, with mental illness, HIV, homelessness, criminal behaviors and healthcare problems, who were essentially a rejected, dejected population when I encountered them in the 1970's and the 1980's and when I began to push myself to develop programs for them. One of the important things was that MI provided a model that included the elements necessary to really work with co-occurring disorders. This includes non-confrontation, stages and phases of moving people through the process of change, humane acceptance, and more.

Of importance is that the MI model came from the addiction field. My own work came from the mental health field and dual disorders work requires cross-training across multiple disciplines and systems, therefore teaching a mental health non-confrontation model to addiction providers in 1984 was a stretch. Having an addiction model that adhered to these same principles was just very exciting for me and from the time I learned about MI in 1991 I integrated it into my work in the field of dual disorders.

I'm a graduate of the New School for Social Research, which was founded by the professors in exile, Köhler, Werthheimer, experimental psychologists. The first thing that came to my mind when I began writing my tribute to Bill were Köhler's words in the first paragraph of his book on Gestalt psychology in 1947: *"There seems to be a single starting point for psychology, exactly as for all the other sciences: the world as we find it, naively and uncritically."* And certainly MI is a derivative of that premise. In my work it was experienced certainly in the 70's and 80's that the dually diagnosed population were not uncritically accepted, rather they were unacceptable and they were critically unaccepted. MI really cut right through that bias and came through with a number of important concepts, the first one being *acceptance facilitates change.* Other important derivatives, *expressing empathy, supporting self-efficacy, rolling with resistance,* the power of *hope* and *faith.* The *counselor expectancy effect*, which at the time when I started working in the field of dual disorders was that *we don't want to work with these people, there's no hope for them, they can't make it.* I just want to point out that we were working with people who were physically addicted to drugs and alcohol with flaring mental health symptoms who were actively using and who didn't have any concept or idea about changing, were afraid to even talk about their substance use because they would be thrown out of programs, or rejected in other ways.

I would like to talk about the scientific importance of Dr. Miller's work and all the effort and hard work he puts into the science of research and how it has really given MI a legitimate place in the field of dual disorders. His research has provided documented outcomes and this research was included in the report to Congress on the Prevention and Treatment of Co-occurring Substance Disorders and Mental Disorders written by SAMHSA in 2002. The report advocated for various interventions for co-occurring disorders and many of the different MI research projects were written into that report thereby heralding MI an evidence based model that was effective for co-occurring disorders. MI really gave the field a premise of some scientific value.

I want to make sure we don't leave out some of the more global benefits to the clients and to the programs in general. In the field of dual disorders it is a premise that we treat all symptoms simultaneously, we don't wait until one clears up and then look at the other one or try to figure out what came first or second, and MI can do that; we can design plans with multiple symptoms and multiple levels of readiness to address symptoms, it is very complex. Some of the benefits of integrating MI into dual diagnosis for clients in general are *empathic acceptance*, interventions that improve the engagement potential for many clients who have been disengaged, they're homeless, they're in the criminal justice system, they are disengaged from treatment due to rejection and/or lack of competent care. Client centered interventions

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facilitate gaining knowledge and understanding of each client's values, who they really are, interacting with the client themselves, versus what we find in many systems, the medication model and symptom-focused interventions where providers are not really engaging with the client at all. Group treatment has evolved as a primary treatment approach for co-occurring disorders, and the inclusion of MI materials and concepts in the psycho-education element is invaluable, for example, teaching people the process of decision making. Whether groups are conducted with MI topics and materials alone, or MI materials and interventions are integrated into other existing groups the benefits to clients enhance their recovery. In addition, providers who treat co-occurring disorders learn another comprehensive set of principles and skills that really enhance their work.

I just want to close with this. In co-occurring disorders we usually begin our work with people who are not ready for change and the concept that people change in increments is of great value. In contrast it has been construed that we have failing programs and failing clients because people can't reach action or can't get into action fast enough. Providers can really get it, they feel that the burnout of having to make people change who are in no way ready, or even know what's wrong with them is unrealistic. This is in contrast to providing interventions that move clients along a continuum where they can incrementally and strategically facilitate people to move along in the change process, and chart successful outcome through increments of change, rather than failing outcomes with one global measure, action or non- action. I just want you, Bill, to know how important that is to the people who work in the field of dual disorders, and *we* thank you. *(applause)*

Claire Lane

I kind of feel a bit humbled standing here cause I've only been a MINTie myself for a year, but I felt that I wanted to contribute this because I felt I had to let Bill know about what an effect he's had on my life. It's slightly because I'm not a clinician, I don't work on the ground, but I used to once upon a time. A lot of people ask me Claire, what's your background? What do you do? Are you a psychologist? No, I'm not a psychologist (yet!) I'm actually a linguist. I graduated from a linguistics background, and I kind of graduated knowing that I wanted to work with people, but I didn't really know what I wanted to do.

I wanted to do something where I was communicating with people. I don't think helping's quite the right word, but I felt I wanted to make a contribution, so I ended up taking a job on a program that runs in the U.K. called New Deal. Now, this is an employment program, working with long-term unemployed people mandated to attend a course of job search, work training and work placement in the hope that they'll give them this dose and then they'll just go off and won't be a problem to the system anymore—they'll just go and get a job. I think that anybody working in that field knows that these people have been unemployed for a long time for a reason. It was stressful, and it was quite challenging being 21, going in and talking to people who were your parents' age and trying to empathize with them and be there for them. I felt I was lacking something in it because I actually enjoyed doing the practical work, but it didn't really have the intellectual stimulus for me, so I thought well, I want to go on, I think I want to go into research and want to do something more and use my brain.

As I thought about that I noticed an advert for a studentship in Communication in Healthcare with a guy called Rollnick. I thought, right, okay, this sounds like it might be good, so I'll just google this Rollnick guy and find out what it's all about. That was the first time I'd even heard of the name Bill Miller at that point. I thought, this stuff is absolutely fascinating, because as a linguist I know that the way that you say things and the way that you talk to people can have such a profound effect on their lives, so I applied for it and the rest is history, I'm obviously here now.

When Allan put out the thing on the listserv and said perhaps you'd like to reflect on what Bill has meant to you in your life, I began to reflect on the first time I met you Bill, which was last year in Amsterdam. People had always said to me in Cardiff, because you know, Steve's old news out there, no one really cares about Steve very much *(laughter).* Well, that's probably being a little bit mean, but you know, he's kind of 'just Steve' to us—we see him every day! *(laughter)* Well Bill Miller, wow—they are all in awe of the unknown quantity known as Bill Miller—they have all asked me "What's Bill Miller like?" And I'm like, "I don't know, I've never met him."

But, I did meet him last year, and he wasn't what I expected. In my head I was expecting him to be like an American version of Steve. *(laughter)* I was absolutely dumbfounded by what I saw because they were absolutely nothing like each other. Can I have my first slide please, Allan?
(laughter at slide—photo of a bowl of cornflakes, and a pint of milk)

I thought, yeah, corn flakes and milk, they're nothing like each other at all, but when you put them together they actually create something that's quite beautiful and wonderful. But as another MINTie mentioned to me last night, who shall remain nameless, "If you leave them together too long they're bound to become a bit soggy" *(laughter).* If I could move on to my next slide please, Allan. [slide of Claire's wedding photo]

Right, now this is something that happened to me in 2003, I married my boyfriend who is now my husband, Graham. I was working with a bunch of medics, they all decided that it would be really funny to go around saying that I'd used motivational interviewing to get my boyfriend to marry me *(laughter).* But there's many a true word said in jest, and I wouldn't say that I used MI, but I learned a lot of communication skills *(laughter)* that motivational interviewing incorpo-

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rates. And amplified reflections when you're having an argument—very, very useful! If I could have my next slide. *(laughter at a slide: a photo of Yoda from Star Wars)*

Where am I going with this? Well I actually made the mistake last year of getting Graham to proof-read my PhD thesis for me, and he came storming upstairs and said, "You've manipulated me!" I protested, "I didn't manipulate you!" He replied, "All this stuff you're writing about here in chapter one, all the skills used in MI, you do that with me, whenever I'm not sure of something you sit there and you do this reflective rubbish with me... and it works really well!" *(laughter)* He continued, "So what's all this 'MINT' thing? Are you all like Jedi Knights going round using the force on people?" *(laughter)*

I just put that [slide of Yoda] up because that's my husband's perception of Bill OK *(laughter),* and I think I'm going to leave it there.

I just want to round off by saying Bill, may the MINT be with you, always! *(applause)*

Chris Dunn

Okay, this is the last time I'm going to tell this story. It's about a one-second event that happened at the Maui TNT in 2002. And I was very proud and excited to be co-teaching at the TNT in Maui with Bill and Terri. All through grad school I was told that I was a bull in a china shop, I had an impulse control problem *(laughter)*. And I don't really think those psychologists thought I'd make much of myself, so here I am up here in Maui co-teaching with Bill Miller at the world conference and I'm thinking, "What would those jackasses think now, huh?" *(laughter)* So on the first day I'm a little nervous and rattled, I'm just trying to get through the day without screwing up; I'm starting to loosen up a little bit on the second day, which is good and bad *(laughter)*, and we were taking turns teaching, and the theme, one thing that came up was Martin Buber's book called *I, Thou*. He was a theologian and a philosopher and he was talking about beingness, that's ***b*** as in Boston, **~~e-i-n-g-n-e-s-s.~~** Like how you *be* with somebody is really everything. And so then it's Terri's turn and you know, she comes up the aisle, and like, poof!—she drops this bomb, and she says, "How do you teach the spirit of motivational interviewing?" And Bill and I are standing over here as I recall, and you're not supposed to answer the question, right? I got that much figured out. So I'm thinking, "But I know the answer!" *(laughter)* Oh it was hard, and no one was saying it! And I'm thinkin', "I can do it for these people," so I'm thinking, count to five, and if they don't get it, I'll answer. So it got to five and I blurt out, but I bobbled it, I said, "Use your Be-ness!" *(Laughter)* That's ***b***, as in Boston, ***e-n-~~e-s-s~~***, but it seems like everybody heard as in "johnson," that's what they heard *(laughter)*, and so they exploded just like that. And then there's this second that comes up, where Bill show's what he's made of, it's just silence, and everyone looks, even Terri is silent *(laughter),* and I'm just standing there. And everyone looks at Bill and he goes, "Now that's *out* there." *(laughter)* And I'm thinking, you know, this is where they ask me to go home *(laughter)*. And it wasn't judgmental, it wasn't punitive, there was maybe a little concern *(laughter)* but it wasn't like, "You sick ----". So that was Bill, if that didn't trigger admonitions or judgmental-ness, then I don't think anything will. That's my story about Bill. *(applause)*

Chris Wagner

So Bill's retiring right? Not from MINT but from his career, from full-time work. Yeah right, right, right. He's going to ratchet down to a merely human level of activity! Bill, have you written an article yet since you've been here the last few days? *(laughter)* You don't need to answer, you'll make us all feel bad.

So some of us were talking about it, trying to imagine Bill retired, trying to picture it. Nothing came to mind. So we decided we needed professional help. Bill, could you come here for just a second? So we got some professional help to try to imagine Bill retired. Bill, could you open this? [presents scroll] Take a look at that. [Opens scroll]

Bill: "Hey look at this!"

We can show it to everyone. [Drawing is displayed] So there's Bill retired, with a cactus for a body, with a little bolo tie on *(applause).* Just to keep the spirit, we're going to keep this guy up here behind us [PowerPoint slide of caricature]. You should have seen the caricaturist as we were presenting him with these little teeny photos we printed off the web at Kinko's last night. And he's like, "I can't do this, I can't do this without seeing the guy." Pretty good, right? Right!

Please look around the room. Raise your hand if you have a friend here [all raise hands]. Thank you, Bill, we're all friends because of you, and this is amazing. Thank you! *(applause).*

I'm from a small farm town in Indiana. I grew up wanting to be a mailman, because I thought it was really cool, I'd get to be outside walking around, and I'd get to know everybody in my little town of a few thousand people. I now have friends not just in my town, not just in my state of Indiana, not just the United States, not just North America, but all around the world, and it's the most important thing in my life—well, don't tell my wife that *(laughter)* , but other than my family, and I just can't tell you how much I appreciate it.

MINT, *us,* Bill says it wasn't his idea. I think he's a little modest. Bill was talking about when he and Steve realized they couldn't train everyone in Motivational Interviewing, which, just that comment yesterday, I was laughing, that there was ever an idea that the two of them could train everyone. He looked around and said, "What do we need to do here?" What could he have done? He could have come up with some lock-step manual to write and say here's how you learn it, without any personal touch. Instead, what did he decide to do, along with Steve? Have workshops, go to places people wanted to be at, develop a

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process to choose the right people who would be able to take these ideas, make them their own, bring them to others in a living kind of way, have international workshops, develop a participatory community, us! Encourage us to think, encourage us to be ourselves, bring ourselves to training and make MI come alive.

Over time our participatory community I think has started to do participatory development of MI: *OARS, dancing versus wrestling*, this idea of ditching this "*avoiding argumentation*." These are things that have developed as a community and have worked their way into MI. Seems to me like Bill reads every message on the listserv, he doesn't always reply but it seems he always kind of knows when a topic comes up and it's been on the listserv. Some of you know that it's a little busy. It seems to me we're all developing MI now. And that's because Bill and Steve chose to bring in people from different cultures and different professions working with different issues and different populations and it seems to me it led to these different cultures and ideas being embedded within MI as it's developed as opposed to a model where MI was just exported to other countries and other places and other cultures. It's seems to me that it's developing now in a communal, organic way.

And as I look forward, I think about what can we do to prevent MI from becoming frozen, becoming something that just is one thing and when Bill stops writing about it, it stays locked like that and then it fades away. You know, not to pick on other approaches, but like transactional analysis. Someone may have something to offer, but it's of a time, it's of a place and it never changes. What I hope is that we can continue to have this as a living therapy, something that develops and grows. Bill's encouraged us to learn from our clients, right? My hope is that we keep learning from our clients, we keep on learning from research on what is motivation, what helps people figure out how they can live more satisfying lives. It seems to me if we become too attached to the current techniques as they are right now Motivational Interviewing will die off in the end, instead of having a living therapy that will bring in new data, not just new data of the kinds we have now, but new types of data, qualitative data, client perceptions and reactions, and what they've learned and what they can teach us about MI, by reflecting back with us. Theory development and making friends with our MI neighbors, much as we've made friends with one another. One thing about MINT, we're all very communal and yet it seems to me there's person-centered therapists out there, a whole group of people, there's cognitive behavioral therapists, a whole group of people, the twelve step culture, all these people who are trying to help one another, and as we've made friends with one another, we can reach out and make friends with our MI neighbors and keep this alive and keep this going forward. Thank you, Bill, for that spirit that you've given us. *(applause)*

Sandy Downey

I put my thoughts together in the form of a letter, Bill, and I would like to read that to you now:

Dear Bill, I wanted to tell you about the profound impact that MI has had on my work and in my life. For a while I had difficulty finding the words to capture what I have experienced since I first began learning MI in 1998. Then one evening when I found myself alone and able to reflect in a quiet house, as I sat down to write it occurred to me that you have already described the essence of what I wanted to say. In the February 2004 edition of the *MINUET*, you wrote in your column, *From the Desert,* an article entitled "Transcendent Moments." In it you describe an experience that is sometimes reported by practitioners of MI in which the practitioner is fully present, and experiences a transcendent, loving and powerful moment of oneness with the individual before them. You write that practitioners have described it as "a qualitative shift in my consciousness" and further summarize their experience by stating, "I am fully and literally present with the person. My whole loving attention is focused on the other, whom I experience with awe-filled respect." You offer further support of this experience in the writings of Carl Rogers, when he asserted that "our relationship transcends itself and becomes a part of something larger. Profound growth and healing and energy are present." Then you note that Brian Thorne also described a mystical kind of experience as a counselor, in which "a new level of understanding is achieved and a sense of validating freedom is experienced by both client and counselor. The surge of well-being that follows such moments is almost indescribable."

When MI began to become a natural way of being with my clients, when I didn't have to concentrate so hard anymore on what to do, I began to experience this type of meaningful connection within the therapeutic relationship. Over time the experience has grown and intensified and become a part of my daily experience surrounding my work as a therapist. It is apparent to me that the empathic, accepting, non-judgmental, strength-based and values-focused approach so central to MI facilitates this sense of oneness and purpose. This leads, I believe, to healing, growth and transformation, for both the client and therapist.

In the preface of MI-One, you and Steve provide a word of caution and informed consent regarding the use of motivational interviewing because practicing MI changes you as the practitioner. That certainly has been the case for me. It has transformed me in many ways both inwardly and outwardly. Outwardly for example, I have become a much stronger and more assertive advocate for my client's needs. I actively seek to develop my knowledge and skills in a variety of clinical areas, to become a better therapist with a greater capacity to provide effective treatment for each person I see. I now take crazy risks, like traveling to another country by myself, despite a travel phobia of sorts, so that I can be with others

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who share my value of helping people in a respectful manner. I used to shy away from counseling-related speaking engagements. Now I eagerly await my next opportunity to help others learn motivational interviewing. I remember to be accepting and kind to all others more often.

My inward changes are more difficult to describe but reflect the deeper connection I feel with my clients on a daily basis. I deeply trust their inner wisdom, personal strengths, and unique gifts and talents. Their desire and ability to have a better life and develop who they were meant to be, is moving. I literally experience a high following many of my individual and group therapy sessions. This feeling stays with me and gives me strength to continue on in this meaningful and sometime difficult work. I am energized by my work with my clients and feel privileged to work with them. I am aware that I learn so much from them, and they help me to be a better person and therapist through this collaborative therapeutic relationship.

Motivational interviewing is indeed powerful. Of greater significance than MI's influence on me is the transformation I have been fortunate to witness in the lives of my clients. Returning to the idea of profound growth and healing that you referenced in your article, I have observed countless moments of growth, healing, courage, positive risk-taking, caring for others and efforts to change that are truly inspirational. MI creates an environment that enables my clients to feel safe to explore all aspects of their behavior. They are afforded the time and space to come to a decision at their own pace regarding their readiness to make changes. Through MI, they experience empathic understanding, caring and acceptance within the therapeutic relationship. Because of this, I continually observe my clients giving voice to their own concerns about behavior they hope to change. I see them grow in their confidence to change, begin to take steps towards a brighter future and develop a clearer sense of who they truly are. It is common for many of my clients to share their reactions to this therapeutic experience in both individual and group therapy sessions. To illustrate, a young woman that was very angry and depressed said "I felt happy" following her first MI therapy session. She shared that she had rarely felt happy in her life, and was surprised to feel this way. Another nearly despondent man later shared that he had asked himself following his initial session "Could this be the start of something good?" It was, he has made so many very difficult changes already and continues to set new goals for himself. In my group work I often listen intently as clients report finding therapy to be a positive, enjoyable and beneficial experience. Frequently such reports emerge despite many of them having been coerced into treatment by others. Recently a group member referred by the court system and initially angry about being there spoke about how treatment has become something she looked forward to at the end of the day. Another member, on the same evening, declared that even though her required treatment was complete, she was choosing to stay on a voluntary basis to work on additional goals.

Experiencing a sense of oneness and purpose in my work with my clients, and witnessing once unimaginable life changes occur for so many continues to amaze, inspire, and transform me. I am grateful to you for your work in developing this transformational therapeutic approach. It has provided me with a renewed understanding of the capacity of people to achieve their very best, and it has provided my clients with an experience of caring, compassion and hopefulness that makes change possible. Congratulations on your achievements and retirement. *(applause)*

Allan Zuckoff

Thank you, Sandy, and thanks to all. We now have time for anyone who'd like to share their thoughts. *[Comments by several participants]*

Paul Burke

Thanking You

(To the melody of "Calling You" from the album "Bagdad Cafe", written and produced by Bob Telson. Original performance by Jevetta Steele)

On a desert road,
Somewhere in New Mexico,
A new way of being, was born into this world.
And we're here to thank you —
For all that you've given,
For listening to Spirit —
And to the callings it brings.
(Hear it call you)

"I am calling you."
"I am calling you."

The voice of the Spirit,
Now whispers its "thank you"
(The voice of change, always whispers its words).
Your voice of compassion —
We learned by example.
(When we listen so deeply,
Our Spirits will to be heard.)

"We stand here to thank you."
"We stand now, to honour you."
(You.)

We want to thank you. We thank you. (You.)

And we're here now to thank you
For all that you've given,
For this new way of being,
And for the healing it brings.
Thank you for listening.
Thank you for teaching.
Thanks for liberating —
Your gentle Spirit of change!

On a desert road,
Somewhere in New Mexico,
A Quantum Change,
Breathed new life in our world.
(Applause)

Bill Miller

Well I'm certainly not an American version of Steve Rollnick, my dear bushman friend, and I never wanted to be a mailman. I did think about being a desert monk, and it's a challenge for me as an introvert to hear all this, but you make it easy to hear. I thank you for that.

Motivational interviewing has

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been an amazing ride for me. When I sit with a client, I don't have a sense of "doing something" or of being in charge, but rather I have a sense of being a privileged witness to the change that happens in front of me. I don't have a sense of ownership, or of having created this approach. It was elicited by a community in Norway, and I've watched it unfold. Together we've been riding this incredible wave that's going somewhere very powerful, and the power doesn't come from us, but it's there. We are not the wave, but thank goodness we've at least got a board to ride on. If I have contributed something, perhaps it is that I've helped to provide a board with which to ride this wave.

It's not my spirit that we've been talking about here. I don't give that spirit to anyone; that spirit is something that we all share, and that our clients also share and is in all of us. It does get covered over sometimes. We do forget about it as human beings, think of others as objects or enemies and lose touch with that spirit that is in us and that connects us. It is not ours to control, not ours to give, and not ours to bestow in any way. It is only to call forth, for it's already there in everyone. In my own understanding, it is the loving spirit of God that we're talking about. It's the spirit that the quantum changers whom we've had the privilege to interview got just a glimpse of, and it changed them forever.

And so I am very blessed that we together have opportunities to call forth that spirit in each other, and in those with whom we are privileged to work. Thank you.

Editor's Note: I am deeply grateful to Harry Zerler for recording and transcribing this session, so that it might be preserved here.

MI in Behavioral Health Settings

Jonathan Krejci & Michael Giantini

In the first part of the workshop, Michael Giantini focused on systemic issues in implementation. He shared information on agency and larger health care system implementation of evidence based practices from the National Implementation Research Network (http://nirn.fmhi.usf.edu), a US agency funded to review and disseminate research in the area of implementation of behavioral health practices, and the US Substance Abuse and Mental Health Service Administration's (SAMHSA's) Center for Mental Health Services (http://mentalhealth.samhsa.gov/cmhs). Particular emphasis was placed on: 1. Use of active and qualified purveyors of the evidence-based practice (purveyor = consultant– trainer, who interacts at multiple organizational levels), 2. Systemic use of implementation drivers (a process for Continuous Quality Improvement (CQI)) focused on the evidence based practice, including administrative policies, outcomes and fidelity measures), 3. Vertical integration: to align larger systems in the implementation process in order to support improved outcomes, and 4. Attention to the stages of implementation: Exploration, Installation, Initial implementation, Full implementation (2 to 4 years for these first four stages), Innovation and Sustainability. The information is complementary to published work on MI training and implementation.

The second part of the workshop, presented by Jonathan Krejci, described a specific effort to implement "good-enough" MI in Princeton House Behavioral Health, an outpatient substance abuse and mental health treatment setting in which:

- Staff are interested, but very busy, and work at five geographically dispersed sites;
- Rigorous fidelity measures (scales, tape review) are probably unrealistic;
- Most treatment is provided in a group format, in the context of an intensive outpatient or partial hospital program day;
- Group therapy membership is constantly shifting;
- Presenting problems (target behaviors) and motivational levels are varied.

The model presented included:

- A series of brief one-hour presentations on MI, with the goal of introducing shared concepts and language;
- Training of clinical supervisors, with the goal of helping them integrate MI concepts and techniques into regularly scheduled clinical supervision;
- Follow-up case presentations following an MI-consistent format;
- Development of a goal-oriented MI checklist;
- Creation of a group-based MI manual.

The goal-oriented checklist is designed to help clinicians consider MI-consistent interventions in response to specific clinical goals and dilemmas, and to structure clinical discussions. Each goal is matched with suggested MI interventions, for example:

Goal: Assessing motivation

- Identified a target behavior
- Identified stage of change
- Used importance, confidence, readiness ruler
- Differentiated between different areas of motivation (e.g., substance use vs. mental health; treatment vs. change)

The group-based MI manual includes guidance for group leaders, along with group exercises and activities appropriate for clients with a wide range of target behaviors and motivational levels. Topics include:

- In-depth discussion of spirit and microskills;
- Is MI Appropriate in Crisis Situations?
- Establishing and Maintaining an MI-consistent Group Climate;
- Establishing a Target Behavior;
- Blending Individual and Group Process;
- Normalizing Motivational Differences;
- Responding to Resistance in a group setting;
- Combining MI and Skills Training.

The Behaviour Change Counselling Index (BECCI)

Your Questions Answered!

Claire Lane

Within this session at the Forum, time was quite tight. I heartily admit that as a result, I almost fell into the 'expert trap' that the nurses and GPs I have trained often fall into when they are pressed for time. I came up with a number of 'short but sweet' PowerPoint slides and a regimented minute-by-minute plan that I fully intended to inflict onto the poor, unsuspecting Minties who came to the workshop. The night before however, I had second thoughts, and decided that an 'elicit-provide-elicit' approach would probably be a little less sleep inducing! For my sins, this meant that I overran into Michael Madson's time by about 10 minutes, and am taking this opportunity to publicly apologise for that...

In writing up the session, I have chosen to focus on the questions that were raised by the audience.

What is BECCI, and Why was it Developed?

BECCI is a twelve-item, global rating measure that assesses practitioner competence in the behaviour change counselling (BCC) adaptation of MI.

It was initially developed to satisfy a local need regarding BCC training in Cardiff, with trainers rather than researchers in mind. We were looking to create an instrument that could provide an overview of a trainees' competence in BCC at different stages of training. We wanted to know what skills they were using well, and which ones they were not using quite so well.

Back in 2001 (when the development work started on BECCI), the only instrument in existence that could potentially do this was the MISC, which was recognised as quite complex and time consuming for a trainer who had twenty eight-minute consultations to score before the next training session[1]. Trainers needed an instrument that was quick and easy to use, and could reliably be scored by somebody with a good general knowledge of MI. To this end, we aimed to design BECCI with these users in mind.

How Do You Use BECCI?

Each item is scored globally on a likert scale from zero (not at all) to four (a great extent). BECCI has a scoring manual which gives guidance as to what constitutes a high and a low score. One comment was made during the session that the statements in the manual are quite broad. During the development of the manual, we did try to add descriptions for each discrete point on the likert scales, but this made consultations harder to code, and reduced reliability coefficients both within raters and between raters.

Another question that was raised was 'How do you derive an overall score on BECCI?' An overall mean score across items can be reliably derived. However, as a trainer, I actually find it more helpful to look at individual items to see where people could improve their practice.

How Does BECCI Differ from MITI?

BECCI and MITI are complementary to each other—BECCI is subjective and MITI is objective. BECCI produces an overall rating of competence, whereas MITI provides behaviour counts. Scoring on the BECCI is as much about the quality of the behaviours as the quantity.

The biggest difference between the two instruments is that BECCI was primarily aimed at trainers, rather than researchers. It was designed to be picked up and used by someone with a good basic understanding of MI/BCC, rather than having to attend a coders' training course. BECCI has also demonstrated excellent sensitivity to changes in BCC consistent behaviour at different stages in the training process.

What Research has been Done with the BECCI?

BECCI was developed as part of my own PhD research and was tested for validity, reliability and sensitivity to change.[2,3] One study that involved the use of BECCI during the training of diabetes specialist nurses in BCC has been published.[4] Another study that formed part of my PhD (which compares the use of simulated patients with the use of role play in acquiring skills in BCC[2]) has been submitted for publication.

BECCI will also be used as part of the Pre-Empt study in the UK (an RCT of the efficacy of using BCC in primary care).

Can You Use BECCI as a Training Tool?

I can only talk from my own experience, but I actually chose to use BECCI for this purpose within an action research project that I worked on in South Wales. This study was based in a cardiac rehabilitation team, with clinicians from a range of disciplines (including nurses, physiotherapists, dieticians and psychologists). The overall aim was to help the clinicians to incorporate MI into the different aspects of their service delivery. At

the start of the project, we encountered quite a bit of resistance from practitioners who objected to having their training consultations assessed by a 3rd party (also known as me!). The practitioners asked 'Could we BECCI ourselves?' as they felt this would be less face threatening.

This led me to a 'Yeah but no' response. Evidence shows that generally, self assessment leads to inflated or deflated scores[5]. So, I compromised, and got the team to sit down in small groups and score a video clip.

As the third party, I knew that the majority of this group were not incorporating much empathic listening into their practice, and showed them a tape where little empathic listening took place. Playing devil's advocate, I asked the group who were scoring 'empathic listening statements' what score they would give the practitioner. They said 'Four, he was very empathic, very understanding'. I said that was interesting as I would have given it just a one. I asked if anybody else would have given it a one. Three psychologists put their hands up, and explained that the practitioner only actually made one empathic listening statement during the consultation.

The rest of the team identified that they did not understand empathic listening, and decided that they wanted some top-up training in this skill.

So to answer the question, it has worked well in this situation, and I think it would probably work in others! BECCI is a relatively young instrument, and there is great potential to experiment with it in training. I would encourage anyone with ideas of using BECCI in training to go for it... as long as you promise to share it with other Minties!

Can You Use the BECCI in Supervision?

I personally have used it as a supervisory tool along with a copy of the practitioner's transcript. After explaining what the items on BECCI mean, and emphasising that BCC inconsistent does not mean that the practitioner has 'bad clinical skills', I allow the practitioner to absorb the information on BECCI, and in their transcript. From this point, in my experience, I can sit back and say very little. The practitioner is able to pinpoint what they did well and less well on the BECCI and relate this to what they did in the transcript—highlighting missed opportunities and BCC inconsistent behaviour.

As I said above, if anyone has a creative idea, then try it out and share it!

Do You Listen to the Full Session When Coding Using the BECCI?

Yes, because BCC consultations are not generally much longer than about 20 minutes. I was sent some consultations to score from another study that were an hour long, and I found it more difficult to score an entire session. This is simply because I found it near on impossible to concentrate for more than about 30 minutes. In consultations of that length, it may be wise to follow MITIs lead and select a 20 minute segment for coding, but I would suggest that if anybody wanted to do this, they should run Cronbach's alpha on the items to check the internal consistency of the items.

It would be nice to use BECCI to score trainees, but there is only so much coding we can do.

What are Your Thoughts about Larger Groups (Such as Healthcare Teams)?

You need to look at what resources you have, and what you need to score. In most cases, we expected people who had a good working knowledge of MI to be doing the scoring, but in reliability testing we actually took a research secretary who had not previous knowledge of MI and gave her some preparation exercises to do (these are mentioned at the start of the BECCI manual). We achieved good inter-rater reliability with her.

If you can, see if you can get a group of you together to do the coding, and draw on other members of your team to help with the coding.

There is no coding lab to offer external coding as yet. If someone else wants to set one up, then go ahead!

Where Can I Get a Copy of BECCI and the Manual?

You can get a copy from the MI website:

http://motivationalinterview.org/library/BECCIForm.pdf

http://motivationalinterview.org/library/BECCIManual.pdf

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One Size Fits All?

Adapting MI for Psychosis

Rory Allott and Paul Earnshaw

The key question posed by Paul and Rory to participants in this workshop was:

- Is there a need to alter MI to respond to the challenges faced by people experiencing psychosis?

Hearing Voices: An Exercise

They invited participants to try out an exercise they are developing in attempt to provide a springboard on which participants could begin to answer this difficult question. Although Paul acknowledged that they had "nicked" the exercise from Ron Coleman, of the Hearing Voices Movement, they wowed the audience with their adaptation!

Attendees were asked to break into triads: one therapist, one client and one member who sat slightly behind the client and played the role of "the voice" in the client's head. The therapist was asked to conduct an MI session with the client while the voice, using a large, paper cone held right up to the client's ear, whispered continuous, punitive messages. The voice was asked to observe the impact of their mutterings on the relationship between the counsellor and their client.

Debriefing the "Client"

When debriefing the exercise and guiding participants to consider the question posed, Paul and Rory asked that we put the client first and hear from them what the experience had been like. It was fascinating to learn how one client felt that she was more bonded to the voice than to the therapist. Other clients had similar experiences and found that they too related to the voice, visibly moving toward the voice on their chair and trying to make sense of what they were hearing. Further feedback illustrated how difficult it was for the clients to actually hear what the therapist was saying. The consequence was that many clients did not respond to the therapist's skilful reflections and open questions and others responded merely with monosyllabic answers. A key question became, what has to happen between the client and the therapist to get past the voice?

Debriefing the "Therapist"

In attempting to respond to the challenges faced by the clients, the therapists' debrief revealed that they stayed with Phase I MI and paid much greater attention to the client's non-verbal communications than they would normally. Many felt very unsure about where to go or how to move directionally. Competing with another bond (the voice) significantly slowed the pace of MI. It seemed important just to "hold" the client (using OARS). But even then, using OARS was made difficult by the monosyllabic responses the therapist was faced with. Instead, the therapist wanted to physically reach out and touch the client to establish and maintain contact, something that was hard to do through talk alone. The overall conclusion was that working using MI was really difficult and there appeared to be a need to put greater emphasisis on MI's relational components rather than the technical ones. This view accorded with that of a service user, Richard, a recording of whom was later played discussing his views and experiences on receiving a diagnosis of schizophrenia (see below).

Debriefing the "Voice"

People acting the role of the voice reported how they seemed to produce a competition to the therapist and the counselling relationship. It surprised, even the voice, just how much the individual they were abusing appeared to relate to them. How could the client have a relationship with "the voice" when it is so punitive? Some people noticed that as the relationship strengthened between the client and the therapist, so the influence the voice had in disrupting the conversation seemed to weaken. For others, however, the client wanted the voice to stop so she could engage with the therapist but this was not possible and left her frustrated. It was extremely upsetting being "the voice" as it illustrated to participants just how difficult it must be for clients to engage with the counsellor, who can be insensitive to the client's situation.

The entire exercise was very moving for everyone concerned. All three roles were able to clearly see how hearing a voice can impact on an individual's ability to relate to a counsellor and people in general. The second part of the workshop focused on these challenges and clearly showed just how close a parallel to the actual experience of hearing voices in a session of MI the exercise had been.

Challenges For MI

Challenges from the Individual

The challenges of conducting MI with people experiencing voices included such things as thought disorder, negative symptoms, and poverty of speech. However, rather than merely accepting these experiences as symptoms of 'schizophrenia', Paul and Rory reframed them as understandable consequences of distressing beliefs or voices. Indeed, they reflected on the fact that impoverished speech, thought disorder, and negative symptoms were all experiences reported by participants in the aforementioned exercise.

Challenges Beyond the Individual

They then went beyond the individual and identified specific challenges faced by this client group, such as medication side effects, being detained or incarcerated, and experiencing high levels trauma and the related distress. Others included the client's limited social networks, which can sometimes comprise a handful of helping professionals and other service users. Limited opportunities for housing and employment were further limitations. Indeed against all measures of economic and social success, they reported that people with a diagnosis of schizophrenia fair worse than people with other mental health and substance misuse problems. This fact in itself, they suggest, presents

a challenge for MI, which assumes that people will be able to mobilise their existing social and personal resources to make a change. To iterate this point they presented a photograph of a liquor outlet, one of the few shopping outlets in a typical neighbourhood where their clients live. The sign on the outlet was "BARGAIN BOOZE" and the slogan on the side of the building read "Making the Poorer Richer".

The Special Problem of the Label of 'Schizophrenia'

Notwithstanding all of these challenges to MI, the diagnosis of Schizophrenia itself was regarded as the ultimate challenge. Several themes emerged from a discussion of how the label of schizophrenia presented a special challenge to the practice of MI:

- Being labelled 'Schizophrenic' and the discrimination associated with it squanders hope in the individual and reduces their self esteem, self-efficacy and ultimately motivation for change.
- The diagnosis can overshadow the person and therapists can fall into the trap of seeing symptoms and not the person.
- Diagnostic overshadowing can lull people into the false assumption that all people with 'schizophrenia' are equal, when the reality is that we are talking about a very varied group of people with different responses to differing circumstances.
- Why have we easily moved away from the label of 'alcoholic' in MI and yet we still think it acceptable to use label 'schizophrenic'?

Further discussion revealed how some practitioners respond to the label of schizophrenia or questions from clients about the labels in their session:

- Comments from the group included the importance of differentiating between "you have symptoms of schizophrenia" versus "you are schizophrenic".
- The group also identified that the client retains the ultimate right to label him/herself.

Hearing from the Client

The presenters then played an audio tape from Richard who talked about the impact of being labelled 'schizophrenic'. Richard stated that the label no longer has a place in the English language. He pointed out that the label and its associated stigma (i.e., dangerous, never to recover) were internalised by individuals receiving the label, which made it difficult for them to grasp the autonomy being emphasised in MI. Rory noted that such an observation had been made by Rogers and his team in their trial of person-centred counselling for people diagnosed with schizophrenia.

> *The word "Schizophrenia" becomes a damning designation. To have it once applied to a young man can be to ruin a career...the very naming it can damage the patient whom we essay to help.* (Rogers and Stevens, 1967; p. 156)

Adapting Motivational Interviewing for Psychosis? A Reflection from the Trainers

The timing of the workshop did not allow for us to discuss the ways in which we have used MI with clients in the tmulti-site trial evaluating the effectiveness of an integration of MI and Cognitive Behavioural Therapy for people given a diagnosis of schizophrenia and concurrent substance misuse.

rial and therefore answer the primary question of whether we had 'adapted MI for psychosis' or not. At the outset of the workshop we were truly ambivalent, but having had the chance to participate in such a fascinating workshop with many skilled and thoughtful practitioners, we decided we had not.

Like the participants of the workshop, we have found that we have needed to slow the pace of MI for some people and make slight changes to the way we reflected and summarised, offering less complex reflections and detouring emotional material that led to distressing 'psychotic' symptoms (e.g., voice hearing). Like others working with this group (Carey, et al., 2001; Martino, et al., 2002), we have used written materials to help people with memory problems, made sure that sessions were brief, and met people wherever they preferred (e.g., at home, a café, in the park etc.). We have avoided reflecting on the traumatic life events which this group have experienced more than any other, as this too can lead to 'psychotic' experiences. Instead, we have placed more emphasis on affirming the client and ensuring that there is a strong relationship. Given the multiple dilemmas faced by this group, our target behaviours for MI have included: the use of medication, using drugs and alcohol and engaging in therapy. Moreover, as has clearly been illustrated by the participants in the workshop, a further dilemma for the client is whether to make any changes that might lead to a reduction in the experiences described by others as psychotic symptoms.

Whilst all of these 'adaptations' show some difference in emphasis, none of them are fundamentally different from the spirit of MI or its principles. Moreover, it struck us that asking the very question 'Is there a need to adapt MI for psychosis?' revealed the trap that we had very nearly fallen into: that one size fits all. That is, we had very nearly cast a diagnostic shadow over the very people we work with, who in reality, comprise a group of varied individuals, with varying problems and a multitude of resources from which to make the changes they want in life.

Thank you to all those colleagues who made suggestions and comments on how to develop the workshop. This has helped us to reflect at a meta level on the issues arising from the exercise. One area that was identified as needing further attention was in the debriefing from roles. We very much welcome any further comments on debriefing or any aspect of the work.

Note: This article is an edited version of notes kindly taken by Kris Robins, a participant in the workshop.

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Plenary Session

What Coding Has Taught Us About MI

Terri Moyers, Denise Ernst, & Carol DeFrancesco

Editor's Note: This summary was prepared by Carol DeFrancesco.

We know MI works but we don't know exactly why. Finding out is the goal of coding. What is it exactly about the interaction of two people that either facilitates change or impedes it? Can we capture the most important elements of MI by distilling a conversation to utterances and codes? In the days preceding our session, Terri, Denise, and I wondered out loud if you could capture anything interesting through coding. As Terri says, "What you can measure most reliably is least interesting." But yet, I thought if we don't listen in and try to account for what is done in a session how will we know what happened and how will we learn about and refine this interpersonal process? With all its limitations, I believe coding remains one of the essential tasks for advancing the science and practice of MI and behavior change generally.

Our plenary session began with my summary of our coding work as part of the Behavior Change Consortium (BCC). The BCC is a group of 13 studies funded by the NIH to investigate the process of health behavior change (http://www1.od.nih.gov/behavior-change). Four of those studies tested motivational interviewing and one tested self determination theory (an approach that shares many similarities with MI). Ten changers and ten non-changers were identified from each site using the common outcomes of fruit and vegetable intake (3 sites) and smoking status (2 sites). With this selective sample, we hoped to link coding results with outcomes. Six researchers from Oregon Health & Science University coded 300 tapes using the MITI (Motivational Interviewing Treatment Integrity) coding scheme.

The data revealed that 'changers' were exposed to significantly fewer instances of 'giving information', more reflections and, curiously, more closed questions. Cathy Cole and David Rosengren offered a couple of possible explanations for the closed question finding. Cathy reminded us that scaling questions are coded as closed (e.g., on a scale of 1 to 10...). David added that closed questions can sometimes function as reflections. The coding also revealed that three of the five sites did not meet MI criteria for Globals and behavior counts. The Globals hovered around four (minimum proficiency is 5, see table below). Complex reflections were low for all the sites, ranging from 5 to 35%. The ratio of reflections to questions was especially low for conversations occurring over the phone. The ratio was 0.47 over the phone and 1.0 for in person visits. The means are listed in the table below, along with the threshold standards for MI proficiency.

One of the BCC studies, PHLAME (Promoting Healthy Lifestyles Alternative Models Effects), was modeled after Project MATCH, where MI was combined with feedback from physical and dietary testing. Denise Ernst trained the counselors on this study and they were able to achieve MI proficiency. These sessions lasted 45 minutes and were set in the fire station. Through PHLAME we demonstrated that it is possible to meet MI proficiency standards in a health promotion setting.

Denise has been leading a project for her doctoral dissertation where 200 tapes were coded using the MISC (Motivational Interviewing Skill Code). Nurses counseled patients over the phone as part of a chronic disease management program sponsored by their health insurance company. Like many of the BCC sessions, the telephonic interactions did not meet MI proficiency and very few instances of 'change talk' were identified. After listening to the tapes, Denise realized that several meaningful client statements would not be captured in any of the change talk categories. She gave an example of a client reflecting that pain was not the most prominent aspect of her life anymore and that the client

	Phone	In Person	Threshold Proficiency
Empathy	4.3	4.7	>5.0
Spirit	4.1	4.6	>5.0
Client Self Exploration	4.4	4.9	NA
Reflections to Questions Ratio	0.47	1.0	1.0
Percent Complex Reflections	15.1%	20.2%	>40%
Percent Open Questions	32.7%	34.2%	>50%
Percent MI Adherent	80.2%	76.1%	>80%

Coding Plenary ¦ continued

was engaging in activities that she previously thought were impossible. To account for these meaningful statements, Denise added a qualitative pass to her assessments and is now finishing that part of the project. Maybe we can get her to share the rest of her research at the next MINT meeting.

Terri Moyers focused on change talk in her portion of the presentation. Change talk is unique to MI. And as Bill Miller reminded us, the intensity of change talk statements and their increasing frequency through a session predict outcomes. Based on the work of linguist Paul Amhrein, change talk was expanded into the DARN-C plus T categories (Desire, Ability, Reasons, Need, Commitment and Taking Steps) in the most recent version of MISC 2.0 (http://casaa.unm.edu/download/misc.pdf). Each of these categories was further defined by an intensity code on a scale of minus five to plus 5 (with no zero). A 'positive 1' might include the phrase 'I guess' where a 'positive 5' would be a stronger 'I guarantee'. Change talk statements relate specifically to a target behavior (e.g., alcohol use, intake of fruits and vegetables).

Terri's coding work has focused on coding these new categories reliably and linking them with outcomes. Terri described several studies with acronyms such as AFTER, COMBINE, SCOPE and PREMIR. In the first two, 250 and 311 tapes were coded, respectively. Despite what Bill said, she found that coders could not reliably code the -5 to +5 strength categories. They abandoned those ten categories for six (high, medium and low; positive and negative), but were still unable to achieve reliability. They returned to the original change talk categories from MISC 1.0: change talk (positive) and counter change talk (negative) and they reached reliability.

Coding the DARN-C,T categories also proved difficult. For AFTER and COMBINE, the ICCs ("intraclass correlation coefficients," a measure of agreement between coders) ranged from acceptable to very good, but the factor analysis didn't make much sense, according to Terri. In PREMIR, tapes were coded by rating each client and therapist utterance in order with both audio and transcripts. The utterances on the transcripts were parsed ahead of time. Using this system and +/- intensity, her coders were finally able to achieve reliability for DARN-C.

Consistent with Paul Amhrein's work, Terri found that where the change talk occurred in the session mattered. It is important to look at change talk across time in a session. Terri summed up her recent work with change talk this way: "1. My lab cannot measure strength reliably (though we can get positive and negative); 2. DARN-C categories are not intuitive for average English speakers trying to evaluate speech; 3. DARN-C categories seem to miss some of the underlying structure of the way clients speak about changing; 4. Good News: Change talk and counter change talk seem reliable and valid."

What has coding taught us about MI? We still have a few questions to answer.

1. How does MI work? Is it the spirit that carries the interaction? Is it the level and amount of reflective statements? Is it the change talk? Is it developing discrepancy? Is it the lack of confrontation, advice giving or information giving? Is it all these things and if so—which are most important? Do the essential elements of motivational interviewing vary from one setting to the next? Does a person stopping a behavior like drug use respond to the same set of skills as someone adding a behavior—like regular exercise?
2. Are the MI proficiency standards meaningful ways to measure MI fidelity? Many of the health behavior studies discussed in this plenary failed to meet MI standards but produced positive outcomes. Were they doing MI or not?
3. What can qualitative coding tell us about how MI works? Can we learn more about meaningful client statements and behavior change by applying qualitative techniques? Who is doing this work? Will you tell us about it in the next *MINT Bulletin*?
4. In the end, what does coding say we should do in an MI session? Reflect, accept, don't give too much information, and build change talk throughout the session.

MINT Forum 2006

Poster Session

Henny Westra & Allan Zuckoff, Co-Facilitators

We are pleased to present the proceedings of the first MINT Forum Poster Session. The idea to hold the session arose serendipitously. Several months before the meeting, longtime MINTie Chris Dunn queried the MINT listserv as to whether posters were being accepted for submission. Allan replied that we'd never held poster sessions before, but didn't it seem like a good idea to do so? When shortly thereafter Henny offered to take the lead in making it happen, and the Planning Committee gave its hearty approval, the die was cast.

In retrospect, a poster session seems to us to have been an idea whose time had come. With the growth of MINT, and the record-setting Forum regstration, it will be increasingly important for future Forums to offer a venue for members to present their work in brief, and to have the opportunity to engage in informal discussion about that work. In light of the positive comments we received in the aftermath of this year's session, from presenters and attendees alike, we hope that it will mark the start of a new Forum tradition.

We offered participants the options of publishing the abstract submitted for the session, creating a fleshed-out "expanded abstract," or presenting the poster itself in full or in part. Posters are listed in the order of publication; the presenter is designated with an asterisk. We hope that what follows will provide readers with a rich sense of what transpired in the session, and encourage those who attend the 2007 Forum to join the fray and submit a poster of their own. MB

Interrelations between Officer Clinical Skills and Offenders' Motivation to Change Antisocial Behaviors: Preliminary Findings based on Audiotapes of Supervision Sessions

Brad Bogue & Beate Ehret*
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Adapting M.I. for Use with Acquired Brain Injury and Substance Use: The Latest Chapter of a Productive Hospital-Community Agency Partnership

Tim Godden[1] & Carolyn Lemsky[2]*
[1]Center for Addiction and Mental Health, Toronto, Ontario
[2]Community Head Injury Resource Services of Toronto

Predictors of Training Impact: The Role of Disease Model Beliefs in Retention of MI Skills Among Substance Abuse Treatment Staff

Bryan Hartzler, Andrew Slade, Avry Todd, David G. Peterson, David B. Rosengren, & John S. Baer*
Alcohol & Drug Abuse Institute, University of Washington

MI-How the Pieces Fit

*Cathy Cole**
Chapel Hill, North Carolina

Motivational Interviewing: Can it be Incorporated into Outpatient Cardiac Rehabilitation Groups?

Linda Speck[1], Claire Lane[2], Stephen Rollnick[2], Adrienne Cook[1], Nick Brace[1], Michelle Gray[1]*
[1]Cardiac Rehabilitation Team, Bro Morgannwg NHS Trust [2]Department of General Practice, Cardiff University, UK

Opening Doors to Treatment: A Voucher Enhanced Motivational Intervention for Syringe Exchange Participants

E. Disney, M.S. Kidorf, Jim Blucher, J. Depo, C. Burke, R.K. Brooner*
Behavioural Pharmacology Research Unit, Johns Hopkins School of Medicine

Applying Motivational Interviewing to Group Therapy: What We Have Learned So Far

Frances Dannenberg & Steven J. Feinstein*
VA Pittsburgh Healthcare System, University of Pittsburgh School of Medicine

Whoops: An "MI Training Effect" from a Non-MI Workshop!

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Disseminating Screening and Brief Intervention Programs in Trauma Centers: It's Not Just a Training Task...Will MI Be Left Behind?

Chris Dunn[1], Kathy Williams[2], Becky Martin[3], & Doug Zatzick[1]*
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A Pilot Study Testing the Effectiveness of Single Session Motivational Interviewing in Engaging Depressed, Pregnant Women in Mental Health Treatment

Heather A. Flynn & Sheila M. Marcus, University of Michigan Medical School*

Training, Training and More Training: The Stages of Change Interventions, Assessment and Learning (SOCIAL) Manual Pilot at the California Substance Treatment Facility at the State Prison at Corcoran

Ali Hall, Walden House, Inc.*

MIA:STEP: Motivational Interviewing Assessment: Supervisory tools for Enhancing Proficiency

Denise Hall[1] & Steve Martino[2]*
[1]Mid-Atlantic ATTC, Department of Psychiatry, Virginia Commonwealth University
[2]Clinical Trials Network, Department of Psychiatry, Yale University

Measures of Fidelity in Motivational Enhancement: A Systematic Review

Michael B. Madson[1]& Todd C. Campbell[2]*
[1]The University of Southern Mississippi
[2]Marquette University and the Center for Addiction and Behavioral Health Research

Preparing High-risk Sexual Offenders to Participate in Treatment Groups

*David Prescott**
Sand Ridge Secure Treatment Center, Mauston, Wisconsin

Incorporating MI into Anger Awareness Treatment

*Carol Rankin**
University of Illinois at Springfield

A Single-Pass Method to Evaluate Clinical Performance and Patient Response

Christopher C. Wagner[1]& Karen S. Ingersoll*[2]*
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Utility of a Single-Pass Method for Evaluating MI Clinical Skills and Training Needs

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MI Performance of Disease Management Coaches Pre and Post MI Coach Training

Christopher C. Wagner[1]& Karen S. Ingersoll*[2]*
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Treating Complicated Grief in Substance Abusers

Allan Zuckoff, Katherine Shear, Ellen Frank, Dennis C. Daley, Karen Seligman, Patricia Houck*
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Interviewer Skills and Change Talk

A Research Study on Motivational Interviewing Skills and Offenders' Willingness to Change Problematic Behaviors

Brad Bogue & Beate Ehret

Introduction

There is good evidence for the efficacy of motivational interviewing skills with addictions populations (Hettema, et al, 2005; Burke et al., 2003). Some research has examined its efficacy specifically with criminal justice populations (Saunders et al, 1995; McCambride & Strang, 2004; Harper & Hardy, 2000; Ginsburg & Weekes, 2000, Ginsburg et. al. 2002). However, it is still unclear if Mi is as *efficient* with criminal justice populations compared to clients in clinical settings and if the *mechanisms* that lead to "change talk" are identical for this particular target group of offenders. Change Talk is select client language indicating a desire, ability, reason, need or commitment to change. These questions are addressed in this study.

Methods

Data was drawn from audiotapes of 144 different probation officers' supervision contact sessions and 23 staff in a forensic unit. These officers received training in motivational interviewing a few weeks prior to taping these sessions. After this training, audio or video tapes that recorded at least 30 minutes of 1- 3 supervision contacts were collected and rated by individuals trained in the MITI and other rating protocols for MI. The sample combines data from Cook County, Des Moines, Arizona, Idaho, and Maine.

Officer skills in MI were coded using specific *behavioral counts* (e.g., number of open questions, affirmations, etc.), as well as *global* interview assessments of six dimensions (e.g., acceptance, egalitarianism, etc.). Relevant interview specifics were also coded, such as indicators of a possible overemphasis on questions.

Offenders' responses were rated for certain types of speech indicating their willingness to change problematic behaviors. The total number of such client utterances expressing a desire, ability, reason, need (DARN) or commitment to change was coded as *change talk*.

The main research question addressed is concerning the relationship between specific MI-consistent officer skills and subsequent levels of offender motivation to change problematic behaviors. A relationship that has been recently established as well as linked to actual behavior changes, in general addictions research (Amrhein, et al., 2003; Amrhein, 2004).

Officer behaviors that are consistent with MI are expected to elicit "change talk" on the side of the client. Inspired by recent research of Amrhein, this study added two additional components of change talk: Client expressions of a "commitment to change" and "taking steps to change." Expressions that reflect a *commitment to change* have been identified as the link to actual subsequent behavior changes.

Analysis*

* Please contact the authors for details on the analysis.

Findings

Individual MI Skills

Change talk is more likely to be expressed by the client if *affirmations* and *elicitations* are expressed by the interviewer. (Our rather specific definition of *open questions* is negatively related to offender change talk, because all open questions that lead to change talk are coded as *elicitations*).

Regarding dimensions of change talk, offender expressions of *commitment to change* show an almost identical (although slightly weaker) relationship with *individual MI skills* as total *change talk.*

The overall SKILL BALANCE across these *individual MI skills* is significantly correlated with *change talk,* as well as with expressions of a *desire, reason, need* or *commitment* to change.

Global MI Skills

CHANGE TALK is more likely if the interviewer expresses *acceptance* and his/her style comes close to the overall *MI spirit.* The *global average* across all global skill dimensions is also significantly related to *change talk.*

Of all *dimensions of change talk*, expressions of an *ability* to change and *taking steps* to change show the closest positive relationship to all global MI skills.

Interview Specifics and Reflections

All *interview specifics,* e.g., length of interview, the number of times 3 questions were asked in a row (per hour), the longest question string, that are expected to be inhibitors of change talk, show significant *negative* correlations with offender *change talk.*

Complex reflections expressed by the interviewer show significant *negative* correlations with offender *change talk* and utterances of a commitment to change. This finding would contradict assumptions of MI technique about the importance of reflections for client progress. It may be related to this specific target group of offenders, but needs further clarification.

Ratio of all reflections and summaries to all questions: Competent MI practitioners try to use at least one, but preferably two reflections for each question asked. Although not related at all to change or commitment talk, this ratio shows a significant positive correlation with t*aking steps to change.*

Conclusions (preliminary)

Officer skills as well as overall characteristics of their adherence to MI technique are highly relevant for their clients' change talk. Amongst individual MI skills that matter in that respect are *affirmations* on the part of the officer in response to the client. *Confrontations,* as well as *open and closed questions* during the

supervision session have negative impacts (again, open questions are restricted to those that do *not* elicit change talk), meaning they function as inhibitors of change talk.

Of all global skills, an officer's adherence to the overall s*pirit of MI* matters the most for offender change talk, directly followed in importance by officer expressions of *acceptance.* One explanation of this finding may be that offenders are facing many judgmental if not denouncing reactions within the criminal justice system setting. *Acceptance* is coded particularly as the interviewer showing respect. If changes in problematic behaviors are a desired goal of community supervision, these results could provide guidance for officers. However, because these findings are preliminary in nature, they await further analysis regarding the *relative* importance of such skills by means of regression models.

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Adapting M.I. for use with Acquired Brain Injury and Substance Use

The Latest Chapter of a Productive Hospital-Community Agency Partnership

Tim Godden & Carolyn Lemsky

Introduction

In 1999, the leadership of a small group of Toronto agencies and hospitals formed a project team to explore what could be done to improve access to treatment for clients with both Acquired Brain Injury (ABI) and substance use problems. The project team found that clients with this complex combination of concerns face formidable barriers in obtaining appropriate care because:

- Substance use treatment providers traditionally haven't been trained to identify or manage the cognitive and behavioural problems that clients with brain injuries present.
- Brain injury providers traditionally haven't been trained to identify or manage substance use problems.

In the fall of 2001, the project team produced "Brain Injury and Substance Abuse: The Cross-Training Advantage," a resource booklet and video package designed to enhance the ability of therapists from both sectors to identify, assess and treat people with both ABI and substance use concerns.

Representatives from Community Head Injury Resource Services (CHIRS), the Centre for Addiction and Mental Health (CAMH) and the Acquired Brain Injury Network of Toronto have continued this spirit of collaboration in two recent projects:

- The SUBI (Substance Use/Brain Injury Bridging Project) Client Workbook (available at www.subi.ca).
- Clearing the path for change: Using motivational interviewing to enhance self-awareness and collaboration. A presentation to the Toronto ABI Network Conference, Nov. 23, 2006.

Presentation Abstract

What follows is the abstract from the conference presentation by Tim Godden of CAMH and Carolyn Lemsky of CHIRS:

Relevance: Our experience tells us that impaired self-awareness is common after ABI. Sometimes refusal to acknowledge a problem is the direct result of neurological injury. Sometimes, it's the result of the

client's psychological response to the injury and its consequences. Most of the time, it's a combination of the two. As clinicians and family members we are always looking for ways to continue moving forward, even when clients' goals and expectations are in conflict with our own.

Strategy for Clinical Practice: For nearly 20 years Motivational Interviewing (MI; Miller and Rollnick, 2002) has provided a practical framework for preventing and dealing with resistance to behaviour change. Client-centered but therapist directed, this model for therapeutic interaction has been repeatedly shown to address ambivalence and encourage change in varied populations, including those living with the effects of acquired brain injury. Research has repeatedly shown that the more statements a person makes about the need for change, the more likely they are to make a change. Questioning, confrontation and advocating change are likely to backfire, limiting a client's tendency to talk positively about change. Using MI strategies along with appropriate adaptations to the counselling sessions enables the therapist to move forward even when the client's apparent resistance to change is great. This presentation provides a brief overview of the basic concepts of MI, applications with ABI, and the authors' recommended adaptations for persons with significant cognitive/executive impairments.

Post-script: Reflections on the Poster Presentation, MINT Forum, 2006

An exciting and encouraging series of discussions sprung up around this poster. The ideas generated by these discussions will provide a number of promising pathways for inquiry in the months ahead. Two of the themes touched on were:

- There are enough similarities between the clinical presentations of people with severe psychiatric symptoms such as psychosis and of people with Acquired Brain Injury (ABI), that some of the lessons learned through using M.I. with the former group may apply well in working with the latter.
- That consistently demonstrating empathy and generally embodying the spirit of M.I. is particularly important with clients with Acquired Brain Injury because this will increase the likelihood that clients will be leaving each counselling visit in more positive affective states – a key consideration given that many ABI clients forget significant session content but retain the memory of how they felt during the last stages of the session.

I remain grateful for the opportunity I had to exchange ideas with the truly remarkable group of people that is MINT.

Predictors of Training Impact

The Role of Disease Model Beliefs in Retention of MI Skills among Substance Abuse Treatment Staff

Bryan Hartzler, Andrew Slade, Avry Todd, David G. Peterson, David B. Rosengren & John S. Baer

Introduction

Learning of evidence-based approaches, like motivational interviewing (MI), is a complicated yet key initial step in their adoption into community-based practice. Formal MI training evaluations reveal variable practitioner skill gains that—on average—fall short of desired competency levels. Thus, it is important to identify practitioner attributes that predict learning and—particularly—skill retention. Prior research (Baer, et.al., 2004; Miller, et.al., 2004) has been unable to identify such predictors of training response, though there may be practitioner attributes that have not yet been explored. One seemingly relevant domain may be practitioners' beliefs about the origin and treatment of substance use disorders, given how such beliefs may guide one's therapeutic work. The current study explored predictors of training response, with particular attention to the impact of beliefs congruent with the disease model (DM) of addiction, on learning and retention of MI skills.

Procedures

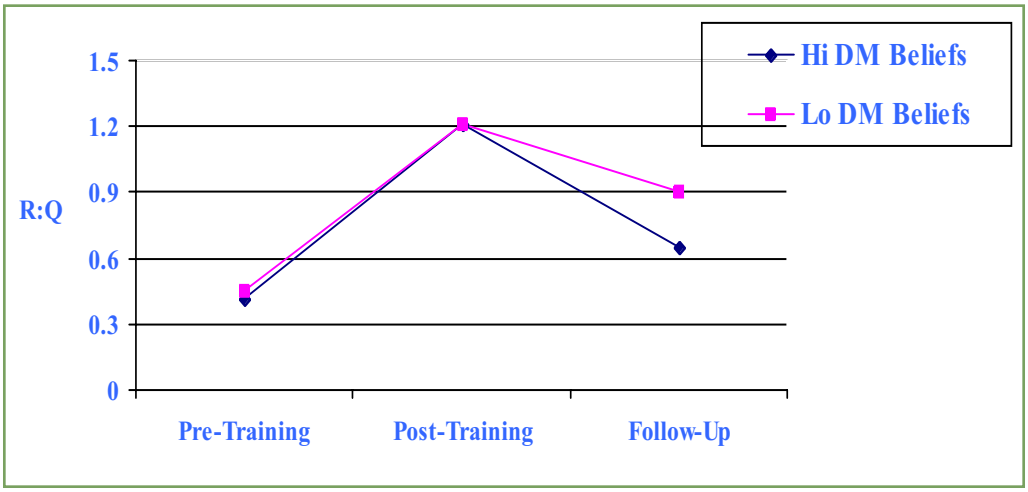
All study procedures, which were part of a larger ongoing comparison of training approaches, were approved by the UW IRB. Participating practitioners were recruited sequentially from each of four treatment agencies, and offered free training to occur at their respective facilities. Interested staff provided informed consent and completed baseline self-report measures of personal demography and background (e.g., education, recovery status, prior MI exposure) as well as an inventory of their beliefs about the origin and treatment of substance use disorders (SUSS; Humphreys, et.al., 1996). In addition to attending structured training processes, each also completed an audio-recorded standardized patient (SP) interview prior to, immediately after, and 3 months following training. Participants were provided personal financial compensation for time taken to complete assessments.

MI training was approximately 15 hours in length, and facilitated by two licensed psychologists, both members of the Motivational Interviewing Network of Trainers (MINT). Training format was intentionally varied across treatment agencies, though traditional components (e.g., didactics, role-plays, small group exercises) were reliably included in training at each facility. SP interviews were audio-recorded, 20-minutes in length, and included the portrayal of a recent referral to the agency. Audio-recordings were later coded by independent raters for standard elements of the MITI 2.0 coding system, from which a composite ratio of reflections to questions (R:Q) was computed. Analysis of intra- and inter-rater reliability of interview coding for the relevant elements were all at or above an acceptable range (ICC values = .61 - .98).

Results

The three SUSS subscales (Disease Model, Psychosocial, Eclectic) were computed, and resulting scores were entered as covariates in a repeated-measures MANOVA evaluating temporal change in practitioner R:Q. Effects of time, $F(2, 54) = 6.65$, $p < .01$, and disease model beliefs, $F(2, 54) = 5.44$, $p < .01$, were detected. For descriptive purposes, a median split (high, low) of disease model belief scores was performed. Comparative means for R:Q were then computed at each time point. As Figure 1 illustrates, these sets of practitioners exhibited highly similar pre-training skill levels as well as nearly identical initial learning slopes. The groups diverged, however, with respect to skill retention at follow-up, with skills of those endorsing high disease model beliefs deteriorating at twice the rate as that of practitioners endorsing low disease model beliefs.

Figure 1: Temporal trends in MI Skill



Additional practitioner background attributes were next explored to account for the differential rate of observed skill deterioration. No marked group differences were evident in self-reports of: 1) agency characteristics (e.g., resources, cohesion), 2) years of clinical experience, 3) satisfaction with training, 4) prior MI exposure (via trainer-assisted or self-study methods, or 5) personal demography (see Table 1). As noted, the groups did differ in their reports of formal education completed.

Table 1: Provider Background Indices

	Low DM	High DM
Mean Age in Yrs. (SD):	46.0 (12.1)	47.3 yrs (9.5)
Gender (% Female / %Male):	78% / 22%	72% / 28%
CDP Certification:	47%	44%
In Recovery:	56%	51%
Prior MI Exposure		
Via Trainer-Assisted Methods:	38.5%	36.4%
Via Self-Study Methods:	42.3%	33.3%
Education Level:		
Any Post-Secondary Degree[1]:	92%	63%
Bachelors/Graduate Degree[2]:	59%	27%

Conclusions

This study explored predictors of skill retention among a set of community-based practitioners following participation in MI training. Despite a growing focus on technology transfer within the field of substance abuse treatment (Miller, et al., 2006), research to date offers little direction as to whether and which attributes predict one's acumen for meaningful integration and maintenance of the spirit and skills of MI into daily practice behavior.

In the current sample, strong ascription to the disease model of addiction was identified as a predictor of poorer MI skill retention. Of note, strength of disease model beliefs did not adversely influence baseline MI skills, nor the demonstration of initial skill development as assessed immediately following training participation. In fact, practitioners in the current sample who strongly ascribed to the disease model were not unlike their counterparts in most other respects, with the noted exception that they did report having completed lesser formal education.

Perhaps, as is sometime speculated, dissimilarity in the precepts and principles governing MI and disease model approaches strain their integration. Persons with less formal education may be exposed to fewer therapeutic models, or otherwise may struggle more than their peers to integrate competing models in the conduct of their daily work. As trainers, we may do well to recognize the uneven 'learning terrain' that our trainees experience, and acknowledge unequal processes of assimilation that impact their skill maintenance.

Acknowledgements

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MI-How the Pieces Fit

Cathy Cole

Workshop participants often have difficulty recalling all of the concepts and important operative parts of MI. The poster below pulls the parts of MI together based on Stage One and Stage Two of MI with examples of what is MI consistent and non consistent with the use of MI. Participants have this available as a part of the workshop handout in training.

MI—How the Pieces Fit—Cathy Cole

STAGE ONE	*BUILDING MOTIVATION FOR CHANGE*	*ENHANCING CONFIDENCE FOR CHANGE*	*BLOCKS*
Principles of MI The Structure	***Strategies The Implementation***	**Sounds like this**	**Not this**
Express Empathy- Listen until you understand	Ask Open Ended Questions *Affirm—Support all efforts* Reflect Summarize	What is your concern? You made a strong effort. You are feeling more certain. Many things are motivating you, your health, your	Are you happy? You should have done better Are you feeling more certain? Enough said.
Develop Discrepancy- What is desired vs what currently is: goals/values	Reflect Elicit Change Talk (CT) ➢ Open questions about change ➢ Ruler exercise ➢ Decisional balance ➢ Elaborate on reason for change ➢ Querying extremes ➢ Looking forward ➢ Looking back ➢ Goals and values Emphasize CT over Sustain Talk (status quo)	You are strongly considering making a change What are some good reasons to make a change? Why is it a 5 on importance and not a 3? You are feeling two ways about this, etc... And why would you make that change? What's the worst/best possible outcome? As you look ahead on either choice..... When you weren't smoking, what was it like? How does this fit with your values as a parent? You can think of some reasons for change.	Make this important! You have to change It should be more important Focus on the good reasons! That should be easy. That outcome will be bad. It's best for your future. It had to better before... You should think of your kids You want to stay the same.
Roll with Resistance- Pushing away from change; behavior that is influenced by the interaction with the interviewer; the goal is respond in a way that allows the speaker to	Reflections (simple, complex and amplified) Double sided reflections Reframe Agreeing with a twist Shifting focus Personal choice and control Coming alongside	You are really upset about this. You see reasons against and reasons for change. You've tried; it's true that stopping smoking is hard. He preaches at you, expresses his concern this way. I'm not here to place blame; I want to understand. It's true that you have to make the choice, not me. Now is not the time, I hear; when might be the time?	Don't be so upset! Just look at the positives! Just decide to do it! He just cares about you! You got yourself into this! I want you to do this! Do it now or never!
Support self efficacy- The belief in one's capability Often downplaying of importance is a cover for lack of self efficacy	Affirmations Eliciting confidence talk Use of confidence ruler Past successes Personal strengths and supports Brainstorming Information and advice Reframing Hypothetical change	You are working hard at deciding on this change. Where might you start, a way that works for you? On a scale of 1-5, where are you in confidence? What have you succeeded at in the past? Who can support you in your plan for changing? Let's generate some ideas about where to start. I can provide information on some ways to start. You have tried, not gotten as far as you wanted. If you make this change, what might life be like?	You should try harder. Anyone could do this. Be more confident! Haven't you succeeded at anything? You'll get support, I'm sure. Here's how to do it. Just do what I tell you; you'll be fine. You failed in the past. Just think how great it will be!
Stage Two	***Strengthening Commitment to Change* The Implementation**	***Sounds like***	***Is not this***
Signs of Readiness *decreased resistance *less discussion of problem *resolve *change talk *questions about change *envisioning change *experimenting with change	Summary	You realize your drinking is causing problems in many areas of you life...job, family, health; your doctor has told you of health problems and your wife and boss will not put up with the drinking any longer. From what you have shared with me, it appears serious and you want to make some changes.	Okay, so you have figured it out! (overly reassuring)
	Key Question	Where do we go from here?	Now this is what you need to do. (taking over)
	Giving information and advice	I'll be happy to share some ideas, ways that others have gone about this; but first, let's make certain you have talked about all of your ideas.	I can tell you exactly what to do. (unsolicited advice)
		If it's okay, I'd like to share a concern I have about....	I will just keep my mouth shut. (not enough direction)
	Negotiating a change plan	Setting goals: 'What is your goal? What will life be like? What are both sides of making this change?'	Here are your goals. (taking over)
		Change options: 'What are the ways you will go about this?'	Do it this way. (taking over)
		Plan: 'What exactly will you do? What is the first step?'	Start here and finish here. (taking over)
		Getting a commitment: 'How likely are you to do this? Is this what you want?'	Of course, you'll do this. (directing)

Motivational Interviewing

Can it be Incorporated into Outpatient Cardiac Rehabilitation Groups?

Linda Speck, Claire Lane, Stephen Rollnick, Adrienne Cook, Nick Brace, & Michelle Gray

Traditionally, cardiac rehabilitation programmes in the UK have been designed to encourage patient lifestyle changes through the provision of advice and structured exercise. However, research has shown that adherence to lifestyle change programmes is often low, especially in patients with coronary heart disease.

As motivational interviewing (MI) is a facilitative, client-centred counselling style that has been successfully used to help patients make lifestyle changes, it was anticipated that it might be a useful method to employ in cardiac rehabilitation. This poster focused on one part of an action research project funded by the British Heart Foundation, which involved training a cardiac rehabilitation team in MI. The objective of this part of the study was to go beyond simply training staff, by continuing to work closely with the cardiac rehabilitation team (who were based across two sites). We aimed to assist them in transferring the skills they had learned into their everyday practice, not only with individual patients but also with groups of patients within cardiac rehabilitation programmes, together with restructuring their service in a way that would facilitate closer team working across the two sites.

Eight hours of MI training were just the starting point for this team, who identified that transferring MI skills into clinical practice was at times, easier said than done. They initiated a series of team meetings over a period of eighteen months, where they identified the barriers to implementing MI in practice. They brainstormed ideas, shared experiences, tried new approaches to practice, and then came back as a team and discussed what went well, and what they might do differently. Ideas were tried and amended several times, until the team felt they were workable in practice, and reflected the skills and spirit of MI.

This poster gave an overview of how motivational interviewing spirit and techniques have been incorporated into the outpatient group sessions delivered by this cardiac rehabilitation team. Some skills seemed to work better certain topics than others. The team also found that having co-facilitators, who reflected what the patients raised during sessions and recorded this information on flip-charts for later use, made the process easier. The outpatient group programme developed by the team is shown in the table below, with a summary of the MI skills used in each session.

The team have successfully put the above programme into use with their groups. No two groups are ever the same, and they find that although this format is useful in most cases, it is important to be flexible in their practice and adapt the sessions in response to patient needs. Patients have reacted positively to active participation within sessions, which now involve much more patient led discussion, and are much less expert driven. Team members now find working with groups far more rewarding as they are helping patients to identify their individual needs and are tailoring the information they deliver accordingly.

Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7
General Introduction (inc. ground rules) **Risk Factors** *+Pros/Cons* *+Importance/ Confidence* *+Reflective Listening*	**Activity/Exercise (inc. angina)** *+Pros/Cons* *+Importance/ Confidence* *+Reflective Listening*	***Feedback** *Brainstorming* (keep flipchart for future sessions)	**Medication** *+Elicit-Provide-Elicit* *+Reflective Listening*	**Stress Management** *+Elicit-Provide-Elicit* *+Reflective Listening*	**Investigations & BP** *+Elicit-Provide-Elicit* *+Reflective Listening*	**Risk Factors** *+Elicit-Provide-Elicit* *Importance/ Confidence* *+Reflective Listening*
Feedback*	**Feedback***	**Feedback***	**Feedback***	**Feedback***	**Feedback***	**Feedback***
Active Exercise	**Active Exercise**	**Active Exercise**	**Active Exercise**	**Active Exercise**	**Active Exercise**	**Active Exercise**
BREAK	**BREAK**	**BREAK**	**BREAK**	**BREAK**	**BREAK**	**BREAK**
The Nature of CHD (inc.angina/stents/ bypass) *+Elicit-Provide-Elicit* *+Reflective Listening*	**Introduction to Stress Management** (inc. CBT) *+Elicit-Provide-Elicit* *+Reflective Listening*	**Stress Management** *+Elicit-Provide-Elicit* *+Reflective Listening*	**Emotional Issues Discussion** *+Elicit-Provide-Elicit* *+Reflective Listening*	**Healthy Eating** *+Pros/Cons* *+Importance/ Confidence* *+Reflective Listening*	**Stress Management** *+Elicit-Provide-Elicit* *+Reflective Listening*	**Phase IV Info** **Evaluation Questionnaires**

Feedback A session where individual progress and other issues are raised by patients for discussion, and are linked to previous discussion sessions.

Opening Doors to Treatment

A Voucher Enhanced Motivational Intervention for Syringe Exchange Participants

E. Disney, M.S. Kidorf, Jim Blucher, J. Depo, C. Burke, & R.K. Brooner

Opioid-dependent syringe exchange participants engage in high rates of intravenous drug use and other HIV risk behaviors, yet few enroll in drug abuse treatment. This study examines whether an intervention combining motivational interviewing and treatment readiness groups, with and without monetary incentives for attendance, improves the rate of enrollment in treatment among participants in the Baltimore Needle Exchange Program (BNEP). Opioid dependent study participants referred by the BNEP are randomly assigned to one of three interventions: 1) 8 individual motivational enhancement (ME) sessions and 16 treatment readiness group (TRG) sessions (Motivated Referral Condition - MRC), 2) the MRC intervention with monetary incentives for attending sessions - MRC + Incentives, or 3) a standard referral condition which offers participants a list of treatment programs currently admitting patients (Standard Referral - SR). Preliminary results (n=200) indicate that MRC + Incentive participants were twice as likely to enroll in opioid-agonist treatment (49%) than MRC-only (24%) or SR (24%) participants (p<.001). Incentives increased rates of attendance to study sessions: participants in the MRC + Incentives condition attended 67% of scheduled ME sessions and 27% of TRG sessions, while those in the MRC-only condition attended just 8% of ME sessions and 5% of TRG sessions (p<.001). More frequent attendance was also related to increased rates of treatment entry; individuals who entered opioid-agonist treatment attended 77% of scheduled ME sessions and 52% of TRG sessions, versus 35% and 15% for those who failed to enter treatment (p<.01 for both). The combination of motivational interviewing and behavioral incentives with a treatment readiness component appears to be an effective way to reduce human suffering in this important subset of untreated drug users, and improve the public health contributions made by community syringe exchanges.

Applying Motivational Interviewing to Group Therapy

What We Have Learned So Far

Frances Dannenberg & Steven J. Feinstein

We have been conducting a therapy group at the VA Pittsburgh Healthcare System for the past 5+ years, applying MI philosophy and techniques. While we have not collected outcome measures, both the therapists and veterans feel this group has been a success in a variety of ways and is quite well attended (on average 20+ members per group). The group is 30 minutes in duration, is held five days a week and has a different facilitator each day. This is a walk-in outpatient group, consisting largely of dually diagnosed veterans, spanning all stages of change, without pre-screening. It appears that fostering and maintaining the spirit of MI is critical to the success of this group. Our poster summarized the MI themes and techniques that we have found to be most useful.

Whoops

An "MI Training Effect" from a Non-MI Workshop!

Chris Dunn, Jana MacLeod, Dan Hungerford, & Bryan Hartzler

Although MI is the treatment of choice forming the evidence base for why we should perform brief interventions (BI) for alcohol in trauma centers, it may not be practical to teach MI to surgery residents. Therefore, we provided a one-day workshop in BI—but not by teaching MI—that taught them a simpler form of BI combining brief advice and brief negotiation skills. To evaluate the BI skill gains made by surgery residents (n = 22) by attending this workshop, we gave them before and after the workshop a BI challenge with a standardized patient actor playing the role of a patient with an alcohol problem. These 6-minute BI interviews were audiotaped and coded for BI skill levels. A comparison group of medicine residents (n = 37) received no BI training but also completed the BI challenge at both time points. As expected, the residents who attended the workshop (surgery residents) demonstrated superior gains in the following BI skills: discussing a drinking goal with the patient and not suggesting action prematurely. To our surprise, without receiving MI-focused training, the following surgery residents' BI skills improved in an MI-consistent direction: percent open questions asked and offering encouragement or hope. Without training but just by practicing the BI challenge twice, the comparison group of medicine residents shifted their BI skills in a markedly MI-inconsistent direction.

Disseminating Screening and Brief Intervention Programs in Trauma Centers

It's Not Just a Training Task...Will MI be Left Behind?

Chris Dunn, Kathy Williams, Becky Martin, & Doug Zatzick

The American College of Surgeons requires that trauma cen-

ters (hospitals specializing injury treatment) implement programs providing Screening and Brief Intervention (SBI) for injured patients with alcohol problems. This mandate was driven by several studies showing that in trauma centers SBI—when using Motivational Interviewing for the brief intervention--reduces drinking, drunk driving, and future injury. In Washington State, the Department of Health has encouraged SBI implementation by providing free SBI training to over 30 designated trauma centers. We surveyed a convenience sample of these trauma centers 1-2 years later to assess their SBI operational success. We found that a typical SBI start-up sequence is as follows: 1) Trauma Nurse Coordinators (TNCs) designate clinicians in their hospitals (e.g., nurses, social workers) to absorb brief intervention duties into their current job descriptions without additional salary support, 2) an outside trainer visits the trauma center to provide a one-shot SBI workshop for these clinicians, and 3) no process tracking is set up to allow TNCs to describe these newly operational SBI programs. No TNCs interviewed mentioned Motivational Interviewing as the treatment of choice. With one exception, no TNCs were able to say what percentage of injured patients were screened, what percent screened positive, nor what percent received brief interventions. To potentially remedy this situation in the U.S., our research group has applied for NIAAA funding to test the effectiveness of a 3-pronged organizational intervention with trauma centers to enhance SBI start-up. Trauma centers will be randomized to a Self-Start-up Condition (as above) or to an Enhanced-Start-Up Condition: a) a national SBI opinion leader will persuade the Chief of Trauma at target trauma centers to support SBI start-up, b) ongoing consulting will be provided to establish SBI tracking, and c) an MI workshop plus ongoing MI practice with standardized patients and telephone coaching. Outcome analyses will compare the operational success and patient outcomes of trauma centers in the two conditions.

A Pilot Study Testing the Effectiveness of Single Session Motivational Interviewing in Engaging Depressed, Pregnant Women in Mental Health Treatment

Heather A. Flynn & Sheila M. Marcus

Prenatal depression affects up to 20% of women, yet, despite the availability of effective treatments, most remain untreated. Left untreated, prenatal depression presents risks to the pregnancy, the infant, and functioning of the mother, constituting a major public health concern. Previous studies have shown than prenatal care clinic screening, feedback and referral only slightly improves rates of depression treatment use in this population. The purpose of this pilot study was to test the effectiveness of a single session of MI in improving rates of treatment in women with Major Depressive Disorder (MDD). All women completed depression screening (Edinburgh Postnatal Depression Scale - EPDS, n= 1,700) at their initial prenatal care visit. Consenting women with EPDS > 12 completed a diagnostic assessment including the SCID. All women meeting criteria for MDD (n= 25) received a standard care intervention consisting of depression feedback, nurse-delivered mental health referral, and notification of treating physician of depression status. Half of the women with current MDD (n= 13) were randomly assigned to one session of MI in addition to the standard care feedback and referral. The MI focused on depression and treatment related content. All women completed follow up interviews after 1 month and at 6 weeks postpartum to assess mental health treatment use. Of women who received the MI, 67% followed through with mental health treatment, compared to 42% of the standard care group (p =.20). This represents a clinically important increase in the number of women suffering from a disabling illness who connect with needed treatment.

Training, Training and More Training

The Stages of Change Interventions, Assessment and Learning (SOCIAL) Manual Pilot at the California Substance Treatment Facility (CSATF) at the State Prison at Corcoran

Ali Hall

The Stages of Change Interventions, Assessment and Learning (SOCIAL) Manual was designed to assist clients incarcerated in the California Substance Abuse Treatment Facility (CSATF) at the State Prison at Corcoran as they progress through the stages of change with respect to their self-selected problem behaviors and/or activities. The six-week SOCIAL Manual pilot was initiated with 10% (N=150) of the eligible CSATF population. Clients participating in the pilot receive an introduction to treatment services and complete a four session treatment readiness group. Together with a staff member trained in MI and other appropriate interventions, clients utilize an Agenda-Setting Chart to select a problem behavior or activity that they will work on in weekly groups and individual sessions. The range of behaviors/activities selected by clients include: tobacco use; violent behavior; criminal thinking; criminal behavior; overeating/unhealthy weight gain; drug use; and alcohol use. Clients then complete a Problem Behavior Questionnaire, to assess the transtheoretical model stage of change they are in with respect to that behavior. Clients are asked to join stage-appropriate groups and receive treatment based on motivational-content exercises contained in the SOCIAL Manual, with a focus on building

motivation and readiness to change. Following completion of various, specified treatment interventions, clients re-assess their stage of change with respect to the targeted behavior. For more information about the SOCIAL Manual, please contact the author at ahall@waldenhouse.org.

MIA:STEP

Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency

Denise Hall & Steve Martino

The National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) are pleased to announce the availability of a new evidence-based treatment protocol that has emerged from the work of the NIDA National Drug Abuse Treatment Clinical Trials Network (CTN). A Motivational Interviewing Assessment protocol, which consisted of the addition of a 20-minute MI enhancement at the beginning and end of the usual assessment interview, was tested and found to produce improvements in client engagement and retention during the first four weeks of treatment. Both engagement and retention have been shown to be important contributors to positive treatment outcome.

Other lessons learned were: (1) development and maintenance of MI skills was a challenge for the counselors engaged in the study; and (2) participating in training was not sufficient preparation; and (3) on going feedback and mentoring were needed in order for most counselors to use MI with fidelity. To facilitate training and retention of MI skills, a package of products was created for use in the context of clinical supervision or mentoring. These tools can help enhance both counselor MI skills and the quality and nature of the mentoring process. It's a win-win situation for clients and agency staff alike.

The MIA:STEP package includes a comprehensive collection of materials and tools aimed at reinforcing basic MI concepts and skills. It is not meant to be used as the basis of an introductory course in MI.

Measures of Fidelity in Motivational Enhancement

A Systematic Review

Michael B. Madson & Todd C. Campbell

The movement to use empirically supported treatments has increased the need for researchers and clinical supervisors to evaluate therapists' adherence and competence to particular empirically supported interventions. As the movement evolves, evaluations must be guided by scientifically validated evaluation tools. Several researchers have begun to answer this call. One intervention, motivational interviewing, has seen the development of several different instruments. We provided a systematic review of the attempts made by researchers to develop instruments that yield reliable and valid data. Recommendations for refinement of the measures and future research were also discussed. For details, see: Madson, M. B., & Campbell, T. C. (2006). Measures of fidelity in motivational enhancement: A systematic review of instrumentation. *Journal of Substance Abuse Treatment, 31,* 67-73.

Preparing High-Risk Sexual Offenders to Participate in Treatment Groups

David Prescott

Recent research indicates that sexual offenders can benefit from cognitive-behavioral treatment. At the same time, not all sexual offenders are ideal candidates for therapy and failure to complete treatment is associated with increased risk for recidivism. Thus, treatment providers have an obligation to make options available to clients who are having difficulty engaging in the treatment process. This poster described a treatment group that uses MI principles and strategies with high-risk offenders who have displayed significant treatment-interfering factors such as disruption or deceit. The purpose of this group is to provide a venue where they can explore their commitment to returning to treatment and the factors that have interfered with their meaningful participation.

Incorporating MI into Anger Awareness Treatment

Carol Rankin

One of the challenges in the area of counseling and human services is providing training opportunities that are experiential or contextual. This poster presentation showed how to use a contextualized training opportunity for students in a university training program. The poster presented how students can learn basic cognitive-behavioral and motivational interviewing skills in a group format to address anger. The format itself is one that can be used with either students or clients and incorporates material from the texts: *Cognitive Therapy of Substance Abuse* by Beck, Wright, Newman, & Liese, 1993; *Anger: Deal with it, Heal with It, Stop it from Killing You* by DeFoore, 1991; *From Anger to Forgiveness* by Larsen & Hegarty, 1992; and *Motivational Interviewing* by Miller & Rollnick, 2002.

A Single-Pass Method to Evaluate Clinical Performance and Patient Response

Christopher C. Wagner & Karen S. Ingersoll

Using items from MISC1, MISC2, MITI along with other variables of interest, we developed a single-pass audio review method intended to provide maximum relevant information regarding clinician MI performance and patient response. Modifications of variables included coding change talk as positive/negative rather than -5 to +5 and combining Desires, Needs and Reasons into a single "Importance" item. In addition to standard reporting metrics such as reflection to question ratio, we developed a visual profile that shows the relative use of standard MI microbehaviors on a per-minute basis, allowing comparison across sessions of different lengths as is common outside of standard outpatient psychotherapy settings. We suggest that such profiling may be useful to establish standards for MI performance in various settings that have different requirements and constraints than those characteristic of unstructured interviewing/therapy (e.g., information and advice-giving may be more common in medical settings).

Utility of a Single-Pass Method for Evaluating MI Clinical Skills and Training Needs

Christopher C. Wagner & Karen S. Ingersoll

We considered the utility of a single-pass audio review method using sessions rated as "exceeds expectations" and "below expectations" on an overall quality monitoring performance review in a telephone-based disease management setting. We showed how this method can be used to identify relative strengths and weaknesses of clinician performance. Compared to a high-performing clinician, a lower-performing clinician received lower global ratings, and relied more heavily on questioning, information provision and advice-giving. The second clinician also had a lower reflection-to-question ratio, more use of advice-giving without permission, and more use of all proscribed MI behaviors. The patient with the lower-performing clinician disclosed less, was less engaged and cooperative, and had many fewer positive change-related statements.

MI Performance of Disease Management Coaches Pre and Post MI Coach Training

Christopher C. Wagner & Karen S. Ingersoll

Using a single-pass audio session review method, we identified a number of MI training goals to be addressed as part of training medical personnel to become "coaches" regarding use of MI strategies by other health professions staff. A post-training review in this pilot project suggested that several of these goals were met, including increasing the use of an empathic stance among clinicians, reducing clinician talk time, reducing the number of questions relative to reflections, reducing the use of closed-ended questions relative to open questions, and increasing positive patient change talk.

Treating Complicated Grief in Substance Abusers

Allan Zuckoff, Katherine Shear, Ellen Frank, Dennis C. Daley, Karen Seligman, & Patricia Houck

The need for effective interventions to address grief problems in substance abusers has long been recognized in the clinical literature, but little research has been conducted to determine who should receive such interventions or how they should be structured. This poster outlined an empirically-derived model of “complicated grief,” preliminary data regarding its prevalence in those receiving substance abuse treatment in a methadone maintenance treatment clinic, an empirically supported treatment for the syndrome, and an approach to adapting the treatment for those with co-occurring substance use disorders that showed promise in an open prospective pilot study. The role of MI in both the standard treatment, and the adaptation for those with SUDs, was highlighted. For details, see: Zuckoff, A., Shear, K., Frank, E., Daley, D.C., Seligman, K., & Silowash, R. (2006). Treating complicated grief and substance use disorders: A pilot study. *Journal of Substance Abuse Treatment, 30,* 205-211.

Plenary Session

A Refresher for Maturing MINTies

Bill Miller

I developed this presentation in response to a request from MINTies who were trained in earlier TNTs, asking for an update on what had changed since they were trained. I organized it around (1) things that changed between the first and second edition of *Motivational Interviewing*, and (2) new developments since publication of the second edition. In outline form, here's what I covered:

Changes between MI-1 and MI-2 (1991-2001)

Statement and new emphasis on the underlying spirit of MI: collaboration, evocation, and honoring of autonomy
Reduction to 4 principles instead of 5 (cutting "avoid argumentation" because it is subsumed within "roll with resistance")
Description of the "righting reflex"
Description of OARS as basic client-centered skills
Substitution of "change talk" for "self-motivational statements"
Construing "resistance" as a signal of dissonance in the counseling relationship
Material on ethical aspects of MI practice
Differentiation of MI from the transtheoretical model and stages of change

Developments in the Field During this Same Period

Publication of Project MATCH (1990-1999) and MET manual (1993)
Rapid diffusion of MI into healthcare
Development of group delivery formats for MI
Early diffusion of MI into corrections
Publication of about 70 randomized clinical trials of MI
Roughly 375 publications on MI
Training for New Trainers (begun in 1993)
Organization of MINT in 1997
Training videotapes become available in 1998
Shift from content to process focus in TNTs, and menu of training exercises
My acquaintance with Monty Roberts and parallels of MI with Join-up

Developments Since the Publication of MI-2 in 2002

Consensus statement on what constituted change talk (DARN, commitment, taking steps)
Differentiation of sustain talk from resistance
New emphasis on commitment language and implementation intentions
Relatedly, better understanding of processes in Phase 1 vs. Phase 2 of MI
Progress toward a theory of MI, with relational vs. technical components
Broader diffusion of MI into corrections
Early diffusion into mental health services

Developments in the Field During this Same Period 2002-2006

At least 90 more randomized trials published; now over 160
Total publication on MI doubled to over 750
Meta-analyses of MI research appear
Muiltisite trials of MI in UKATT, COMBINE, and the Cannabis Youth Treatment Study
Four new MI multisite trials completed in the NIDA Clinical Trials Network
The vast majority (about 65%) of all MI outcome studies are now outside addictions
EMMEE study and new research on how to teach MI
Shift in MI training model from installation to learning-to-learn
MI fidelity coding systems like MISC, MITI, MISTS, BECCI, etc.
Training outcome norms and targets become available
Differentiation of levels of MI training with different goals; advanced MI training
Development of MI supervisor training
Rapid growth of MINT - now over 1000 trainers, who speak at least 25 languages
Beginning of non-English MINT groups and regional MINT meetings

Coming Soon

MIA:STEP protocol and training of supervisor trainers within the Clinical Trials Network
Motivational Interviewing in Healthcare (Miller, Rollnick & Butler)
Motivational Interviewing in Mental Health (Arkowitz, Westra, Miller & Rollnick)
Continuing series of MI books from Guilford Press
MI practitioner certification by the MI Campus (Rik Bes and Jeff Allison)
Further evolution of MINT as it grows rapidly

Training Exercise

Drumming for Change Talk

Steven Malcolm Berg-Smith

The purpose of this exercise is to provide a fun, interactive activity to increase trainees' sensitivity in recognizing change talk. It requires 15 minutes and 1) a list of client statements; 2) slides to display the messages that follow. (MINT members can access these materials in the members' section of the website.)

Opening Comments

As we've discussed prior, a primary goal of MI is to evoke increasing levels of change talk—to counsel in a way that invites the client to make the arguments for change and ways of achieving it. This is important, because we know from the research that there is a relationship between clients' change talk and the probability of change actually happening. Again, change talk is a broad term that refers all kinds of dialogue that favor change. On the slide are the primary categories of change talk that we summarize by the acronym DARN CT.

As the training progresses, we'll be exploring different strategies & approaches for evoking client change talk, and more importantly—what to do when you start hearing it. Before we do all of that, there's a very important first step. And the first step is becoming adept at recognizing change talk— training our ears to be very sensitive to it. Because when you start to hear change talk, you'd don't want to stand there like a deer looking into head lights. When you hear it you want to immediately encourage it, reinforce it, and reflect it.

Drum Roll

Can you all give me a drum role on your table tops. Excellent! Right now I'm going to read you some statement that clients have said to me over the years. And I want you to be the judge of whether or not what I'm reading is change talk. If it is an example of change talk, please give me a drum roll. If it's not, hold silence.

[Begin reading statements]

Fantastic! We're getting the hand—literally—of recognizing change talk.

Commitment Talk

Now there's another level to change talk. When it comes to change talk, there is a certain kind of change talk that we especially want to attune our ears to, and that's commitment language: a client giving voice to intentions, obligations, or agreements. Recent linguistic research suggests that the kind of change talk that actually predicts behavior change is commitment language—or more specifically, the strength of commitment language. Clients may express their desire, ability, reasons & need, but still not take the step of committing to doing something. However, encouraging DARN is still very important because it moves a person towards commitment to change!

DARN is the prep-step before commitment. And commitment language is what actually predicts change.

Massage the Pearl

I'd like to show you something else. Place your palms together, and give me a rub. Historically, in parts of Asia, there's the tradition of dragon paws: rubbing your hands together. The idea is that when you hear something positive, something life affirming, a dream, a vision, a commitment, something hopeful, you treat what you've heard as if it's a pearl and you want to massage that pearl.

When it comes to change talk, there's a certain kind of change that we might think of as a pearl. What do you suppose that kind of change talk is? The 'pearl' of change talk is commitment language or commitment talk. When we hear commitment talk, we really want to massage that pearl. This is the kind of change talk we want to especially reinforce and navigate our clients towards.

I'm again going to read you some statement that clients have said to me over the years. And this time I want you to be even more discriminating. As I'm reading the statements, I want you to be the judge if what I'm reading sounds like general change talk (desire, ability, reasons, need), commitment talk (intentions, obligations, agreements), or if it sounds like neither. If it sounds like general DARN talk, what are you going to do? [drum roll] If it sounds like commitment language, what are you going to do? [massage the pearl]. If it sounds like neither, what are you going to do? [silence]. Let's begin…

Closing

As the training progresses, we'll be exploring different strategies & approaches for evoking client change talk & commitment language, and more importantly—what to do when you start hearing it. And the first step is becoming adept at recognizing change talk; training our ears to be very sensitive to it. Because when you start to hear change talk, you'd don't want to stand there like a deer looking into head lights. When you hear it you want to immediately encourage it, reinforce it, and reflect it.

Exploring Ambivalence

More Than a Decisional Balance?

Editor's note: What follows is two perspectives on this session: first, that of the presenter; then, that of a participant. I'm grateful to Christina and Kris for agreeing to my request that we publish these separately rather than integrating them into a single description.

Exploring Ambivalence: More Than a Decisional Balance?

Christina Näsholm

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

To helpfully explore ambivalence we need to reflect on and try to find the answers to several important questions.

Some of these questions were addressed during the seminar. Just a few of them can be covered in this brief summary. For MINT members, the slide presentation from this session is available in the MINTNET section of the MI website.

Questions

What is our understanding of ambivalence and of the dynamics of hesitance?

Should we understand ambivalence as a state in a change process, or rather as a stage?

A recurring state in change processes and a constant companion?

There are many words to describe ambivalence—such as hesitance, indecision, vacillation, irresolution and even fickleness.

What is ambivalence? A natural human state with different possibilities for understanding and action? A state of openness and opportunity? A capacity to see, understand and cope with ambiguity and complexity? A creative state, a creative space, with the possibility of mentally exploring and testing out different possible selves, different preferred selves? An important state or stage in a change process when the person starts and hopefully continues to think about, contemplates and explores the possibility of change?

How do we use the idea of ambivalence as an asset in the process of change?

What strategies do we use and what strategies are helpful in various situations?

It is well known that in some situations exploring ambivalence can be unhelpful and even harmful.

When does exploring ambivalence not help the person arrive at a solution?

When does exploring ambivalence move clients away from change?

When does exploring ambivalence lead to reinforcing sustain talk and resistance, instead of eliciting and reinforcing change talk?

What might be needed to make an exploration of ambivalence helpful for clients in their process towards change?

Which or what perspectives need to be focused on and explored?

Are the two perspectives "status quo" and "change" sufficient, or do we need to split the concept of "status quo" into two separate perspectives, "current situation" and "no change and sustain"? Which or what perspectives are helpful to explore, with whom and when?

The concept of ambivalence can be seen as simplification—a simplification of a more complex multivalence. At the same time this simplification is not experienced as an oversimplification since it retains the complexity of the issue.

The idea of ambivalence is a helpful simplification, "as if" there are only two sides, where thinking and talking about "one side" opens up and starts thoughts about "the other side" of the issue.

Models of ambivalence work as "maps" for finding the way out of a complicated uncertainty. They help us invite the person to take a step back to see herself from a perspective outside from herself, to enter a mental state where both self-observation and self-confrontation are possibilities.

Which model is useful, when and with whom? When is a simple decisional balance helpful and sufficient? When is a double or a triple decisional balance needed?

Evidently formulating and choosing helpful headings are of crucial importance for the result of the exploration. Which heading captures the essence of the clients' motivational struggle and how do we find "the name of the issue"? What is the helpful name of the dilemma and how should the dilemma and the different alternatives or choices be formulated?

Exploring ambivalence is about listening and guiding, following and leading an exploration through a helpful model. Before exploring ambivalence we have to identify ambivalence and ask for permission. How do we use our "third ear" to hear early seeds of ambivalence? What words from the client help us hear and identify signs of ambivalence that are in the direction of change? And how do we construct, how do we build a helpful map and model for finding the way...?

Tentative Answers

During the seminar I presented the idea of a cross road, a fork junction, as a metaphor, as an alternative and often helpful model for ambivalence exploration.

The participants in the seminar were invited to try out the cross

Exploring Ambivalence ¦ continued

roads and fork junction model and reported many creative adaptations of our model.

Exploring ambivalence can be neutral, goal oriented and directive or non-neutral, goal oriented, and directive. A neutral, goal oriented and directive exploration is an empathic, balanced, and still directive exploration of ambivalence with the purpose of helping the person to a decision, irrespective of which decision. A non-neutral, goal oriented, and directive exploration is an empathic, directive exploration of ambivalence, selectively eliciting and reinforcing change talk, with the purpose of helping the person to a decision in a certain, particular, desired direction.

Exploring ambivalence is not about ”nailing” a person’s dilemma. Nor is it about confronting the person with discrepancies and inconsistencies in her life. Exploring ambivalence is an empathic, person-centered, directive and goal oriented strategy to help the person become aware of, understand, resolve or take control over her ambivalence (including discrepancies and inconsistencies) in order to take a stance, make a decision and move on in her process of change.

Exploring ambivalence is a process which involves identifying, eliciting, safely exploring, reinforcing, summarizing and concluding, and within this process (in a non- neutral exploration of ambivalence) involves identifying change talk, eliciting change talk and reinforcing change talk.

Exploring ambivalence is not only about exploring rational arguments. It is more often an expanded and in-depth psychological process, including exploration and reinforcement of the emotional quality and affective context of the desires, reasons and needs for change. It is a process which often crystallizes dilemmas. A process where the person is helped to see, explore, evaluate and reevaluate herself, the situation and the possibility of change.

Exploring, summarizing and concluding ambivalence involves skills in using both simple and complex reflections as well as selectively reinforcing and helpful double sided summaries. Sometimes it is about “either … or …”. Sometimes it is not about ”either… or …”, it is about “both… and …” . Most often it is about “both at one and the same time” which helps the person become aware of and understand that apparently irreconcilable elements can be pulled together into a nuanced whole.

Exploring, summarizing and concluding ambivalence often contributes to important shifts of perspective, which promotes change.

The essence of ambivalence exploration is to help the person in an empathic and supportive way to construct a picture, a map, of her complicated uncertainty and guide her through her ambivalence. To help her make a choice, take a decision and move on in her process.

Be that a change or stabilization.

Acknowledgment: I would like to thank MINTie Tom Barth, Norway, my dear friend and colleague, with whom I developed these ideas and reflections on ambivalence during our years of collaboration.

A Participant’s Perspective

Kris Robins

Christina Nasholm's session on ambivalence revolutionized the way that I think about clients' dilemmas pertaining to change. Christina's ideas will also dramatically alter the way I discuss potential change with clients. The following are some of the key themes that emerged as being important for me during the short workshop.

Exploring ambivalence with clients can be so much more than using a decisional balance technique. Christina's work in moving forward Bill and Steve's concept of multivalence provided me with the "thing" that has been missing for me in working with clients who seemed to exhibit resistance to viewing their choices as limited to simply two.

Christina introduced us to the concept of a "triple decisional balance" that resembled a path on which the client encountered a fork in the road s/he was traveling. In this "crossroads" metaphor, Christina outlined the importance of talking with clients about their current behavior and asking clients to name the decision that they faced when coming to the crossroads. She emphasized asking clients, "What is the name of the decision?" In this way, the therapist could utilize the client's language when referring to the decision. Christina also pointed out the importance of listening to how clients describe the decision as this, too, can be very telling.

If we reference the analogy of coming to a crossroads, Christina pointed out that it is helpful to ask clients, "What is the name of the road" that branches off to the left (the change road)? Clients are also asked to name the road that branches off to the right (the "sustain" or no change road).

Of incredible insight to me was Christina's belief that there might also be a third option, which would be to walk through the fork on the road and consider forging a new, forward path that allows the client to explore doing some of each (i.e. reduction strategies, harm reduction, etc.). In other words, the client's decision does not have to be an either/or decision but might result in the creation of something new and individualized to the needs of that particular person.

As Christina's presentation unfolded, she talked about the importance of looking at the good things and the less good things of all of the paths.

Also highly significant for me was Christina's teaching that exploring the "sustain" road is a highly self-confrontational experience for the client. Christina talked about how she sometimes asks clients to imagine meeting themselves on the "no change" road 10 or 15 years into the future. She asks clients to describe what it would be like and how they would see themselves in the future picture. I can imagine a client having some impactful "aha" moments as part of his or her journey with Christina!

Teaching Empathy

Guy Azoulai

The purpose of the workshop was to share considerations on the way we bring about empathy in our seminars. Examples of exercises around the personal experience and understanding I have come to have on the subject were given to illustrate.

Research has pointed out for years the importance of expressing empathy in the therapeutic process. It has been identified as a major factor promoting change in the treatment of addictions. It is also central to the spirit of motivational interviewing. Yet few are the specific exercises to be found with the purpose of developing and expressing empathy. If evidence based practice shows empathy to be a key factor, then should not developing empathy be a specific training target, and if so, how to go about it? Here are some of the basic questions that may need some answer in order to help do so:

- What is empathy?
- Why does expressing empathy help promote change?
- How can we know when we are empathic?
- How do we express empathy?
- When are we to express empathy ?
- How do we recognize it in others?

In order to have it as a specific target, we would need to have a working definition of empathy we could all agree upon. To illustrate the differences in the way empathy is understood the group is asked how they would define the word. As usual there was a wide array of answers, far from being equivalent. The word seems to have a very "shapeshifting" meaning to diverse people who are all in the same field. It would therefore seem essential to be able to agree on what empathy is. Without that, answers to the other questions could be hard to determine. Once that is done, we may need to do more research into why and how the expression of empathy in the therapeutic process helps promote change. We may also want to find personal criteria to know that we are really the being empathic. As we also know that the choice of words and the way they are phrased may have consequences on people's perceptions and may need adjustments from one culture to another, who wouldn't we not also need to find specific ways of expressing it? And for research purposes would we not need criteria to recognize and the able to code for the expression of empathy? Would we need to to take into account criteria that takes into account the sincerity of what is expressed? And how exactly do we do that?

The simplified version of Carl Rogers' definition of empathy could be "the understanding without judgment of another person's thoughts, frame of reference, and feelings". Empathy-based training would then surely start by the trainer being himself a role model for the trainees. That would imply helping trainers develop their empathy skills and empathy teaching skills—helping them incorporate or adapt in their seminars exercises to develop awareness and acceptance of the other, as well as developping insight into the trainees' own personal agendas. They would also have to help trainees let go of personal fears and ego issues that can hamper their listening and keep from being client-centered.

In order to bring this spirit into training I have created or adapted a few exercises. The idea is to have trainees become aware of their own thoughts and considerations while they are listening as well as those a speaker may have. This can be done from the very start using the very first "ice breaker". Here are some examples of exercises that have been very helpful.

First, I will have trainees pair off in dyads and give each other a three-minute interview, giving information on how the other person wants to be presented to the rest of the group and the reasons for his presence that he is willing to share. The interviewer will then give a 30 second summary, but before they start I have them think about how they felt while they were being interviewed and the conditions that facilitated the exchange. The groups come up with what can be considered as basic ground rules for good communication. The trainees will usually describe being on the same level, having common objectives, feeling free to say what they feel like sharing, having mutual respect and trust, etc.

They are then asked what could possibly overrun those conditions when working with patients. The therapists will try then to see things from the patient's point of view as well as their own. This can be exploited in a variety of ways. It is always interesting to help the therapists find that is their own point of view concerning the patient that they are expressing, and also the find how they can know more about the patient's own point of view. It mainly comes down to giving him a chance to speak and listening. The therapists will find that there are two 2 major issues that are present in both therapist and patient: fear and lack of trust. The trainees can then do some brainstorming to find ways to help dissipate fears in both themselves and their patients and to build trust and mutual respect.

Another exercise I have found mostly valuable in helping therapists catch their own agendas and become conscious of speaker's needs is the "silent listening" exercise, in which the listener is not to use words or sounds in order to make a speaker know he/she is listening. When debriefing the

Teaching Empathy ¦ continued

speakers usually say that it was nice not to be interrupted and the same time uncomfortable not having any verbal feedback concerning the listener's interest and understanding, as they are concerned with the reactions to what they are saying. The speakers usually report having to censor themselves from things they want to say—to share their own experiences, make comments, give solutions, or ask specific questions. When asked how the speakers can give feedback without interrupting or putting in their own agendas the trainees usually come up with rephrasing, setting the basis for reflective listening. As paraphrasing can be one way of expressing empathy, it makes sense that trainees understand what it is and have some practice before working on empathy.

An exercise I developed to help trainees understand and differentiate empathy from other attitudes, especially from sympathy, is the "crying man" exercise. The trainees are asked to think about the different ways people may respond when seeing a grown man crying and the things they might say. A variety of ways in which people will respond emerge. Some people may choose to ignore, others may feel sorry, others yet may find that attitude inappropriate. These different attitudes are known and have been defined for a very long time; as a matter of fact, the words that are used to define these attitudes can be found with their exact definition in an 18th century dictionary (the meanings of the words used to initially describe these attitudes have somewhat evolved since then). They are all composed of the root "pathy" that comes from the Greek and means suffering in an emotional sense. They each comprise a prefix that defines a person's position in regards to another person suffering.

When ignoring or not giving response one will show "apathy"

When rejecting or invalidating one will show "antipathy"

When feeling sorry and identifying one will show "sympathy"

Where does that leave empathy? It literally means to be within but not to be a part of, to be able to apprehend the other persons thoughts, way of thinking and emotional reactions without judgment.

When seeing through the filters of listening understanding and guiding, out of these four attitudes there is only one which shows both listening and understanding while being non-judgmental and allowing for guidance, and that's empathy. It makes people feel they have been understood, helps them "get a load off their chests", makes them "feel better", shows it's safe to talk, builds trust, makes them more open to express themselves, and opens doors to "getting better".

In order to illustrate the effects of suffering on motivation and performance I use Yerkes and Dodson's law, which predicts an inverted U shaped curve. All cognitive capacities are hampered when people are in deep distress. They cannot be attentive, concentrate, think straight, memorise, or be creative in that state. Expressing empathy can help patients calm their suffering, be more receptive, and form a better working alliance.

In order to have the trainees practice recognizing different types of emotional distress and expressing empathy I will have them do the following types of exercises:

- Emotional charades, where one trainee tries to get the other to recognize an emotion through nonverbal expression.
- Empathic real play, where the trainees do reflective listening on the real personal situations of ambivalence they can share with the group, trying to keep their own personal distress level no higher than six on a scale of 1 to 10.
- Empathic role-playing, where the trainees use real situations that they have encountered with patients in which they will be playing the role of their own patient.

These are just a few examples of ways to incorporate teaching empathy into training. The field seems still widely open, ready to yield much more questions and reflections, as well as creative new exercises and adapting of existing ones. The intent of this workshop was to promote the above.

P.S.

Like a singer sings the blues to get them out of his system, I've included a little poem to illustrate the importance of expressing our distress.

Dont repress distress

If you repress and don't express,

It will oppress and then compress,

Till you depress and then suppress

Just to impress and make the press

Coaching in the Moment

Cathy Cole

The purpose of this exercise is to allow workshop participants to practice MI and receive immediate feedback. It requires approximately 30-60 minutes for the exercise and discussion to follow. It is useful in the beginning of an advanced training to establish a baseline of basic skills of the group and establish comfort in immediate non-private practice. In an introductory workshop, it is useful after basic MI concepts are presented and have been demonstrated by the workshop leader. It is most valuable in a group of 15 or less. If used with a large group, the presenter would need to alter the exercise for participants and viewers, much like the original fishbowl exercise.

Structure

Have participants sit in a circle. The workshop leader becomes the client / person with a matter of ambivalence. Select a dilemma that is likely to be different for the participants re: their own client group. Each workshop participant conducts the interview, usually going 3-5 interactions in the interview and then passing it to the next participant. The trainer comes in and out of 'role' to do teaching moments re: MI concepts, question why the participant is moving in a particular direction, or 'coach' on use of MI tools. Participants have access to the MI tools as below and can track what is happening or just observe until their turn arises. Participants have to be reminded to attend to the interview and pick up where the last person ended.

Type	Count	Good Examples
Open questions		
Affirmations		
Reflections		
Simple		
Complex		
Summary		
Double sided		
Change Talk		
Evocative questions		
Ruler questions		
Pros/cons		
Looking forward		
Looking back		
Querying extremes		
Goals/values		
Handling resistance		
Simple/complex reflection		
Amplified reflection		
Double sided reflection		
Shifting focus		
Reframing		
Agreeing with a twist		
Personal choice and control		
Coming alongside		

Promoting Best Practices in MI Training While Keeping Your Clients Happy

Deborah Van Horn

From what I've read on the MINT listserv, I'm not the only one who gets difficult training requests, generally falling into the two broad categories of "my client wants something impossible" and "my client is impossible." It may be a side effect of MI's having achieved flavor-of-the-month status: suddenly everyone wants MI training, whether they know what MI is or not. Some possible solutions include better marketing of best practices such as follow-up coaching; focusing on long-term system-level interventions; and recognizing when to turn down a job (repeat after me: "Your failure to plan is not my emergency"). But what about when you decide to go ahead and train in less-than-ideal circumstances?

From this premise we had a lively discussion about the essentials of MI training. "Essentials" in this case referring to what you do when whoever hired you is not ready to follow through on what it takes to learn and implement MI with any degree of proficiency. And yet, they expect workshop participants to be able to do something different at the end of the half-day, even when they can't articulate what they want them to be able to do.

I argued that it is not unreasonable for trainees to expect to be able to do something different even after a brief workshop. I agreed with emphasizing spirit over technique during training, and presenting training goals in learning-to-learn terms, but I also think that one of the great strengths of MINT-style training in MI is the explicit instruction in how to put that spirit into practice. Those of us who aren't naturally gifted therapists may not make that leap on our own!

So, we discussed the question, What do you want trainees to be able to do after a workshop, knowing that whatever it is, it won't be ideal? Some of the data presented at the Forum suggested that this isn't only relevant to difficult training requests; even the most extensive training doesn't always produce proficient clinicians. Along the way, we discussed relatively simple techniques that have the potential to facilitate the kind learning we hope will take place after the workshop. Examples included importance and confidence rulers, agenda-setting, short summaries, and simple reflective listening as a means of rolling with resistance. We also discussed ways to

incorporate collaboration and a learning-to-learn stance into workshops, and identified some of the challenges inherent in that approach.

Comparing Advice-Giving to Reflective Listening

Bill Miller's Introduction to MI in 3 Exercises

David Rosengren and Stephanie Ballasiotes

We led the group through a series of three exercises, intermixed with brief lecturettes, which illustrated a method for introducing MI in an experiential manner. Bill Miller developed this sequence as a method to introduce MI to groups, including very large groups, while also providing interactive activities. The slides that accompanied this presentation, as well as Bill's description of the exercise, are available to MINT members in the MINTNET section of the MI website.

Soccer Guy Succinct

Chris Wagner

In this session, we reviewed a 19-minute edited version of the Allyn/Bacon "Soccer guy" video, featuring brief clips demonstrating various MI strategies and techniques. I provided a handout with each section labeled by the key strategy demonstrated and including key statements made by the therapist, Bill Miller. I also focused trainers on using the video as an example of an unfolding training technique, in which participants process reactions to the client, hypothesize about the client's motivational concerns and brainstorm potential potential strategies that might be used (or avoided) as the session continues to unfold. One key issue appears to be the potential harm that might be done by therapists who would choose to pursue a "need to change" strategy regarding this clients alcohol use (emphasizing the extent to which the client appreciates negative consequences of drinking or experiences discomfort with continuing drinking). Instead, by pursing a "desire to change" perspective and focusing on cigarette use rather than alcohol use, the therapist opens a pathway to change that the client personally desires to make, rather than feels pressured by others to make. This pathway eventually incorporates a desire to change alcohol use as well, which most participants agreed would not have been possible had the therapist focused on developing discrepancy directly around alcohol use. The session was lively, with MINT members sharing their own individual perspectives on various client attributes and therapeutic strategies shown this clinically-rich video demonstration.

Lluvia de Ideas: Exchange of Training Ideas in Spanish

Carolina Yahne

MINTies representing Brazil, Chile, Venezuela, and the USA participated in this brainstorming session. We shared PowerPoint slides, handouts, DVDs, and exercises that had worked well in training speakers of Spanish.

The conversation about cultural differences and similarities touched on (1) how time is allocated during a training workshop, (2) how willing or reluctant participants are to share audiotapes of their sessions, and (3) how coding models can be translated to provide useful feedback to practitioners.

We exchanged e-mail addresses and have already sent one another electronic materials. One goal of the session is to continue to add to the growing international network of Spanish speaking MINTies for collaboration and collegiality.

Por favor, escribanme si hay otras personas que quieren participar: CYahne@UNM.edu. Gracias!

Using Standardized Patients in MI Training

Chris Dunn & Laura Travaglini

This was a "question-and-answer" format encouraging audience participation. The audience contributed some of the summary points below.

Below is an outline of topics and a summary:

1. Examples of how we have used SPs
2. How do you train SPs?
3. Who makes a good SP?
4. Advantages/disadvantages of using SPs for MI training
5. Summary:

- Some SPs are more resistant than real clients, so train them to respond to MI with change talk
- Encourage learners to suggest a scenario for the SP to play so the training can best address their learning needs and it will be context-relevant to learners
- SP sessions are "trials by fire" for learners, so try to defuse their nervousness, which makes it hard for them to do their best MI
- Counselors don't like to listen to their own tapes, so extra measures are needed to get them to do this
- Counselors bond strongly with the SPs, despite the tension and pressure of role plays with them.
- Professional actors not always necessary for SPs.

Twas the Week Before MINT-mas

Harry Zerler

Twas the week before MINT-mas and all through this vale
Every client was rushing to get to a sale
Watching their watches as sessions evolved
In hopes that ambivalence would soon be resolved

Sessions ended, the MINTies were snug in their beds
With complex reflections that danced in their heads
And Bill in a bolo, and Steve feeling fine,
were relaxing with ice-tea, and a glass of good wine

When out on the list-serv there arose such a clatter
They both spilled their drinks seeing what was the matter
A curious message appeared on the screen
That challenged the MINTies like nothing they'd seen:

"We're wanting MI to be taught in this place
To quickly establish an evidence base;
In keeping with our logistical limits
We need you to do it in less than five minutes."

Impossible! Never! the MINTies replied
But one little message took the opposite side
"I can give you the essence, and do it real fast
though I can't guarantee the effect size will last,

Close up your lips and open your ears,
Embrace all your hopes and abandon your fears,
See that our clients have got what it takes
To grow and develop for healthiness' sake

It won't take forever, we can do some today,
If you gently consider what gets in the way,
Importance and Confidence, shaky intentions
Can be greatly assisted with empathic reflections

Affirm them with OARS, never wrestle but dance
When you happen upon a piece de resistance
If you DARN any holes in the minutes remaining
MITI coding will show that they'll all be abstaining!"

How perfect! How Thrilling! But it gave them all pause
To see that the message was signed: Ambi-Claus
They could scarcely believe, but it did seem to show
MINT holiday spirit, maybe yes? maybe no?

THANKS to ALL who have posted, and to all who have lurked
As your wonderful musings enlighten our work
THANKS to all of our mentors, may the season be bright,
Merry MINT-mas to all and to all a good night!