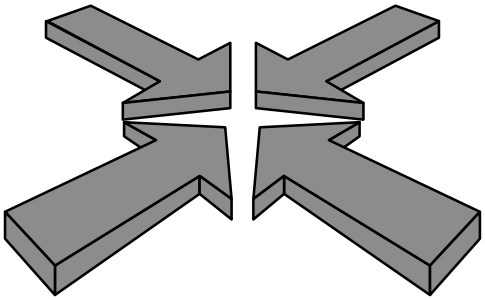
Motivational Interviewing Newsletter: Updates, Education and Training

September 1, 2001 **Volume 8, Issue 3**

A Publication of the Motivational Interviewing Network of Trainers



New Perspectives

From the Desert

Owing in part to some long plane rides since last time, and in part to honor Denise's last issue as Editor of this newsletter, I have contributed the following series of thought pieces. As always, responses are encouraged!

Bill Miller

On Practicing What We Preach

"Good trainers can get a horse to do what they want it to do. A great trainer can get a horse to want to do it." – Monty Roberts

One of the puzzles posed by research on motivational interviewing is how such brief interventions can exert a significant impact on behavioral outcomes. There is no skill-training going on in MI. No real-life contingencies are changed, and certainly personality is not altered. Yet most outcome studies have reported substantial and relatively stable behavior change after MI.

But then it's not entirely clear either what the active ingredients are in psychotherapies in general. Often most behavior change happens within the first few weeks of treatment. Outcomes are frequently predictable from a measure of working alliance at the second session. Reviewing research on coping skill training for alcohol problems, Jon Morgenstern and Richard Longabaugh found no evidence that acquisition of the intended skills bore any relationship to outcomes. Even our treatments that work well may not work for the reasons we think they do.

One familiar explanation of these puzzling findings is that there are some common active ingredients in many psychotherapies, that exert their effects relatively early by influencing client motivation for change. In this view, the primary obstacle to change may be motivational factors like apathy or ambivalence, rather than any dearth of coping skills, knowledge, wisdom or insight. If something causes the person's self-perceptions to shift, increasing importance (or confidence, or readiness), change is more likely to occur, often drawing on existing skills and resources. The fault, dear Brutus, is not in our skills but in our selves (or at least self-perceptions). Remember Premack's smoker, who quit abruptly when smoking threatened the perception of himself as a good father.

In a stimulating conversation with Tom Barth recently, it occurred to me that I have been making the same dubious assumption about MI trainees that I used to make about clients in treatment: that they have come ready to change. How many hours have MINTies sat fretting about how best to teach useable skills in initial workshops? Our training data indicate that trainees leave MI skill

workshops with significant but modest behavior change on average, and high variability in the degree of change. Does this sound familiar? Does it sound, perhaps, like the typical outcomes of treatment for addictive behaviors, or of psychotherapy more generally?

Suppose that instead one assumed that trainees come to their first MI workshop relatively uninterested in changing their current practice behavior, seeing no persuasive reason to do so. They come perhaps out of curiosity, or to find out if there might be something worthwhile to, at most, add to their current repertoire of clinical methods. They come *wondering* if there *might* be something useful, but skeptical that these experts really have much that is new or different. Some need continuing education hours, or are sent by a supervisor. They come for various reasons, perhaps open to but mostly unmotivated for making significant changes in their established practice behavior. We respond by teaching them skills for how they can change.

If this scenario is anywhere close to accurate, then chances are that we have been answering the wrong question in much of our entry-level training. The primary question is not, "How can I?" but rather, "Why should I?"

The acknowledged guru on why people adopt new practices is UNM Professor Everett Rogers, whose classic *Diffusion of Innovations* is going into its fifth edition. To oversimplify his lifetime of work in a list, he describes five attributes of innovations that favor adoption:

> ***Relative advantage*** is the perception (regardless of objective evidence) that the innovation is in some way better than current practice. With motivational interviewing (MI), for example, a possible incentive is that clinicians often perceive client motivation for change (or lack thereof) to be a significant obstacle to change, and seek more effective ways to deal with this common problem.
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> ***Compatibility*** also favors dissemination - the perception that the innovation is not fundamentally inconsistent with current values and experiences. MI is not founded in a particular view of etiology, and from our training experience it seems to be a clinical style that is compatible with many therapeutic approaches including cognitive-behavioral, twelve-step, and psychodynamic methods. Because of the common emphasis on client-centered methods in professional training, MI tends to be perceived as particularly compatible by counselors, social workers and nurses as well as by doctoral mental health professionals.
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> ***Complexity*** can be an obstacle to adoption if the innovation is perceived to be difficult to understand and use. On first exposure, the compatibility of MI with more general client-centered and patient-centered methods often makes it seem quite comprehensible. In fact, it is not uncommon for trainees to perceive themselves as already proficient in this approach. With further exposure, however, trainees usually discover the difficulty and complexity of this clinical method. Thus perceived complexity is a factor that may favor initial interest in MI, although discouragement later in the acquisition process is an important potential obstacle.
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> ***Trialability*** is a term coined by Rogers to describe the extent to which the innovation can be tried out on a tentative basis, without fully committing to it. This is a potential strong point of MI, because it can be gradually incorporated into practice without dramatically altering (in most cases) ordinary clinical methods. Indeed, successive approximation appears to be the modal method by which MI is acquired.
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> Finally, ***observability*** refers to how readily the results of the innovation can be observed by the adopter and by others. MI training has taken some advantage of this aspect, because client behavior (e.g., cooperation versus resistance) can be dramatically altered within sessions by a change in counselor behavior from a directive-confrontive style to a reflective-supportive MI style. This means that even after training, counselors can readily observe the immediate effect of changes in their style of intervention. MI trainers typically rely on this process for generalization of training, and teach trainees what client behaviors to watch for in order to know whether they are effectively practicing MI. In terms of observability to others, this is less likely to occur through direct observation of practice (since most treatment happens behind closed doors) than through word-of-mouth shared enthusiasm within informal clinician networks.

Note that with the exception of observability, these are predominantly *perceptions*, just as the primary obstacles to behavior change for heavy drinkers (such as reasons for not seeking help) involve their perceptions of themselves and their drinking.

How might we train differently if one of our primary objectives were to accurately enhance trainees' perceptions of the relative advantage, compatibility, complexity, trialability, and observability of MI? Chances are we would ask trainees to *tell us* how these things are true of MI, and why.

Relative Advantage

Here I have relied primarily on presenting outcome data, a strategy that in retrospect strikes me as weak at best. Certainly we owe it to our trainees to provide a succinct and accurate summary of efficacy evidence, but it is abundantly clear from Rogers' masterful history of the diffusion of innovations that evidence of efficacy is neither necessary nor sufficient to foster adoption. One danger here is the perception, "I already do this," which removes any relative advantage. At the opposite end is the judgment that "this wouldn't work any better than what I already do." Either of these perceptions would decrease the trainee's interest in trying MI or learning more about it – exactly what we observed after our first training study in Oregon. This raises the specter that ill-focused training may actually *inoculate* participants against future training and skills acquisition.

Compatibility

Even if trainees are convinced that there would be an advantage in MI relative to their current practices, there are other potential obstacles. One of these is compatibility: How well does MI fit with my own personal philosophy and approach? How much would it require me to change what I already do? Are there current practices I value which are incompatible with MI, that I would have to give up? In a recent 2-day workshop in Norway, we added a discussion at the end of the first day, asking trainees to tell us how what they understood of MI would be compatible with their own approach.

Complexity

Even if trainees believe that MI offers a relative advantage and is basically compatible with their own current style, they may be dissuaded from adoption if they perceive it to be too difficult and complex to learn. Is the relative advantage worth the effort required? Models who are perceived peers might be helpful here, and there is a danger if models look too proficient. Michael Mahoney distinguished between a *mastery* model and a *coping* model, the former embodying errorless perfection. A coping model, on the other hand, demonstrates imperfect competence, making mistakes but coping well with them within the general style. Mastery models can be inspiring, but coping models are more credible and empowering.

Trialability

Here, I believe, we have been wiser in our training. MINTies typically provide more practice than instruction, more trying and showing than telling. What better way to demonstrate trialability than to try it out during training? Such practice should be designed, of course, to yield an experience of success. If trainees flounder in initial trials of MI, or are defeated by the client from hell during practice, they are likely to be discouraged about future applications. Similarly, MINTies have been ingenious in designing applications "in the spirit of" MI that can be readily learned and applied in practice, and are likely to yield satisfying results. In early training, we ought to emphasize methods that can actually be learned in the time we have, can be easily applied in daily practice, and are likely to yield observable positive results.

Observability

By observability, Rogers seems to mean that the innovation and its results are observable *to others*, thereby encouraging further diffusion. Looking in a neighbor's field, the farmer sees taller corn and a

more abundant crop, and is curious. A rival company seems to be more successful in retaining employees and keeping them happy. Yet psychotherapy is, by its very nature, a private affair and its practice and results are not so publicly observable. Its diffusion relies heavily on word-of-mouth reputation among clients and colleagues. A good story may be more persuasive than a dozen randomized trials.

As discussed above, however, MI has some advantages in the observability of its results to the counselor in training. Besides the fact that the behavioral impact of MI is often seen quite early, Paul Amrhein's work is providing us with clear guidelines as to what to watch for *during MI sessions*. Certain patterns of client in-session response predict behavior change – notably, an increase in commitment language (change talk) and a diminution of resistance. One therefore gets *immediate and ongoing feedback* about counseling style. Change talk is a green light, a signal of being on the right path. Resistance is a signal to change direction, avoiding a dissonance collision.

More generally, *practice with feedback* is a key to learning. This is one advantage of a smaller ratio of trainees per trainer. The MISC system offers a means for giving structured, specific feedback of MI proficiency within a work sample. We are considering how we might incorporate rapid-turnaround MISC coding within intermediate or advanced trainings, as an aid to coaching and learning.

Incorporating Rogers's Principles in Training

Here is a new challenge for MINT creativity: How can we design training in order to enhance perceptions of relative advantage, compatibility, manageable complexity, trialability, and observability? Consider that the most important and appropriate goal in initial training may not be establishing competence in MI, but rather enhancing motivation to *try* it, to adopt it. We have known for some time that it is important to manifest the *spirit* of MI when teaching it, to train in a manner that is respectful, collaborative, evocative, and honors autonomy. We have, I think, been less intentional about applying the *method* of MI in training!

If we follow our own line of reasoning we would expect, at best, rather limited impact of *telling* trainees that MI is advantageous, compatible, etc. If doing so elicits overt (or perhaps covert) counter-argument, such didactics may even diminish the likelihood of adoption.

This prompts me to reflect a bit on what constitutes "adoption" of MI. For the farmer, adoption of a new seed corn is relatively clear. It is evidenced when the farmer buys the new seed and sows it. In Angelica Thevos's research in Africa, adoption of water purification technology is evident in women's acceptance and use of the device and the ongoing purchase of bleach. Both of these have an all-or-none quality (although the farmer could try the new seed in one field) – either the person is using the innovation or not. MI is acquired more gradually over time, like proficiency in tennis or chess (although even here, it is plainer whether one is spending time playing the game). People can also change their mind about an adoption. The farmer may go back to the old seed, the mother may resume using unpurified water, the player may give up the game.

There are some parallels here to the transtheoretical stages of change. I suggest that most people coming to an initial MI workshop are contemplators. They have not made a definite decision or commitment to use MI. Indeed, they may know very little about it. A good outcome would be for the person to advance to the preparation stage. A great outcome would be that the person goes back and begins trying out MI in practice. That is what constitutes initial adoption.

Now we come to the next challenge: maintenance. If a one-time workshop does little to promote adoption, it does still less to enhance maintenance. This is where ongoing observation, feedback, discussion and coaching can be helpful. I have encouraged peer-supervision groups to continue with on-site review of session tapes, and discussion and shaping of MI practice. MINT meetings serve this function for trainers. There have been requests for more advanced or

intermediate training and refresher workshops, both for practitioners and for trainers.

To return to the level of initial training, though: How could training be enhanced to focus on the process of moving trainees from contemplation to action? Following Rogers's principles, we would seek ways to:

1. Develop discrepancy, in the form of a perceived relative advantage of MI above and beyond current practices. Remember that discrepancy does not require any devaluing of current practice, only an advantage of adopting the innovation. This also involves overcoming the perception that MI is nothing different from current practice.

2. Enhance the perceived compatibility of MI with current values and practice

3. Support self-efficacy, conveying MI as a challenging but attainable and rewarding goal (medium complexity)

4. Promote adoption by increasing the probability that trainees will begin trying MI in everyday practice, with successful and rewarding results

5. Focus on naturalistic feedback that occurs in the practice setting, allowing trainees to have ongoing observable success with MI, and allow not only maintenance but continuing improvement in MI skills.

The answers for how to do these things are not at the end of this article. They are, however, already percolating in the minds of MINTies.

Horse Sense

For those of you who share my admiration for Monty Roberts' work and writings, he has a new book out entitled: *Horse Sense for People: Using the gentle wisdom of the join-up technique to enrich our relaqtionships at home and at work*. It is published by Viking Press (2001).

Some Autobiographical Reflections

I grew up in a religious family, seeing life through the black and white lenses of Protestant fundamentalism. I suppose that the first time I tried out the role of a helper was as a counselor in summer camps. Looking back on what we did, I realize that my concept of how to help others at that time involved bringing them to identify and confess where they had gone wrong, so that they could then be shown the right way. Not surprisingly, I had few friends during this time, and my reservedness in expressing my own feelings caused me to be seen as cold and aloof.

College was in many ways a vital time for me. An undergraduate education was the natural first step toward seminary training and a career in ministry. Along the way, however, I found myself drawn away from organized religion, "across the street" to psychology. It was during graduate school that I met and married the woman who would be my lifelong partner.

The approach to clinical psychology that I was taught during my Ph.D. training fit rather well with my early understanding of a helping relationship. One helped by diagnosing the problem, and then presenting the answer. Helping relied on expertise: the expert discovered, advised, intervened, and shaped the person to yield the desired results.

When I began practicing and teaching psychotherapy, however, I quickly grew restless with this approach. My change of approach was not stimulated by colleagues or by the psychological journals of the time, for these mostly reflected the same expert model in which I had been trained. It was my clients who gently showed me how to work with them. Over time, I gradually came to a very different understanding of the helping process, one based on a deep trust that people already have within them the ability to clarify and resolve their own dilemmas. The helper's job is not to diagnose and then dispense answers, but to be with people in a way that allows their own natural wisdom and experience to come forth.

I found very little interest in or support for this view among my academic colleagues. Instead, the ideas that form the core of my approach emerged through dialogue with my students, and it is a misnomer to designate me as their originator. My thinking and learning continued to evolve, informed in part by my ongoing interest in the interface of psychology and theology, and over time these strands were woven together into a coherent approach. I came to understand what we were doing in the counseling office as essentially the practice of *love*, and eventually I called it by that name in my professional speaking and writing, to the consternation of some of my colleagues. In a way, I became something of an embarrassment to my scientific colleagues in psychology. It hasn't slowed me down, though. I've written a series of books and hundreds of articles and chapters on my central interests in treatment process and outcome, and more generally on what facilitates change.

It disturbs me deeply when people think of what I do as a technique. At this level, the method is easy to caricature and oversimplify, and for a while I moved away from "how to" descriptions, emphasizing instead the essential spirit that is the essence of this counseling approach. Also, the approach itself keeps changing and evolving. It has been particularly useful in this regard to analyze tapes and transcripts of counseling sessions. It allows one to see the orderly sequences of process that are missed in the flow and content of experience. I continue to learn primarily from clients and students.

The broad appeal and impact of my work have always surprised me and continue to amaze me. There has been substantial influence in countries as diverse as Norway, Holland, Australia, Brazil, Italy, New Zealand, Poland, and South Africa, and my work keeps turning up in new translations. I don't attribute this to any special genius of my own, and certainly not to any far-sighted vision on my part. I think that, without realizing it, I have given voice to ideas whose time had come. The central idea is that the counselor is, in essence, facilitating the client's own natural process of self-discovery and self-change.

My work has had relatively little impact, really, within the academy, the world of scientific psychology. It gets mentioned in passing in textbooks, often misunderstood as a technique, but I doubt that there will be a lasting impact of my work within academic psychology. The longer I work, the more I recognize the spiritual essence of what I have been doing, and I think I have often seriously underestimated the mystical, spiritual aspects in my teaching and writing. There is something mysterious here that happens between people, and it is not at all limited to the context of counseling. It also applies in families, in education, in inter-cultural communication and politics, even in relating to nonhuman species. As I've grown older, my love of gardening has increased. I enjoy puttering around in the back garden at home, seeing what I can do to provide the right conditions for promoting natural growth.

The above narrative could in all respects be my own, but in fact I gleaned and paraphrased it from the writings of Carl Rogers. Recently I had the treat of discovering a book of his that I had not seen before, his final book (1980) in which he looks back across his career to summarize his work. Its title caught my eye immediately - *A Way of Being* - for this is how I understand the nature of motivational interviewing. The book is a collection of papers, some previously published and some new. They range widely in topic from autobiographical material, to descriptions of the client-centered approach, to critical commentaries on education, politics, and on the discipline of psychology. It is a rich source of classic Rogers, and I commend it for your reading. I was particularly struck by his chapter-essay entitled, *Empathic: An Unappreciated Way of Being*, which he wrote for this 1980 volume. "It is one of the most delicate and powerful ways we have of using ourselves. In spite of all that has been said and written on this topic, it is a way of being that is rarely seen in full bloom in a relationship" (p. 137). The chapter contains a masterful statement of his understanding of empathy.
This also caught my eye: "The implication of these findings is that we could avoid a great deal of unsuccessful therapy by measuring the therapist's empathy early on" (p. 147).

The Rogers-Buber Dialogue

This led me, in turn, to reread the classic dialogue between Carl Rogers and the theologian Martin Buber, whose work I studied in college. There are obvious parallels with Buber's classic distinction between an I-Thou and an I-It relationship, the latter involving relating to the other as an object. Rogers clearly perceived the expert model of psychotherapy as an example of an I-It relationship, and Buber similarly eschewed the objectifying nature of diagnosis and rehabilitation. In *A Way of Being*, Rogers observes, "In every respect in which we make an object of the person - whether by diagnosing him, analyzing him, or perceiving him impersonally in a case history - we stand in the way of our therapeutic goal. To make an object of a person has been helpful in treating physical ills; it has not been successful in treating psychological ills" (p. 179).

An interesting point on which they differed during their dialogue was on the nature of the human person. Rogers reflected throughout his writings a belief in the inherently positive, universal growth-seeking core of human nature that can be trusted to move in a healthy direction. Given the proper conditions, people naturally develop in a positive identity and direction. "It's been very much my experience in therapy that one does not need to supply motivation toward the positive or toward the constructive. That exists in the individual. In other words, if we can release what is most basic in the individual, it *will* be constructive" (p. 78). In *A Way of Being*, he stated it even more broadly: "There appears to be a formative tendency at work in the universe, which can be observed at every level . . which can be traced and observed in stellar space, in crystals, in micro-organisms, in more complex organic life, and in human beings." (That sounds a great deal like God to me, although Rogers didn't bring himself to say it.)

Buber was less sure of an inherent trustworthy nature, understanding the human condition as a dilemma of existential choice between "Yes and No." He did not equate these with good and evil, and also balked when Rogers suggested that the direction of therapy was to "affirm life." Buber preferred not to assign any object to the Yes and No, though clearly his intent was to foster a way of being that would help others choose the Yes rather than the No. I found this a fascinating parallel to our use of the concept of ambivalence in MI. Consider this from Buber: "Now when I see him [a person with problems], I grasp him more broadly and more deeply than before. I see his whole polarity and then I see how the worst in him and the best in him are dependent on one another, attached to one another. And I may be able to help him change the relation between the poles, not just by choice, but by a certain strength that he gives to the one pole in relation to the other. There is again and again in different manners a polarity, and the poles are not good and evil, but rather yes and no, acceptance and refusal. And we can strengthen, we can help him strengthen, the one positive pole. . . I think the good, or what we may call the good, is always only direction, not a substance." (pp. 84-85).

The Rogers-Buber debate is quite short in narrative form, and an inexpensive corrected transcription of the original audiotape has clarified some confusions arising from errors in earlier transcripts. If you're interested in the interface of psychology and spirituality, it's a classic worth studying.

Rogers, C. R. (1980). *A Way of Being*. Boston: Houghton-Mifflin.

Buber, M., Rogers, C. R., Anderson, R., & Cissna, K. N. (1997). *The Martin Buber - Carl Rogers Dialogue: A New Transcript with Commentary*. Albany: State University of New York Press.

Collective Motivational Interviewing

At the annual Research Society on Alcoholism meeting in Montreal, I had occasion to speak with some colleagues from South Korea, and to see some of the first English-language data on alcohol problems in China. As with Japan, there appear to be relatively high rates of alcohol abuse among men in these countries, and very low rates among women. Two Korean doctors who run treatment programs described a particularly interesting challenge. When a Korean male problem drinker is isolated from his culture (e.g., by spending a period of time in the U.S., or in residential

treatment) his interest in quitting drinking and smoking can be quite high. Upon return to the world of work, however, there is a formidable obstacle. Men in this culture work long hours, and then after work go out together to bars where the real business and decisions are done. Success in the world of work appears to be heavily dependent on participating in this after-hours process of socialization and negotiation, which is suffused with smoking and heavy drinking. To be absent from these sessions is literally to be shut out of success at work.

Think about the futility of an individualistic motivational interviewing focus in this context! Asian cultures are imbued with collectivism, and American individualism is often viewed (appropriately, in my opinion) as egoistic and self-serving at cost to one's family, work group, and society. Motivational interviewing, as we have modeled it on training tapes, has usually been focused on evoking the individual's perspectives and interests. Such a focus is rather antisocial within a collective society. This caused me to reflect on how motivational interviewing might function within an Asian context.

Perhaps the focus would be more on the values of and impact on one's reference group. I can imagine individual men, in a motivational interview, talking about the ways in which drinking and smoking may adversely affect their social group, family life, collective productivity, and such. The discussion could focus not so much on the person's own drinking (and smoking), but on the effect of these health behaviors by the larger group. It might, in fact, be easier to evoke examples of concern for others based on their substance use, than to elicit problem perception at the individual level, and to evoke change talk at the group rather than individual level. What might be the impact of doing such individual interviews with every member of a business working group who drink together? There is also potential, of course, for motivational interviewing with the group itself *as* a group – an issue we are struggling with more generally. I thought I would pass along this challenge of *collective* motivational interviewing, in hopes of generating further MINTy creativity.

Motivational Crossovers?

A brief look at MI in "non standard" areas

Mark Farrall

The MINTynet has seen a wide-ranging discussion recently on whether MI can be used with all client groups or not. A theme at the most recent MINT meeting in Santa Margarita was the use of MI in contexts other than those for which it was 'designed' or which are outside of health, substance misuse and so. Various MINTies revealed shameful episodes of sales in their pasts (no names mentioned but the guilty parties know who they are!) when MI style techniques helped them to make a fortune (or at least sell cars). In this article I would like to describe some of the most recent 'adapted MI' work in which I have been involved (very little of my work involves 'straight' or 'pure' MI actually) and discuss a few points which may be of interest.

'Forensic' MI

This is a term I have coined for the use of MI in criminal justice or correctional settings. The question has been asked of me, 'Why forensic? Why isn't it just MI with offenders?" Fair point, but I do think there are several differences between MI applied in this context and otherwise.

First let's look at the similarities. A trained counsellor might use Motivational Interviewing within an alcohol or drug agency to work with an offender on their substance misuse as one part of the offender's criminal behaviour. Fine, then lots of straightforward MI material applies. However, even in this setting, the client is coerced, a difference that means a slight change in approach. In Santa Margarita one session looked at how to use MI in a (Scandinavian) setting where the 'helper' social worker type professional is also the one who will cut off state benefits if behaviour change targets worked out between client and professional are not met.

We considered whether it was possible to use MI in this context, and for me the answer is yes, provided that the worker is entirely honest about the power differentials and their capacity as an enforcement agent. This is slightly different from a context where the client can come or not come and their individual choice is respected. Our discussion decided (I think I am right in saying) that so long as this dimension of enforcement is open and on the agenda from the start, then it is congruent with MI spirit and technique.

The observation is often made to me by National Probation Service staff that offenders are hostile to them. Again, this is a slight difference to mainstream MI. The levels of hostility and types of hostility – i.e. 'in your face' verbal aggression or threatening body language - seem to be much higher in criminal justice circles than in non criminal justice. The cumulative effect of this on workers seems to be more wearing. In training MI in this context then I spend much more time on the boundary issues and dealing with resistance than would be the case for other settings.

Group work

Most offending behaviour work in the UK is now done in groups on an accredited programme. The difficulty is that this move is mostly ignoring the process issues of the way in which material from a programme manual is delivered. This is where MI comes in. Again, I am attempting to train workers in the foundation skills of MI, but then in applying them to group contexts (see Farrall 2001a). The predominant mode of questioning in programmes at present is ‘Socratic’, meaning a process of leading the individual to discover information they ‘already knew’. I prefer to teach a reflective style, feeling that this is more humanistic and person centered and (as all the evidence suggests) more likely to lead to change.

Prison Staff

I have worked with prison officers who are not trained counselors in an effort to inculcate MI practice. My grand vision is of a prison establishment where everyone is trained in MI and all staff-inmate interactions are (at least initially) conducted in an MI way. Imagine the therapeutic atmosphere likely to be gained. Imagine the cumulative effect of inmates being surrounded by firm, fair, respectful empathic staff who are modeling pro-social behaviours every minute of their working day.

This vision has not come to pass for various reasons, but I have heard feedback from a (female) officer who was confronted with an angry inmate wielding an improvised knuckle-duster made from a kettle flex and the plug. The officer (whose reaction prior to training would have been to immediately call for help) use reflections and summarys on the man and fifteen minutes later he was calm and back in his cell.

Investigative Interviewing

A particularly interesting conversation I had in Santa Margarita concerned the possibilities for MI in police interrogations. The person I spoke with was worried that the use of MI called for techniques and attitudes that would provide difficulties evidentially at a court trial. By this I mean that meaning or feeling reflections are potentially suggestive (in a legal sense) because they depart from the supposed purpose of getting information that originates purely from the witness or suspect.

Having said that, two points arise. Firstly, I have had two conversations on the theme of miscarriages of justice around the Birmingham Six or Guildford Four. For the non British MINTs, these cases involved people of Irish extraction convicted of terrorist bombing offences in mainland Britain. After many years of imprisonment, both cases were overturned on the basis of unreliable confessions, police coercion and so forth.

Now, the people I have talked to about this (a prison officer and an ex police officer) took the view that the individuals were obviously guilty (despite all the later evidence to the contrary) and it was ‘clever lawyers’ who got the defendants off. The relevance of this is that the worry expressed by these two people is that the use of MI would

give ‘clever lawyers’ another stick with which to beat the police.

The second point is that police interrogation in the US and UK is in a pretty bad state anyway. In the US, the ‘standard text’ encourages officers to use psychological coercion, deception and intimidation (Inbau, Reid & Buckley 1986). In Britain the Police & Criminal Evidence Act is supposed to prevent this, but police culture sees a confession as 'good police work’ and as evidence of professionalism. Now, where MI comes in is that evidence suggest that what makes people confess (truthfully) is not intimidation as seen on every cop show interview scene on TV, but *weight of evidence* against them and feeling they are in an environment where confession is *understood and supported*. Motivational Interviewing actually helps toward this by creating the basic preconditions of rapport and respect which helps the effective gathering of information and creates in an offender the feeling that they can confess without adverse psychological consequences to self image and self esteem.

So: That was a long way around, but I have been involved in training the Interview Team of a prison in investigative interviewing techniques which had the MI spirit and some techniques such as content reflection and summary at its core. The response was immensely positive, and the trainees identified all round benefits to this way of working compared to their previous rather confrontative or too-accepting stance.

An interesting training point is that the techniques had to be taught in a very goal orientated, instrumental ‘this will make your life easier’ sort of way. With a prison officer client group ‘trainee cynicism’ is always high, and their professional socialisation weighs against respectful, empathic ways of working: they have a fear of being ‘Care Bears’ (see below.)

Management MI

Another area of adapted MI is management related work. I am aware that Solution Focused Therapy has been pushed in the UK as a ‘new paradigm’ for management and at least one big retail chain has looked at MI with senior managers. My involvement has again been with prison officers, by training them in MI based appraisal skills. Once again, the core MI values and skills of respect, empathy, reflection and summary are crucial and once again had to be presented in a ‘this will make your job easier’ way. This is in tune with MI in terms of starting from where the group is at, but does cause problems in terms of fears of Care Bears mentioned above.

The Care Bears might be a universally known group, but in case they are not(!): they are a bunch of teddy bears who star in a children’s programme and model care, love, sharing etcetera. Prison officers do not seem to feel identification with these teddies. The officers seem to have a suspicion of anything which may appear too ‘soft’: this meant that our skills demonstrations which showed excellent counseling style and skills were initially too slow, ‘low energy’ and ‘round-about’ for the officer group to see the use of.

This raises a point about the level of worker one is training. These officers were the lowest level of management – more like supervisors or forepersons really. They did not want or need to know about the cycle of change, the deeper reasons of why people change or do not change, and were actively threatened by the thought of exploring a personal issue with a worker, however much it impinged on their performance at work.

The focus in this arena is not behaviour change *per se*, but some sort of collaborative pre-curser to actually telling someone what to do. Our training was well received but seen by the officers as a first response of being reasonable, respectful and so on rather than having to go immediately to authoritarian manager. This training revealed the difficulty that in this context there may well be a tension between the management aims and the worker aims – not something which the MI client-counsellor relationship usually has.

In the end, we decided that the training would at least humanise the practice of the officers as managers, which had (at least in one case) been openly abusive previously.

MI & Youth work on racism

We are also involved in training detached youth workers in tackling racist thinking and behaviour. Their job involves going onto the streets and estates of South East London (an area where there have been several high profile racist murders) and attempting to connect with the often low educational attainment, unemployed, low aspirational white youths of the area. Motivational Interviewing applies to this in terms of enriching the skills of the youth workers in exploring problematic behaviours (in this case racism) and 'planting a seed'.

The youth workers identified that most of their work is with young people in precontemplation or contemplation; they may see an individual once for a few minutes every few weeks, and there is no common shared agenda for the interaction (again, unlike mainstream MI). Getting across to this under-trained and under-resourced group that they do not have to problem solve everything immediately and that simply reflecting and summarising can be a powerful tool, was a major task. Yet again, the group felt by the end of training that they now had a powerful tool to aid them in their immensely difficult work. The MI skills also will form the foundation of later work in cognitive-behavioural therapy, which I will be undertaking with the group.

MI with special needs children

Although I am about to talk about theatre and action methods with MI, paradoxically this is returning to the roots of MI in substance misuse. A South Wales based counseling agency has recently initiated a service for under-18s (a poorly resourced area in the UK). The service, FUSION, has the innovative brief of finding ways to engage with young people on drug and alcohol issues beyond the traditional verbal MI approach.

My involvement came with training the FUSION workers. We had a pilot project to enter a Special Education Needs (SEN) unit in a local school. SEN children are not necessarily learning disabled or low IQ but exhibit a variety of emotional, communication and conduct disorders. Our brief and wish was to go beyond the 'just say no' approach, do something deeper than the standard police drug box session (where a police officer brings his showcase of illegal substances) and do it in a way that was more likely to engage the young people than a purely verbal approach.

Motivational Interviewing skills were still at the core of this work, but allied to drama methods of role play, creating frozen pictures and using action to facilitate discussion of attitudes and gauge knowledge around substance use. Again, the evaluations have been very positive, suggesting gains in understanding with a very difficult client group for whom a standard MI counseling session is likely to be less productive and with whom drugs education has always been problematic.

Message In A Bottle Theater Company

Finally, we return to my roots in theater. In 2000 we worked with residents of a Cardiff based residential rehabilitation unit for people experiencing severe alcohol related difficulties. The group of 8 residents produced a one off show on alcohol issues, devised from the resident's experience, and intended to be presented to a special audience of political decision makers with power over service provision.

The show, *A Welsh Mystery,* was a bare twenty to twenty five minutes long, but represented a huge effort by the people involved. Everything that is usually needed for theater performance such as concentration, short-term memory, stamina, and self-confidence were absent in varying degrees from the participants. None had previous theatre experience bar one who 'worked' as a clown. The end result was extremely therapeutic for the individuals involved, and their comments on what they had gained from the experience humbling.

Motivational Interviewing skills and spirit were definitely core to this work: eliciting self-motivational statements and increasing confidence and enhancing self-efficacy were on-going themes. The focus was alcohol issues and the exploration of this and translation into theater performance was very similar to the MI process: a dual exploration of experience, behaviour and

meaning while safely reintegrating this extremely emotionally charged material.

Message in A Bottle returned for 2001 devising and presenting a new show, *Anonymous Land*, and once more using a practical application of MI techniques. My colleague who knows theatre but not MI was a useful outside eye on the process: We had one cast member, still in detox, who was extremely difficult to work with in terms of selfish, thoughtless, dominant, immature behaviour. Though this does sound like a lot of actors I have known, he would have been kicked off virtually any mainstream theatre production for his behaviour. Our approach was to maintain an MI approach, constantly working therapeutically to explore and reintegrate his issues, hopefully enhancing the detox and rehab process he was undergoing while maintaining our performance focus. Once again, the evaluation results from the participants in the show (which this time toured to four South Wales venues) were extremely moving.

Conclusions?

So what do I conclude from all this? That the core principles and skills of MI can be applied productively to a wide range of contexts and client groups and there is a lot of 'cross over'. For example, there is a discussion going on about whether you can use MI with 'psychopaths' or personality disordered people at present. Although I have yet to be involved directly in doing this, my suspicion is that you can. MI may be old wine in new bottles but it sure is useful stuff!

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Chris Dunn, PhD, Univ. of Washington, Seattle.

Hello Minties:

As I a mintie growing weary and ever more dissatisfied with providing brief MI workshops and "infomercials", I recently had the refreshing opportunity to work individually with a German anesthesiologist, Tim Neumann, who visited our hospital in Seattle to learn more about doing brief motivational interviewing at bedside with hospitalized trauma patients. I learned more in that week than I have in years. Whoops, it was Dr. Neumann who was supposed to be doing all the learning. But there's something about doing MI with real patients while a "learner" watches, and then talking about it right after that has refreshed me and made me a better MIer. Tim spent 9 days with me, about 6 hours per day, allowing us the luxury of creating together a training menu for him to order from. I started by telling him I had never done this type of training before and would therefore need many suggestions from him. I'll describe what we did.

First, Tim works at the Charite Hospital in Berlin, a trauma center. He has done everything from riding the helicopter, to managing the emergency care of critically injured people in the ER, to proving pre- and post-operative care to surgery patients. Tim has long been a fan of motivational interviewing, and when he arrived in Seattle, said that he often used it during his pre-operation visits with substance abusing patients. During this 20-minute visit, his agenda is to gather facts that he needs to make surgery as safe as possible for patients. He must also give them information about the risks of surgery and deal with their immediate medical concerns. He is a wizard at screening for substance abuse by piecing together constellations of bits of medical data, lab results, medical histories, etc.

Tim was not allowed to talk with patients in our hospital, but had unlimited observation privileges. After training with me during the day, he sometimes spent long nights observing our ER and surgery procedures. He was keenly interested in medical chart data, so much so that I had to drag him away to go see the patient. He watched the first patient interview, and while debriefing, said that he now realized he had not been doing MI, but something else. He has a keen eye for process, as well as a strong reflex to return the discussion to medical data. Before seeing our second patient of the day, I ask him to review the chart thoroughly, and teach me what to teach the patient about the medical findings which suggest an alcohol problem. We then see the patient and I focus mostly on giving the patient information about medical consequences. We then debriefed, and this led to a discussion on how best to give patients information, including medical bad news. We both realize that when we give patients information, we go up in our heads and forget to watch the patient.

Patient-centered talking as well as listening.

During most of our conversations, Tim seemed to reflexively go into a medical knowledge-imparting mode with me. This was both frustrating for me as well as fascinating. So I just tried to model listening, reflecting, and asking permission to move on to another topic.

Soon, Tim wants to practice. So we ask Kathy, our psychology resident, to play the role of an injured patient she recently treated, while Tim practices his pre-operative visit skills. For debriefing, I asked Tim to listen to Kathy's feedback, summarize it, check to see if his summary was accurate, and tell us how he might use her suggestions. He did this beautifully.

Back to the ward to see more patients.

The next day, we ask a trauma surgeon to get us a surgery resident to practice with. He pages one, who appears in the office in 3 minutes. The resident lies on a couch and plays the part of an injured patient very well. Again, the "patient" told Tim what it was like to be interviewed by him. Again, Tim listens, summarizes, and decides what to try differently next time.

Down to the cafeteria. Tim is genuinely interested in addiction, and says he's still smoking cigarettes. We are getting along famously by now, so I ask him if I could practice my smoking cessation skills on him. So we do two sessions three days apart, the first focused on pros and cons of his smoking, the second on how he might change. He liked the first one the most, and said that just the simple pros and cons exercise gave him insights that he had not thought of before. We both realized that he was the one who had generated these insights; all I did was reflect them back to him. He was not so keen to dive in to the second session about discussing possible action, but at least he got to experience how it felt to be pushed by somebody who wanted him to change. I was surprised that he felt pushed, because I thought I was "doing it right". This helped me to recalibrate my righting reflex.

Back to the wards for him to watch more patients.

Oh God, I suddenly realize that I have 30 minutes to make a one-page handout for today's brief talk with psychiatry staff (their supervisor thinks they want to learn MI, so he had asked for the informercial). We dash to the office, and now, with 23 minutes left, Tim wants to teach me how best to make the handout. What could be better? We sit together at the computer editing outlines, and suddenly, as I am typing, Tim is scribbling something in his lap. He's creating his personal outline for doing opportunistic interventions with his Berlin patients. (He does this in English, one of his five second languages.) Here is his outline: "Set the Stage, Broach the Topic, Understand patient's view of drinking, Summarize the View, Discuss the possibility of change, Close on Friendly Terms". Each one of these terms means something to him that he believes are important to include in a talk with patients. As we jog across the street, we agree on the secret goal of eliciting as many change talk statements from the psychiatry staff as possible. We show up on time, the staff are surprised to see us, because they now have to stay 20 minutes longer. Tim watches me

give the informercial to staff, and we debrief the process. He tells me how many change talk statements I elicited. I won't bore you with the exact figure, but I don't remember it being a very large number.

Now, back to the office for more practice, this time with a first year medical student. She was the best actor of the bunch. Tim practices the same scenario with his final outline in hand. This time, I sit behind him and call out two-minute intervals so he can practice all the elements in his outline in 10 minutes. He does it all in 10 minutes, and the "patient" liked all of it and said it made her think about changing.

Toward the end of Tim's visit, he is laughing at himself for 7 days ago using terms such as, "the innocent ones" (non-drinking patients), "launching a long-range cruise missile" ("one day, when you decide to change, you'll be successful" He is also now teasing himself about his "Premature Teaching Reflex". And he is also accusing me of having the same "syndrome". He seems less concerned that open questions might encourage patients to ramble, and more focused instead on saying what he needs to say in much less time. The rest of the last day, we frequently challenge each other to "say what you just said in one sentence". This I need to practice more. I thought I had fixed it seven years ago.

Update on Video Training

Robert Rhode

The substance abuse treatment counselors and providers in the state of AZ had indicated on a survey their interest in motivational interviewing training. A live video training was offered to reach the rural areas that rarely receive training. The training was delivered by sending the video signal across a dedicated phone line to all sites at the same time. The participants at the receiving sites could respond to questions and ask questions of the trainer at designated times during the broadcast. This gave the video training a limited interactive quality. The training sessions occurred once a month for five months with each broadcast lasting three hours.

Consistent with their stated interests, 28 program sites signed up to receive the 15 hours of training. The sites had to be consolidated to 20 because of technical limitations. Over 675 counselors, administrators, and program staff signed up to participate in the training. Some 150 had to be placed on a list to receive the training later because of seating limitations at the sites. Twenty-four counselors who are receiving the video training agreed to provide audiotapes of their sessions with clients so that the adoption of motivational interviewing skills could be assessed.

Session	Date	Participants
1	Jan 19, 2001	351
2	Feb 16, 2001	245
3	Mar 16, 2001	182
4	Apr 20, 2001	92
5	May 18, 2001	173

77% of the participants are between the ages of 26 and 55.
61% are female.
56% have a Master's degree.
89% have some college or more education.
76% are white, 8% Hispanic, 5% American Indian.
27% identify their position as case manager, 29% as substance abuse counselor.
Prior to the first session less than 10% reporting having read the book, "Motivational Interviewing," or the Treatment Improvement Protocol about enhancing motivation published by NIAAA, or watched videos demonstrating motivational interviewing. After the last session some 20% had read some parts of these materials.

Participants' knowledge of motivational interviewing principles was measured prior to the first session and after the last session with 14

multiple-choice questions. The average number correct prior to the first session was 6 with a range of 0 to 12 correct. The average number correct after the last session was 7 with a range of 0 to 12 correct.

Participants rated their skill in using motivational interviewing:
Prior to the first session, 60% "not at all proficient,"
29% "somewhat proficient."
5% "pretty proficient"

After the last session, 65% "somewhat proficient"
25% "pretty proficient."

Most participants were probably thinking of this training as adding to their substance abuse counseling skills as some 40 to 60% agreed with various statements like, "I am effective in accurately gauging my clients' motivation to change their substance use pattern." Or " I am effective in helping my clients reduce their drinking or drug use."

These characteristics appear consistent with successfully reaching the relevant counselors and offering training in an important area. There is some increase in participant's knowledge and confidence in using motivational interviewing.

Eight questions were asked after each broadcast to learn the participant's opinions of the training. These were questions like, "How would you rate the quality of this training?", "Did the training provide you with adequate knowledge on this topic area?", or "Do you expect this training to benefit your clients?" The participants responses to these questions were on a scale from 1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = Excellent. Their responses to the separate questions are highly correlated (r ranges from .5 to .8) and can be considered as one factor reflecting their satisfaction with the training.

Participants' satisfaction
Session Average ratings on the 8 satisfaction questions range from

1	2.8 to 4.0
2	3.4 to 4.1
3	3.6 to 4.1
4	2.8 to 4.0
5	3.1 to 4.0

Session Averaging the 8 satisfaction questions gives one overall satisfaction value of

1	3.5
2	3.8
3	3.9
4	3.6
5	3.6

There were quite a number of comments about the quality of the video and audio signals including not receiving 10 to 70 minutes of the first broadcast, and all sites did not receive the first hour of the fourth broadcast. Many participants may have not returned for the second session because of these technical problems and many participants may have left the forth broadcast because of the delayed start.

Participants were asked at the fifth session the following questions:

Why do you think the people who discontinued coming to these training sessions did so?
Too many technical problems 45 (34%)
Other obligations, changed schedule, time constraints, or busy 41 (31%).

Why did you come to the sessions that you did?
Wanted to learn MI 43 (37%)
Enhance counseling skills 26 (22%)
CEUs 20 (17%)

What part of the sessions you attended was the most useful or did you like the most?
Videos 42 (43%)
Handouts 21 (21%)

What part of the sessions you attended was the least useful or did you like the least?
Tech difficulties, including question & answer periods 39 (46%)
Group work did not happen at this site, small groups, no leader in room to facilitate participation 15 (18%)

How much do you think it would have been reasonable to pay to attend these 5 three-hour motivational interviewing trainings (15 hours total) delivered by video?
$100-150 Average was $75.

How much do you think it would have been reasonable to pay to attend these 5 three-hour motivational interviewing trainings (15 hours total) if it was delivered locally with the trainer in the room with you?
$150-200 Average was $140.

Although the rural areas are less likely to receive training with a trainer in the room because of costs, these participants did not value this form of delivery. The participants did not experience it as interactive and adopted a passive role as evidence by valuing the videos and the handouts while not valuing the interactive exercises with local peers or between sites.

Participants' ability to demonstrate one motivational interviewing skill, reflective listening, has been measured prior to the first session as well as during the second and third sessions, and then after the fifth broadcast. Demonstrating the skill in a way that is rated at three or above on a five-point scale is probably associated with increasing client motivation for change and decreased drinking.

Participants' skill level in reflective listening

Before session 1	1.4
At start of session 2	1.6
At end of session 2	2.0
At end of session 3	3.1
At end of session 5	2.3

Important MINT Dates

Submission	Publication
12/1/01	1/1/02
4/1/02	5/1/02
8/1/02	9/1/02

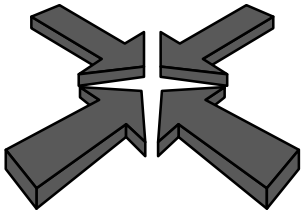
Our new editor

Ralf Demmel, a MINTie from Germany will be taking over the editorship of the newsletter with the next issue. Send him lots of stuff!

From the "old" Editor, now in school

Denise Ernst

This is my last issue as editor. It has been a pleasure to serve the MINT organization in this way. I hope to stay connected and involved with the group for many years to come. Now, I'm not going to get in the "way of being" stuff, but…….the MINT organization (or is it collective?) has a way of being/doing/inspiring/honoring/eliciting the best trainer/scientist/thinker in me. It has enriched my professional life as well as my personal life. Thank you.



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