MINT Bulletin
Motivational Interviewing Network Of Trainers
Volume 14, Issue 1
June 2008

From The Desert

Bill Miller

Tacit Knowing

A Challenge to MI Researchers

The philosopher-scientist Michael Polanyi described "tacit knowing" as a type of knowledge that we hold without knowing how we know it. A master luthier, for example, may know how to craft beautiful guitars that produce exquisite sound, yet may have difficulty verbalizing the decision rules that he or she uses in doing so. In his writings on "psycho-logic," Norwegian psychologist Jan Smedslund has similarly described knowledge that we have of human nature just by virtue of being human, and has critiqued modern "empirical" psychological research as simply rediscovering what we already know tacitly. Carl Jung went further still, postulating a "collective unconscious" containing a repository of accumulated wisdom of the human race.

By now most MINTies will be quite familiar with stories of the origins of MI through conversations I had at the Hjellestad Clinic in Norway with a group of psychologists who included Tom Barth. The implicit procedures of MI were literally elicited from me as I was asked to think aloud about why I was doing what I did in clinical role-plays. Like the luthier, I was trying to make explicit the tacit knowledge that I had been using in counseling. But the question remains: Where did I learn it? My stock answer is that "I learned it from my clients," but I cannot tell you when and how that occurred. I just seemed to know it, and I assume that, like the luthier, I must have learned it through experience with the craft.

Yet I wonder. There is something else puzzling about MI, which is how rapidly and far its popularity has spread with so little promotion other than word of mouth. When thinking about what draws people to MI, the verb that I have used is that they seem to recognize it. That's not always the case, of course. Some come kicking and screaming, others in small gradual steps, but I think it's accurate to say that a fair number of clinicians come to MI because at some level they *recognize* it, they know it. Some say that it makes explicit for them what they have been doing intuitively. That is what happened for me as well.

Then there are those few trainees who take to MI like a fish takes to water. With surprisingly little training and practice they just seem to "get" it naturally. At the end of an initial workshop, unlike most participants, they are doing it. I guess that happens with many skills, like the child piano prodigy. Nevertheless it is a phenomenon that I cannot attribute to random distribution along a normal curve.

Put all of this together, and it suggests that there is a tacit knowing compo-

Editor's Choice

Time for Change

Allan Zuckoff

It has been almost 16 months since the appearance of the previous issue of the *MINT Bulletin,* and although I am pleased and relieved to present the first issue of 2008, it has become obvious that the *Bulletin* has outgrown the one-man or one-woman-job model that had served it since its inception. With the approval of the Steering Committee I had previously accepted a generous offer of assistance by David S. Prescott, a MINTie and former editor of the newsletter of another organization, and without him and his apparently selfless wife, Louise, this issue would still be in progress. But I believe now that the time is right, with the SC's appointment of workgroups addressing core questions of MINT's organizational structure and governance, to go further, and begin preparing for a new model of *Bulletin* publication that will allow it to continue to grow alongside MINT, its *raison d'etre.* While the form of that administration will be determined by the SC, the Professional Issues workgroup, and ultimately the membership as a whole, I look forward to playing a continuing role in bringing the remarkably diverse and distinctive wisdom (and occasionally, whimsy) of our individual members to our network as a whole as well as to the world beyond.

In This Issue

From the Desert, **Bill Miller** suggests that the randomized controlled trial is not the only route to knowledge about MI in *Tacit Knowing: A Challenge to MI Researchers.* **Carl Åke Farbring, Lars Forsberg,** & **Christina Näsholm** provide us a window onto *A Nordic TNT,* and **Melinda Hohman** & **Igor Koutsenok** tell us the tale of *40 Trainers, 132 Trainings and 2100*

Trainees: Development of the Cal-METRO Project. **Grant Corbett** gives us his account of *What the Research Says About MI...Where Do You Start?,* and **David S. Prescott** provides a comprehensive model for MI-consistent supervision of clinicians in *Charting Courses: MI and Supervision.* And the remainder of the issue is given over to the ***Proceedings of MINT Forum 2007.*** Contributers include **Tom Barth, Judith Carpenter, Cathy Cole, Grant Corbett, Merav Devere, Sandy Downey, Linda Ehrlich-Jones, Jacque Elder, Denise Ernst, Mark Farrall, Kerstin Forsberg, Tim Godden, Gian Paolo Guelfi, Karen Ingersoll, Barbara Kistenmacher, Claire Lane, Trudy Mallinson, Bill Miller, Sylvie Naar-King, Christina Näsholm, Kris Robins, Steve Rollnick, Dee-Dee Stout, Guy Undrill, Tim Van Loo, Mary Velasquez, Chris Wagner, Lyn Williams. Sharon Zang,** and **Allan Zuckoff.** I think you'll agree that the quality reflected in these contributions speaks to the extraordinary vitality of our MI community.

Looking Forward

Our next issue will honor Bill Miller and the 25th anniversary of the article that started it all, *Motivational Interviewing with Problem Drinkers,* by presenting the original and uncut manuscript of that seminal paper accompanied by considerations of its (and Bill's) impact. The year's third and final issue will contain the *Proceedings* of our upcoming meeting in Albuquerque, New Mexico, as well as original articles and columns from our regular contributors. And after that... well, I expect that will be a matter for a broader *Bulletin* editorial team to decide. MB

nent, if not foundation of MI, and perhaps it is knowledge, as Smedslund suggests, that we have by virtue of being human. At present we are trying to make that knowledge explicit through the slow and imperfect tools of the context of justification. Fair enough. If an explication of the tacit knowledge is correct, then it ought to hold up in replications, although Smedslund also warns that there are so many additional unknown and uncontrolled variables at work in human discourse (including intentionality) that clumsy tools like randomized clinical trials, which try to tease out one or a few "independent" variables, are bound to detect only small bits of what is happening.

So how, then, might one study this hidden component? If you want to predict what I will be doing on Friday at 3:00 pm, you could draw on a variety of predictor variables from my history and personality, but nothing would capture more of the variance than simply *asking me* what I plan to be doing then. We are intentional creatures, and those intentions do relate to behavior, albeit imperfectly. One approach, then, would be to ask talented MI practitioners why they are doing what they do. This could be done by recording a session and then going back through it, asking the clinician to "think aloud," to reconstruct what she or he was thinking at the time, and why certain paths were chosen rather than others. That's what Barth et al. were doing with me in role plays at Hjellestad in 1982.

Perhaps better still, what about having *clients* think aloud about what was happening during MI sessions? We have struggled to hypothesize what might be happening in MI that results in change, but rarely have we asked the people who have changed. Again, I suspect that reviewing tapes of sessions with clients would be far richer than just asking them to recall in retrospect what happened. A beautiful example of this is Jeff Allison's CD of "The Edinburgh Interview," in which both the interviewer and the client comment on what they were experiencing at various points throughout this moving and exemplary session.

This is qualitative research, of course, and thus challenging to have funded through traditional research granting channels. I have found, though, that the addition of a qualitative component is often received well in combination with methodology that also contains the more familiar conventions of quantitative research. My guess is that qualitative analyses of what counselors and clients tell us about their MI sessions may move us farther and faster in understanding how MI works. MB

MINT Bulletin

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MINT Bulletin is published thrice yearly by the Motivational Interviewing Network of Trainers (MINT), an international collective of trainers in motivational interviewing and related methods who have been trained as trainers by William R. Miller, Stephen Rollnick, or their designees. MINT Bulletin is made available to the public, free of charge, via download at The Motivational Interviewing Page (www.motivationalinterview.org) (Chris Wagner, Ph.D., webmaster). Publication is made possible in part by funding from The Mid-Atlantic Addiction Technology Transfer Center, primary sponsor of The Motivational Interviewing Page. Photocopying and distribution of MINT Bulletin are permitted. Archives of MINT Bulletin and its predecessors, Motivational Interviewing Newsletter for Trainers and MINUET, are also available at The Motivational Interviewing Page.

A Nordic TNT

Carl Åke Farbring, Lars Forsberg, & Christina Näsholm

"This was the best TNT I have ever been to," Lars said with a laugh just after the TNT was over... Well, joking apart, it may reflect the trainers' view that they had managed to deliver a modern TNT based on the best knowledge we have today on training trainers in motivational interviewing.

Hosted by Swedish Criminal Justice, we invited applicants to a MINT-supported 3 day TNT in Norrköping (about 1 ½ hours drive from Stockholm) 14th- 16th November, where we were allowed to use a 1700th century education building. We decided to limit the event to 36 participants and by the end of September (last date for application) we had 59 applicants. We followed all the MINT/TNT rules but we added a tape of a session with an authentic client as requisite to assess skills in MI. A tape sample of MI is a complementary marker of MI competency as compared to mere certificates of MI training. Furthermore we meant to send a signal to the participants that in training MI, taped sessions and feedback are necessary for effective learning. This added extra hours of work for us since we listened to all 59 tapes and used a complicated scoring system for all aspects that we had to consider in the applications. This was difficult and tedious and still perhaps not 100% valid. We agreed to have MITI "in our lap," meaning that we did not actually code the tapes but made notes to be able to discriminate and give feedback to the applicants. It was made clear to the applicants that the tape was only one consideration (and perhaps not even the most important one) but that we were going listen for content that was clearly incompatible with MI as an exclusion criterion. We promised to give feedback on tapes to all regardless of whether they were or were not admitted.

One lesson we learned was that it would have been better to stop intake when the TNT had 36 applicants that we thought met the criteria (we ended up by admitting 39 because we found it difficult to differentiate between a few applicants). Another lesson was to decide on a single format for tapes (e.g., digital recordings), since we had to send tapes between us because we did not at times possess appropriate listening devices. Administration was generously handled by Criminal Justice (many thanks to Tea Stoltz and Christina Lundvall). Because of this support and free use of the school the cost for participation was less than $200 US. All participants received a manual for trainers, partly a translation of the manual that is published on the motivational interviewing website.

We had about ten, 1½-2 hour telephone meetings between us to prepare for the TNT, plus a full day in Norrköping before the training started. We relied heavily on the Miller-Moyers eight steps of learning MI, composing our main themes from those steps, and had much help from previous TNT experiences. This meant that we placed much focus on change talk and differential reinforcement on client talk to hold a "compass course" on behavior change. Christina was mainly responsible for the "meta level" discussions on trainers´ perspectives on what we were doing, using the Steve Berg-Smith "rattle" to announce the shift in focus. The participants showed much appreciation for this perspective. (Many thanks by the way to the TNT trainers from Miami and Sofia who generously shared their experiences!) Christina also focused on other aspects of learning and mirrored these all through the three days. Lars was mainly responsible for MITI coding and coaching, where we were allowed to use an authentic transcript from one of the participants, and Carl Åke took participants through the "compass block" – the change talk- neutral-sustain talk- resistance continuum and relevant exercises that pertained to each stage. We demonstrated exercises in vivo, encouraging the participants to be active and dare use themselves as tools for learning. The time limit for the exercises was obviously too narrow but the message was that this was not the main scene for learning but that learning actually starts by "doing in the real world" as is the case for MI in general. The coaching and implementation perspectives in disseminating MI and optimizing effects—the "learning by doing" perspective and increasing organizational readiness for change—are of special interest to us.

Before the training all participants were told to make a personal plan for development as a trainer, prepare a presentation and bring relevant material to present it. We divided the 39 participants into 3 groups. It was clear that positive feedback on their presentations, which was the core intent of the trainers, meant a lot for the cohesiveness of these groups. At the end of the TNT there were many tender farewells.

We were quite content with the mix of people from different areas of occupation: smoking cessation, health care, alcohol and drugs, social welfare, criminal justice, etc. We had six participants from Norway and two from Denmark. They were all quite skilled and many had been training others in

MI before. As we have noticed before, Danish participants sometimes have difficulties in completely understanding Swedish and vice versa, which can cause misunderstandings. We observed this and tried to address these difficulties but perhaps we did not fully meet the needs of our Danish group. We had no such language barriers with the Norwegian group. Christina sometimes translated Swedish words to Norwegian, which was helpful even for the Danes.

Three days for a TNT is not much. Some participants wanted more specific information about research and material of evidence to present in their own workshops and some also expressed some initial uncertainty on how to set up presentations in their groups. On the whole the feedback forms from the participants were overwhelmingly positive. Many of them explicitly wrote that they felt much more competent after the training and that they were inspired to carry on as trainers with a new feeling of optimism. They are now invited to be part of the MINT and many of them expressed great interest to take part in discussions and sharing experiences with others. We feel that they will all add good quality to both the international and the Nordic MINT!

As trainers we discussed before the training that in fact the three of us are different personalities and that to some degree we may emphasize and have different favourite interests in MI. Most rewarding for us is that we carried out this TNT with 100% support for each other and that we were able to convey MI spirit in our training to the participants. MB

40 Trainers, 132 Trainings and 2100 Trainees

Development of the Cal-METRO Project

Melinda Hohman & Igor Koutsenok

Juvenile corrections has taken on a more punitive orientation in the past two decades (Caeti, Hemmens, Cullen, & Burton, 2003), but as the pendulum has swung in the other direction, towards rehabilitation—and towards evidence-based practice--it is no surprise that there has been a surge of interest in motivational interviewing (MI) (Feldstein & Ginsburg, 2006). The purpose of this article is to describe the history and development of a large-scale training project in MI for the California Department of Corrections and Rehabilitation / Division of Juvenile Justice (DJJ). Utilizing 40 trainers, this project intends to offer one 3-day training and one 2-day follow-up training in MI to approximately 2,100 DJJ employees between 2008-2010. Including training for trainers of DJJ staff in the third year of the project, this amounts to 132 trainings at 8 sites.

The impetus for this project was a series of lawsuits that led to the Farrell Consent Decree of 2004. This decree ordered a complete overhaul of the DJJ system to make it rehabilitative and therapeutic, particularly within institutional settings. In consultation with national experts, remedial plans were established in health care, mental health, safety, and education, and for sexual offenders and youth with disabilities. These plans, for example, called for the establishment of crisis response teams, small psychiatric and drug treatment units; increased staffing that included psychologists, psychiatrists, and social workers; smaller living units; and a focus on non-violent ways to handle conflict resolution, de-escalation techniques, and training for all staff in the use of "motivational enhancement strategies" to engage youths in treatment programming (CDCR/DJJ, 2006, p. 3).

As part of the implementation process, DJJ youth who are less serious offenders are being returned to their home counties for supervision or incarceration by county juvenile probation, and several DJJ facilities will be closed. Currently there are about 2,400 youth (ages 14-25) in institutions or camps and 2,500 on parole (personal communication, Amy Siedlitz, November, 2007). Training of staff has been implemented in many areas such as anger management, crisis intervention, and risk assessment. Thus, trainers who will be conducting the trainings in MI understand that this project has come out of a court order to a system that is undergoing many changes at once.

DJJ awarded a $1,958,791 contract to the Center for Criminality and Addiction Research, Training, and Application (CCARTA) of the Department of Psychiatry at University of California at San Diego for the training of all DJJ staff in MI over a 3-year period, as indicated above. Igor Koutsenok, the Director of CCARTA, assembled a local team of MINT trainers and those who had been involved in training or supervision of MI in UCSD research projects. This "curriculum committee" met over several months to develop an initial curriculum, utilizing their own curriculum along with content from the National Institute of Corrections MI curriculum (see http://nicic.org/Downloads/PDF/Library/019791.pdf). Melinda Hohman, a MINT member from San Diego State University, posted on the MINT listserv a description of the project, which has been named Cal-METRO (California Motivational Enhancement Toward Rehabilitative Outcomes), and asked for trainers to respond. Over 40 trainers from across the

US responded, and they were invited to attend a 2-day meeting in San Diego in November, 2007.

At this meeting, the Training Director of DJJ presented information about the consent decree, changes taking place in the DJJ system, and other aspects of the context of the training. MINT members Joel Ginsburg, Sarah Feldstein, Liz Barnett, and Scott Reiner presented material regarding issues in training and using MI in corrections and the use of MI with adolescents. The initial curriculum was then rolled out and a lively discussion ensued with various opinions of what should or should not be included. The trainers worked in small groups to make suggestions for changes and reported out to the larger group. One main suggestion that was utilized was to develop a "Menu of Options" (MOO) of exercises that trainers could select from. This developed from the need to have a standard curriculum (for fidelity) that could also provide some flexibility for the trainers.

Trainers were concerned about not having a co-trainer for their classes of 30-35 trainees, but due to the enormity of the project hiring co-trainers was not financially feasible. However, those who work in the DJJ training department will attend the first training and then be assigned to help with the rest of the trainings. Furthermore, some trainers elected to split their fees with other trainers, so as to have a co-trainer. Other trainers, who were locals, also indicated that they would like to observe/volunteer to help out, and to get a sense of the work. Trainers from out-of-state volunteered, via the Cal-METRO list-serv, to be available by phone or email to other trainers when they are conducting their workshops.

Suggestions from the San Diego meeting were incorporated into the final curriculum and MOO. Trainers including Ray Gingerich, Dee Dee Stout, Ann Carden, Kathy Tomlin, Diego Rogers, Frances Cox, Colleen Marshall, Pam Smithstan, Ali Hall, Brian Burke, Liz Barnett, and John Martin submitted slides and exercises, and some provided feedback on the revised curriculum. We also added exercises that had been posted by other MINT members on the list-serv. Using the facilities at her university (Oregon Health Sciences University), Susan Butterworth made a video that is specific to MI in juvenile corrections, similar to the PO1 and PO2 video put out by NIC (see http://www.nicic.org/library/022005), utilizing a Latino youth actor. Ray Gingerich volunteered to consult on this project.

In December 2007, local trainers Jim Carter, Melinda Hohman, and Igor Koutsenok met with DJJ administrators and managers in four 1-day meetings held in the Los Angeles area and in Sacramento. Participants were from varied roles and disciplines, such as school principals, facility doctors, psychologists, directors of parole services, directors of security, and facility superintendents and managers. In this meeting the trainers provided an overview of MI and the Cal-METRO project, and held discussions regarding their thoughts, concerns, and ways they could support the project. Reactions to the project were varied, as could be expected of those involved in a system undergoing a large-scale change: some support, some skepticism, some resistance. Overall, most were glad that DJJ was returning to a rehabilitative model, remembering when it had been this way in the past and that they had been proud of their work. Some were still angry about the consent decree, however, feeling as though they were being told their work was "no good" and believing that they already used many of the elements of MI. A concern was raised by some participants that while many of the MI trainers have a background in corrections work, none were familiar with the DJJ system in particular or had seen the correctional facilities to get a sense of the difficulty of their work. (Trainers have since, on a voluntary basis, taken tours of the DJJ facilities.) Other participants in the meetings grasped the difficulty in learning MI and indicated that they planned to attend the trainings and perhaps become coaches for their staff in the use of MI.

As for the process evaluation of the project, a check-off sheet was created for trainers to give feedback regarding which exercises they used from the MOO along with open-ended questions regarding their experience with the training, the curriculum, and the training site. The outcome evaluation will include pre- and post-testing of knowledge and skills using a DJJ-oriented MIKAT and Officer Responses Questionnaire (MINT member Scott Walters was an informal consultant on this aspect). DJJ staff who are being trained in a risk assessment battery are required to be videotaped every 120 days. We will have access to these tapes and will have the tapes coded. We will conduct a small study, where half of the participants will receive mailed feedback and the other half will receive telephone coaching. There is also a possibility to develop the trainers from the training department as coaches in order to provide on-site coaching to another group. It is impossible to measure impact on the DJJ system from this project due to all the other interventions that are being implemented concurrently.

Overall, the development of the Cal-METRO project has been an enormous collaborative process. True to the spirit of MI, many people have offered their expertise and time to launch this project. We are now onto the next step. Further information on Cal-METRO can be obtained on the CCARTA website,http://www.ccarta.com

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What the Research Says About MI . . .

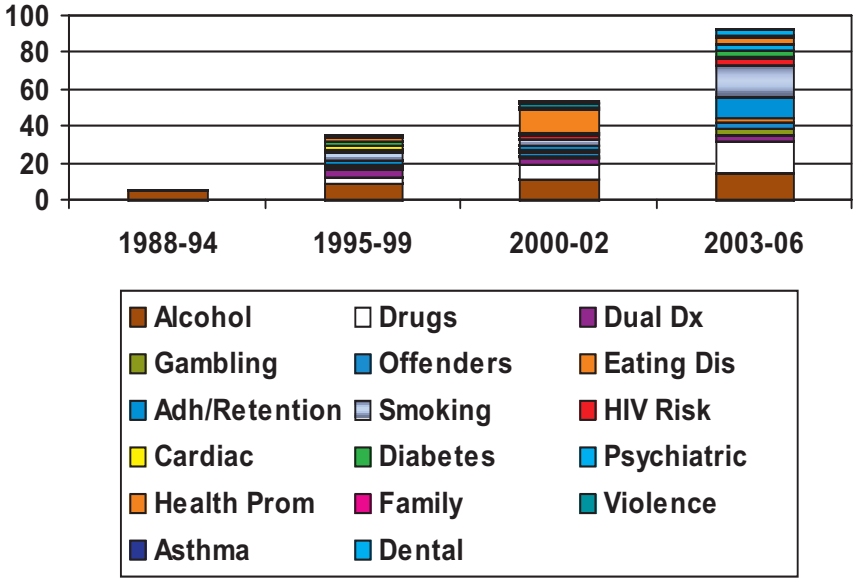
. . . Where Do You Start?

Grant Corbett

What does the research say about Motivational Interviewing (MI)? That question can be answered in at least 17 practice areas, given the exponential growth in studies (see chart; reproduced with permission of Dr. William Miller). Where, then, does one begin to know what the literature is saying? You might choose one of three starting points: individual studies, overview papers or systematic/meta-analytic reviews. We look in this column at where you can find each of the foregoing, and at what they and their authors are saying.

Individual Studies

The easiest means of finding individual papers are MI bibliographies. Thanks to the work of Dr. Chris Wagner and contributors, you will find references, listed by year, at the Motivational Interviewing web site (http://motivationalinterview.org/library/ biblio.html). That listing is updated several times a year. Topical bibliographies are more difficult to find, although the newly published *Motivational Interviewing in Health Care* (Rollnick, Miller & Butler, 2008) includes one as an appendix (for more information, go to http://www.guilford.com).



As papers and chapters on MI are being published at an increasing rate (about 100 in the first nine months of 2007), finding recent research in your field could start using one of three databases. The first is *PubMed* (http://www.ncbi.nlm.nih.gov /sites/ entrez?db=PubMed), which provides free online access to citations from *Medline* and other life science journals. *PubMed* abstracts articles from some, but not all, addictions, psychology and other journals. Thus, second, you may also want to search databases such as *PsychInfo,* available through college and university libraries. Access online, for individuals who do not have library access, starts at US $11.95 for 24 hours (http://www.apa.org/psycinfo/products/individuals.html).

The third source is the most comprehensive. The *Web of Science* is a database, available through post-secondary institution libraries, that abstracts articles from about 8,700 journals. Using the *Web of Science* can ensure that you capture more of what the research says (and the articles themselves can be downloaded electronically as you find citations of interest, if on subscription at your institution). College and university libraries are also a source of electronic PDFs[1] or hard-copies of journal articles themselves, as are authors' web sites (which may include a link to download their papers or their email to request a reprint; see the reference list for examples).

Overview Papers

Another way to know what the research is saying in your area of practice is overview papers (often called review papers). These may include:

- *State of the art reviews.* This form of article or chapter usually considers current research in a given area. They may offer new perspectives or point out the need for further research. The most recent example is Resnicow and co-researchers' review of MI for pediatric obesity (2006). Some reviews, such as by VanWormer and Boucher (2004), "critically appraise"[2] the quality of evidence; others do not. Many state-of-the-art reviews have been published, ranging in focus from psychiatry to speech pathology.
- *Historical reviews.* I would recommend Theresa Moyers' review of the history of MI (Moyers, 2004).
- *Comparison of perspectives reviews.* Two papers, as an example, have looked at how Self-Determination Theory could support development of MI, and vice versa (Markland et al, 2005; Vansteenkiste & Sheldon, 2006).

- *Theoretical model building reviews.* This type of article examines the literature within a given area with the intention of developing new theoretical assumptions. An example is a recent paper by Leffingwell and colleagues (2007) that argues for expanding the influence of social psychological processes upon the practice of motivational interviewing.
- *Synthesis of two fields review.* This form of review can provide insights on a topic, based on a review of literature from two or more disciplines. The was my intent in earlier columns, although these were not intended to be comprehensive reviews:
  - MI skills: http://motivationalinterview.org/mint/MINT11_2.pdf#page=6
  - Change talk (in three parts): http://motivationalinterview.org/mint/MIUET11.3.articles.pdf#page=9 http://motivationalinterview.org/mint/MINT12.1.articles.pdf#page=7 http://motivationalinterview.org/mint/MINT12.2.full.pdf#page=4

Meta-analytic and Systematic Reviews

A final way of knowing what the research is saying comes from meta-analytic and systematic reviews. Meta-analysis in clinical research is based on two simple principles: 1) systematically search out, and, when possible, 2) quantitatively combine the results of all studies that have addressed a similar research question.

While this form of review can provide the strongest evidence of what the research says, there are limitations generally (c.f., Naylor, 1997) and specifically for MI. Bill Miller offers the following (Personal communication, October 4th, 2007):

> The most obvious shortcoming of meta-analyses to date is that they cover only a small proportion of the literature. Clinical trials of MI are appearing rapidly, and there are over 180 in print now. It's a huge undertaking to conduct a meta-analysis of a literature of that size, and so far we have only a partial, albeit encouraging picture of what is happening with applications of MI.

However, meta-analytic and systematic reviews can provide guidance on what the research is saying. Nine of these analyses have been published in English in the past six years. The two most recent reviews were published in 2006.

Vasilaki, Hosier and Cox (2006) looked at the efficacy of MI as a brief intervention for excessive drinking. They located 22 studies, published between 1983 and 2003, which compared MI to no treatment. Analysis determined that MI had a medium-sized effect on outcomes (0.60)[3] when follow-up was done in the first three months or less. The effect was larger when dependent drinkers were removed from the analysis. The researchers found another nine studies where MI was compared to other diverse treatments. The effect size remained moderate (0.43). The authors conclude, "brief MI is effective" (p. 328).

I asked Miles Cox, one of the foregoing authors, if he could put their review in context. Dr. Cox wrote (personal communication, October 08, 2007):

> Motivational interviewing (MI) has been established as an effective strategy for reducing alcohol use (e.g., Burke et al. 2003)... An important finding of our study is that effect sizes in favour of MI compared with no treatment were largest at first follow-up, suggesting that MI's effects fade across time. This finding is consistent with the results of other meta-analyses of MI (e.g., Hettema, et al., 2005). A closer look to the literature revealed that variables such as readiness to change, age, gender, duration of MI, as well as which components of MI are adopted seem to influence MI's long-term effectiveness. Thus, these variables should be further studied in the future.

Knight and colleagues (2006) systematically reviewed the effect of MI in physical health care settings. Eight studies involving "physical health issues", published between 1966 and April 2004, met their criteria. The researchers found that the quality of these clinical trials was "inadequate." However, they concluded:

> MI does appear to have potential to be an effective intervention in this area. (p. 330)

Two substantive reviews were published in 2005. The first, by Hettema, Steele and Miller, provided a meta-analysis of 72 clinical trials spanning a range of problems (but no date range for the studies is mentioned). The average short-term effect size was large (0.77) decreasing to a small effect (0.30) at follow-ups to one year. Of interest was that effect sizes were larger with ethnic minority groups and when MI was not done with a manual. The authors conclude:

> The evidence base for motivational interviewing is strong in the areas of addictive and health behaviors. Useful as a brief intervention in itself, MI also appears to improve outcomes when added to other treatment approaches. (p. 109)

Dr. Jenny Hettema offered the following comment on her paper (personal communication, October 13, 2007), supporting earlier remarks from Bill Miller :

> Our meta-analysis included about 70 studies, but in the last few years the number of randomized clinical trials of MI has more than doubled. We are definitely in need of updated reviews. To make sense of all the data that is out there, it may make sense to conduct reviews within specific behavioral domains (i.e. alcohol, medication compliance, safe sex practices, etc.).

Rubak and colleagues (2005) also included 72 randomized controlled trials in their review, the first of which was published in 1991. Their results are well described in their abstract:

> Meta-analysis showed a significant effect for MI for combined effect estimates for body mass

index, total blood cholesterol, systolic blood pressure, blood alcohol concentration and standard ethanol content, while combined effect estimates for cigarettes per day and for HbA1c were not significant. MI had a significant and clinically relevant effect in approximately three out of four studies, with an equal effect on physiological (72%) and psychological (75%) diseases. Psychologists and physicians obtained an effect in approximately 80% of the studies, while other healthcare providers obtained an effect in 46% of the studies. When using MI in brief encounters of 15 minutes, 64% of the studies showed an effect. More than one encounter with the patient ensures the effectiveness of MI. (p. 305)

Three of the remaining reviews date back to 2003 and 2004 (Burke, et al., 2003, 2004; Tait & Hulse, 2003), and the other to 2001 (Dunn, et al., 2001). Given that more recent reviews have been published, their results will not be summarized here.

Remaining current on where MI is being applied and on studies in topic areas will be challenging. The question, What does the research say about training? was covered in the last two columns:

·http://motivationalinterview.org/mint/MINT13.1.articles.pdf#page=12

·http://motivationalinterview.org/mint/MINT13.2.pdf#page=14

One last question, for perhaps a future column, is What may work in disseminating MI into general practice, in particular in health care and human service fields where clients or patients are ambivalent? MB

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Notes

1 Portable Document Format (PDF) is an Adobe PostScript standard file format that enables a document to be distributed on different computer systems while preserving the layout (.pdf).

2 An explanation of critical appraisal" can be found as a PDF at: http://www.jr2.ox.ac.uk/bandolier/painres/download/whatis/What_is_critical_appraisal.pdf

3 Effect size is a measure of the strength of the relationship between two variables. The most widely accepted convention characterizes effect sizes as small (0.20), medium (0.50), and large (0.80).

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Charting Courses

MI and Supervision

David S. Prescott

Introduction

Many professionals emerge from training in motivational interviewing (MI) enthusiastic about applying its style, spirit, and techniques to diverse areas of their lives. Recently, Bill Miller (2006) wrote about the frustrations of professionals working in settings whose climates are inconsistent with MI. More recently, Miller, along with Terri Moyers and Denise Ernst, have offered more specialized training for those interested both in using MI with supervision and in supervising MI practitioners. Unfortunately, even an outstanding two-day training cannot address the potential complications in making one's supervisory practice more consistent with MI. This article explores some of these elements. It focuses on clinical practice (as opposed to business) settings, and intends to inspire further discussion rather than act as stand-alone instruction.

Background

Those who have supervised newer clinicians may be familiar with challenging situations such as the following:

You supervise staff in a residential treatment center for emotionally disturbed youth. A new clinician describes the fabulous work he has just done. The clinician went to a living unit where his client was involved in an incident requiring physical management. While in the middle of a physical restraint, the clinician engaged the youth in a conversation about their family. The youth became agitated and struggled more while the staff continued to restrain them on the floor; other staff attempted to re-direct the other clients, who were by now watching and commenting. The clinician encouraged the youth to get his concerns out in the open, and the youth complied, becoming exhausted, withdrawn, and ultimately motionless in the process. The clinician is reporting success in exploring the etiology of the young person's behavior problems. The staff members are reporting that the clinician's intervention placed everyone present at increased risk for physical injury. Your immediate thoughts are that this situation can never – ever – happen again.

In another instance:

You supervise a therapist treating a man convicted for spousal assault. The therapist has expressed some suspicions that the man was falsely accused and convicted. You discover that the therapist has just contacted the prosecutor and probation officer to express concern that the man should never have been arrested in the first place. You are now in the position of requiring that the therapist stop all contact with these representatives of the legal system. The therapist says he is simply advocating for his client, while you are aware that the situation is not anywhere near as simple as the therapist seems to think.

Finally:

You are supervising a new clinician assigned to treat a five-year-old who had experienced severe physical abuse by his now-absent stepfather. The clinician reports success in getting the child to express his emotions. In fact, the child tore the office to shreds, breaking toys and knocking over a bookcase. Although no one questions that expressing emotions can be healthy, this was an unsafe situation likely to cause more problems than it solved.

For some administrators, situations like these are common occurrences. Each one likely requires some degree of overt direction from the supervisor. Matters can become complicated for supervisors attempting to use and model motivational interviewing during the course of supervision. The ethical use of MI involves collaboration and supporting autonomy. Supervisors can find themselves in situations where this does not seem possible (e.g., enforcing workplace rules) or where MI techniques would be inappropriate (e.g., asking an employee to describe the positive aspects of absenteeism).

What is Supervision?

An internet search quickly shows many definitions of clinical supervision and no shortage of resources on providing it, many more than this article can cover. Common activities of clinical supervisors include providing support, guidance, direction, encouragement, education, and consult. In practice, however, clinical supervisors typically provide administrative supervision as well. This results in supervisory activities ranging from understanding a specific case to providing specialized treatment, and from managing caseloads to completing paperwork and following rules and protocols. Supervisors can direct, guide, and follow depending upon circumstances. Because supervisors are often responsible for many aspects simultaneously (e.g., quality assurance and performance evaluation as well as support and encouragement), supervisory dilemmas can occur on short notice, making supervisors uncertain how best to pro-

ceed as they strive to be MI-consistent.

Getting Started with MI-consistency

Moyers (2006) observed that many practitioners who become skilled at MI want so much to use it in providing supervision that they wind up distorting or diluting it in order to meet the needs of their situation. In the end, what they are actually doing is either a deterioration of MI or using it unethically. Moyers goes on to remind trainees that, "It's OK not to use MI." By this, she means that it is better not to use MI than it is to use a distorted version in the name of being MI-consistent. There are, after all, occasions when one has an urgent need to give firm directions rather than explore and resolve ambivalence about them.

It is also possible to establish a clinical setting in such a way that minimizes the need for MI-inconsistent supervision practice. One place where supervisors can start is ourselves: To what extent do we have an unexplored *righting reflex* (that urge to intervene in a client's life and make things "right") when it comes to our role as a supervisor or to the process of delivering supervision? To what extent does that reflex prevent our seeing opportunities for creating a more MI-consistent workplace? In some cases, it may be that it is easier to guide client exploration and resolution of ambivalence than it is to understand our own as supervisors. In other cases, our righting reflex may signal challenges in the set-up of our program.

Miller (2006) suggests that organizations can become more MI-consistent by promoting its spirit and practice. He notes that key opinion leaders can promote MI principles such as collaboration, support, and autonomy as well as having teams of individuals encourage one another. He also highlights the importance of hiring MI-consistent staff (e.g., using demonstrated empathy as a hiring criterion) and suggests that this kind of organizational climate may help with staff retention. Taking this further, there may also be some additional, but easily overlooked aspects.

Mission Statements, Job Descriptions, and Supervisory Identity

First, supervisors can ensure that treatment programs develop MI-consistent mission statements. Deceptively simple, some agencies make better use of their mission statements than others do. For agencies seeking to incorporate the style and spirit of MI, the mission statement is a useful place to start. Depending on circumstances, those seeking to refine their mission statement might frame this as attending to what the research shows works in influencing long-term change. In other circumstances, it may be a more overt shift away from harsh and confrontational treatment practice. Schladale (2007) has described a program for youth who had sexually abused others that created their mission statement in collaboration with their clients (p. 349). For purposes of becoming more MI-consistent, it may be helpful to make sure that the core values of a treatment program are as explicit as possible.

One benefit of attention to an agency's mission statement is that supervisors can rely on it instead of their righting reflex. The MI-consistent mission statement becomes a compass to which supervisors can compare the direction of supervision issues. It also provides a framework for "dancing, not wrestling." When a supervisee is heading in an unhelpful direction, the supervisor can clarify the discrepancy between agency mission, values, and protocols rather than the discrepancy between what the supervisor wants and what the supervisee is doing. In addition to helping ensure program fidelity, it also reduces the likelihood that discussions take on an unnecessarily personalized tone; the impatient supervisor can follow an internal script of "this is not about me; it's about the mission, purpose, style, and protocol of this agency."

Additionally, agencies do not always rely on the job descriptions of clinicians as often as they might. The poorly-defined roles in these settings can create confusion, and these treatment programs risk becoming reflections of the strongest personalities within them. Programs that establish job descriptions reflecting MI values leave little reason to be unnecessarily harsh in providing direction because supervisors can reframe situations as discrepancy between one's performance and job description. Such clearly defined roles can serve as the stars for supervisors to steer by in difficult times.

When all else fails, supervisors can always fall back on the MI technique of elicit-provide-elicit for giving difficult feedback in the most respectful possible fashion. Closely related is the feedback sandwich, where the supervisor provides areas for improvement in between affirmations and praise (Dohrenwend, 2002). Supervisors will want to take care to provide affirmations that are clear, specific, personal, and honest, and feedback that is respectful to its core. Simply providing adjectives and vague praise (e.g., "nice job") is less helpful than specific examples (e.g., "Did you notice how that client started to tear up when you provided that reflection? He really understood that you were listening."). Feedback is likely most helpful when it focuses on one specific area at a time. For example, in the vignette involving the therapist contacting the prosecutor and parole officer, the supervisor might wish to say:

> *You are committed to your clients and work to go over and above expectations. If you come to me with these kinds of concerns first, we can discuss the most effective ways to handle them. That way, the prosecutor and parole officer won't be concerned that you're acting outside the mission and methods of our agency. I'm impressed that you're willing to take such initiative! How does that sound?*

Ethical Considerations

Miller and Rollnick (2002) outline three areas of ethical complexity that apply to supervisors' attempts to be MI-consistent (p. 168). These include:

1. The person's aspirations are dissonant with the supervisor's opinion as to what is in the supervisee's best interest.
2. The supervisor has a personal investment in the supervisee's actions.
3. The nature of the relationship includes coercive power of the supervisor to influence the directions the supervisee takes.

Ultimately, the supervisor must be prepared for and accepting of a supervisee's decision to terminate employment. Using MI to coerce supervisees into actions they do not want to take is clearly outside the scope of its ethical use. A key element of the above approaches is that they provide a framework for preventing MI's use for controlling clinicians. All supervisors will experience situations where using MI is inappropriate (e.g., imminent danger). Instead of asking how one can always use MI in supervision, supervisors might do better to ask how best to prepare their environment to be as MI-consistent as possible. This can involve explicitly developing goals for supervision in collaboration with the supervisee.

Traps to Avoid

The general traps that mental health practitioners can experience hold true for supervision. They include the question-answer trap, taking sides trap, labeling trap, premature focus trap (particularly with respect to the stages of supervision described below), and blaming trap (Miller & Rollnick, 2002). Likewise, it can be easy to forget that changing professional behavior can be as difficult as changing personal behavior. Supervisors can overlook the fact that supervisees often place themselves in a position of considerable vulnerability with each session. After all, their very livelihood can depend on their performance evaluation. Perhaps the most important trap, however, is the expert trap of conveying the impression that one has all the answers (Miller & Rollnick, 2002, p. 60).

Professional pride can also be a potential trap in MI-consistent supervision; this can resemble a hybrid of the expert role and righting reflex. Some supervisors need others to perceive them as experts and therefore try to provide answers before adequately asking questions or assessing situations that arise. The unspoken power needs of the supervisor in these situations can result in the end of genuine dialog. One option is for the supervisor to acknowledge that the best answer will come from continued discussion and see what unfolds. Should this not become productive, he or she can then ask permission to share additional ideas, provide suggestions, and ask for feedback. This requires that supervisors see themselves in the role of guide rather than an esteemed expert with all the answers.

People become supervisors for a variety of reasons. Some are competent clinicians for whom supervision is a means to expand or diversify their attempts to help others. Some simply enjoy being in charge of others, while many provide supervision out of a sense of obligation to their programs or agencies. Sadly, there are few educational programs for becoming supervisors (Rich, 2007). In order to be MI-consistent, all supervisors will want to be clear on their values in order to be truly collaborative, evocative, and support the autonomy of supervisees.

A Supervisory Trajectory

There are numerous resources for supervisors of all backgrounds. Many of these resources share common elements with MI. Many others extend beyond supervision and explore the differences between management, leadership, and command (e.g., Gittell, 2003). John C. Maxwell, for example, defines leadership as influence, and describes "laws" for those that lead others. Among his axioms is, "No one cares how much you know until they know how much you care." He also emphasizes that those who follow must know that they are "on solid ground" with those who lead (Maxwell, 2007).

Blanchard, Zigarmi, and Zigarmi (1985) have described four leadership and management styles that can inform supervisors. They include *directing, coaching, supporting,* and *delegating*. These styles make intuitive sense, correlate with the successful development of a supervisee, and may provide useful anchor points for supervisors aiming to be MI-consistent. Each stage involves varying level of direction and support. Like the transtheoretical stages of change model (Prochaska & DiClemente, 1982), this approach may be best used as a rough guide. In line with criticisms of the stages of change model (e.g., Sutton, 1996), supervision may need to move from one stage to another in response to situational needs. Professional development takes place within the context of the employment situation and various life events. These outside forces can influence the internal readiness of supervisor and supervisee alike.

Directing involves providing specific instructions and close supervision of task accomplishment. Affirming, listening, and facilitating processes are all vital means by which these take place, and it is not difficult to see how the MI skills of elicit-provide-elicit will be particularly helpful at this phase of supervisee acclimation and development. Supervisors can use Denise Ernst's recommendations for providing brief advice as a working foundation (Miller & Rollnick, 2002, p. 277):

1. The supervisee asks for information
2. The supervisor has information that might be helpful
3. The supervisor feels ethically compelled to provide advice

The astute supervisor can frame each of these exchanges within a course of asking permission and eliciting responses. This phase of the supervisory relationship has many features in common with phase one of MI, and supervisors can use many of the same techniques as they use MI to teach MI. These can include options menus and variations on the readiness ruler (Miller & Rollnick, 2002, p. 183). One can expect that supervisees may experience ambivalence and discrepancy in a number of areas:

- *I feel two ways about having my supervisor directly measuring my MI skills.*
- *I have never been very good at this area of the job. Do I really want to expend the effort to improve?*
- *I do not really feel like a part of this team yet and am not sure what to make of it. I am more comfortable with some members of my team than others.*
- *I enjoy providing services in one aspect of my work, but I am not so sure about this other aspect.*
- *I am not sure yet how open I can be with my supervisor.*
- *I feel two ways about having to accept explicit direction. The sooner I can be left alone the better.*
- *Conversely, I know my supervisor has faith in me, but I think I need more direct oversight than I'm getting.*
- *I have done this work a long time, but now I am in a new situation. I am a good therapist, but there are some methods here I am not so sure about.*

Ultimately, the supervisee's developmental task is acclimating to a new environment and taking the first steps within it. Virtually all supervisees have a wish for mastery over their work and life with some discrepancy between where they are and where they want to be. Assuming that no ethical issues surface, the supervisor can then watch for change indications such as expressed desire, ability, reason, need to improve in the negotiated areas.

Coaching involves direction and close supervision of task accomplishment. It also involves the supervisor explaining decisions, soliciting suggestions, and supporting progress. Here, the supervisor will wish to be sensitive to issues around leading, guiding, and following. The developmental task of supervisees is to take their first independent steps in this work situation. Possible indications of readiness for this supervisory style can include a stated commitment to and actually taking steps towards improvement in job duties. Supervisors will wish to be cautious at this stage about attempting to strengthen commitment in sensitive areas too quickly or to adhere too rigidly to a manualized approach in supervision (Hettema, Steele, & Miller, 2005, pp. 104-105) in order to prevent further ambivalence or resistance. Rather, classic examples of developing discrepancy can include questions such as "what went well in the session today" and "what would you do differently." In this way, the supervisee can make the argument for change (Murphy & Ford, 2006).

There are several approaches possible in the first vignette, where the therapist could easily have made a bad situation worse by trying to provide treatment during a physical restraint. The first would be to explore the good and not-so-good elements of this approach and provide reflections and amplifications. Depending on whether the supervisee comes to understand the physical dangers involved, the supervisor may also wish to:

- Ask permission to share feedback.
- Describe the inherent dangers of trying to provide therapy during physical management.
- Describe the agency policy on physical restraint.
- Elicit a response.
- Express confidence that the supervisee is able to work within the boundaries and job descriptions that the program has established.

Although each job description and agency mission statement can provide clear-cut goals for supervision, pursuing a long-term plan that considers the supervisee's total experience can be beneficial. In the criminological world, Tony Ward and his colleagues (Ward & Stewart, 2003; Yates, 2007) have described a "good lives" model for offender rehabilitation that has relevance for supervision, particularly in criminal justice settings (where the model is gaining currency).

In essence, the good lives model holds that all people are motivated by primary goods that make life more meaningful. They argue that treatment will be more effective when clients use it to pursue meaningful goals rather than to avoid unpleasant outcomes. In this way, supervisors may wish to gain a clear understanding of who their supervisees want to be in their professional lives and how they hope to get there. To some extent, all human beings want to pursue competence in life (health, functioning, etc.); some kind of mastery at work (and at play); autonomy and self-directedness; inner peace (e.g., feeling safe in the workplace, maintaining emotional equilibrium, etc); feeling that they are part of their surrounding community; having a sense of meaning and purpose in their work; creativity; and a general sense of happiness. Depending on the situation, supervisors can negotiate including one or more of these areas into an options menu as part of a professional development plan. One way to do this might be to present these and other potentially relevant themes as an options menu and ask which, if any, of them the supervisee would care to work toward during the course of their supervision. Although this approach will not be to everyone's liking, it can make supervision more satisfying and provide a sense of collaboration beyond adherence to agency expectations.

Possible areas of ambivalence and discrepancy can be the same as in the first stage, and can also include themes related to the pace of professional development as well as supervisees' personal sense of confidence and importance of each issue in their job description and agency mission.

Supporting means upholding and facilitating the efforts of the supervisee towards the accomplishment of tasks and goals and sharing responsibility for decision making. The developmental task of the supervisee is to take on more responsibility for decisions and treatment provision and become more active in collaboration with the supervisor. This stage has elements in common with phase two of MI, in which professionals strengthen commitment and engage in action planning. Possible points of discrepancy and ambivalence at this stage include:

- *Do I really want to take on more responsibility for the success and failure of treatment?*

- *Is this where I want to put my energies for the future?*
- *I've done well up to this point; do I really want to share the things that are still bothering me?*

These are serious questions deserving of supervisory consideration, and remaining MI-consistent means not taking sides in what are very important decisions for the supervisee. MI techniques such as coming alongside the reluctance can be particularly helpful here.

Delegating means turning over responsibility for decision making and problem solving. The developmental task for the supervisee involves demonstrating increased competence and developing new ideas. Possible points of discrepancy and ambivalence at this stage include:

- *Do I really want to go to my supervisor with questions? Conversely, do I really want this degree of independence?*
- *Do I really want to branch out or advance into different areas?*
- *Do I really want to share my experiences with those are newer to this work?*
- *My supervisor thinks I'm doing well, but I'm not so sure. I'm not sure how comfortable I am talking about that.*

These stages are all excellent opportunities for listening to supervisees and demonstrating MI spirit and techniques, including reflections, summaries, open questions, and affirmations. Techniques such as querying extremes and agreeing with a twist can also extend supervisory discussion and goal setting along the way.

Conclusion

Providing supervision to professionals in mental health settings is a great – and often underrated – honor. There can be many reasons to make one's agency and supervisory style consistent with the style and spirit of MI. Miller (2006) notes that the benefits may include improved staff retention. It seems clear that if MI works in part because it taps the inherent need of all people to experience someone listening to them, then any progress that supervisors can make in the MI direction is a step in the right direction. Further, there is an emerging consensus in the business world that organizational leadership involves many of the same principles as MI. For example, Collins (2001) identifies four basic leadership skills that improve performance for all: leading with questions and not answers, engaging in dialogue and debate without coercion, conducting debriefings without blame, and requiring discussion of sensitive information to prevent ignoring it.

Ultimately, supervisors seeking to be as MI-consistent as possible will want to prepare themselves for times when it may not be possible to handle situations in this way. It is permissible, and in many circumstances more ethical, not to use MI. However, the above suggestions may be helpful to some supervisors as they move forward with making their therapeutic and work environments more MI-consistent. In the final analysis, we can likely:

- learn best from our supervisees how to use MI in supervision;
- learn to appreciate our supervisees' resistance, as it can teach us how to be better supervisors and how to improve our programs;
- stay closer to the mission of our work by dancing more and wrestling less;
- continue to learn patience with all populations we work with -- after all, treatment professionals have as much ambivalence about change as any other human beings. MB

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MINT in a Context of Change

Allan Zuckoff on Behalf of the Planning Committee

Bulgarian MINTie Alexander Kantchelov welcomed the more than 100 MINT members who traveled to meet for the first MINT Forum to take place in an Eastern European locale with an address entitled, "MI in a Context of Change." Although the context Alexander referred to in his lively, informative, and entertaining talk was that of his ancient, long-suffering, yet vibrant country, it struck me that his title could as easily have described the state of MINT itself as we gathered there.

Our 2007 MINT Forum took place during a year when MI continued its remarkable progression of increasing influence in an ever-widening range of clinical and professional contexts. At the same time, MINT was going through its own process of change, as the tightly-knit yet loosely-organized community constituted over a decade of meetings, newsletters, and listserv communications began to confront crucial and difficult questions about its shape and substance with universal agreement about nothing, perhaps, other than the absolute necessity for the spirit of MI, as instantiated in the values and spirit of MINT, to be preserved. While the final form of the answers to many of these questions remains undecided as of this writing, we may one day look back at this period of change, and the MINT Forum that was held in its midst, as the beginning of a future as hopeful and prosperous as the one so strongly wished for by the citizens of Sofia and the nation that surrounds it.

Yet it would also be unjust to emphasize too strongly this serious note, when MINT Forum 2007 was, like every MINT Forum before, full of warmth, levity, and sharing of every kind. From the wonderful singers and dancers in native costume who turned our pre-Forum reception into a celebration, to the stimulating plenaries and exciting breakout sessions, to our visit to the lair of Astor the Magician and the many small, impromptu gatherings of MINTie friends old and new, to the ice-breakers and exercises demonstrated and exchanged, this year's meeting provided food for the mind, body, and heart. On behalf of my fellow "Planning and Doing Committee" members Jacque Elder, Judith Carpenter, and Tim Van Loo (the last of whom is responsible for the committee's revised and more accurate name), as well as local host Alexander Kantchelov and site organizer Rik Bes, I'm pleased to present here a sampling of what those of us who were able to attend this meeting were fortunate to experience in person.

Opening Session

"How I Learned MI"

A Qualitative Inquiry

Allan Zuckoff, Judith Carpenter, Jacque Elder, & Tim Van Loo

The opening session explored attendees' responses to a pre-Forum questionnaire, emailed to all who were registered, on the topic of *How I Learned MI*. The genesis of this theme was a question posed by Steve Rollnick on the MINT listserv: What if we collected accounts of how people have actually learned MI, to inform our efforts to facilitate that learning?

Immediately recognizing the potential for this question to serve as the basis for a qualitative inquiry, it occurred to members of the PC that an ideal group to ask might be MINTies ourselves. After all, we have all learned MI, and we have spent a good deal of time reflecting upon how to help others learn MI. Why not turn the mirror back on ourselves to see what it might reveal?

And so we sent a questionnaire that asked MINTies who registered for the MINT Forum:

- how they worked before they learned MI;
- what their first reaction was to hearing about MI;
- how they were first exposed to the approach;
- the steps they took or phases they went through in becoming proficient;
- how long it took for them to become competent in MI,what sped or slowed the process, and how they overcame the challenges they encountered;
- whether there was a moment when they really "got" MI;
- in retrospect, what the key contributors to learning MI were.

We received 74 questionnaires, for a response rate of 65%. What follows is a summary of the rich and varied responses we received.

MINT members came to MI from many different starting points, and for many different reasons

Pre-MI orientations spanned the spectrum from client-centered to confrontation-of-denial counseling, and included cognitive-behavioral, family systems, psychodynamic, soution-focused, eclectic, existential, and 12-step / disease model

approaches; a number of respondents described themselves as having been "problem-solvers," "advice-givers," or simply "experts."

Interestingly, several people described their pre-existing styles in terms that would normally be seen as oxymoronic—i.e., "Rogerian and CBT," "patient-centered and advice-giving," "openly confrontational and empathic"—but which MI could be seen as integrating. Indeed, one of the reasons given by members for the decision to learn MI once introduced to it was to resolve a tension that existed in their pre-MI style. Others ranged from a wish to add on to what they were already doing, to refining an MI-compatible style further, to finding a new way of working or filling a perceived lack in their existing approach.

MINT members' first reaction to MI varied widely

While some described interest or curiosity followed by growing excitement, and others used words like "fascination" or "elation" or "inspiration," many reported first reactions upon encountering MI that were less enthusiastic. Some were neutral, some were unimpressed, and indeed some were skeptical about the value of the approach. In some cases this lack of enthusiasm was attributed to the poor quality of the instruction; in others, to the content, or to MI itself. On the other hand, some expressed an immediate sense of MI as a natural fit, congruent with their values, that would come easily to them. And a few used words like "homecoming" to describe a feeling of returning to their roots or finding themselves as practitioners after having felt lost or adrift.

MINT members learned MI through a wide variety of methods of varying importance

Methods cited included reading (especially the primary MI text by Bill and Steve), attending workshops or discrete training (including the TNT), participation in exercises and skills practice, and observing practice by MI experts, live or on video. Many highlighted the importance of consciously practicing in MI-consistent ways, and receiving feedback or coaching on that practice from expert supervisors was a common thread—but so, too, was the "feedback" received from clients, direct (compliments or expressions of gratitude) or indirect (more positive responses to interventions, improved attendance, or increases in positive change).

The latter form of feedback seemed to highlight that practitioners learning a new method require positive feedback not only to learn what to do (and not to do), but also to provide continuing motivation to do the hard work of learning. This was also reflected in the descriptions of support from other learners as an important aspect of the process—in particular, the importance of MINT itself, both for new insights into MI and for the sense of community it provides.

Finally, the quality of the teachers encountered was repeatedly cited as an important factor—not only the teacher's level of expertise, but his/her personal qualities and ability to model the spirit and values of MI while training.

MINT members measured their development as practitioners in years, encountered a range of challenges, and saw their learning as ongoing; some came to realize that they had become truly skillful in MI in single events, some over many small moments, and some not at all

Some described the same experience that we hear from our trainees: when they first heard what MI was they thought they were already doing it; only when they went further into the learning process did they realize that they had not been. While some found themselves becoming proficient quickly—typically those who came to MI with a background in client-centered counseling—most described the process as occurring over a number of years. Some learned by focusing on incorporation of MI technical skills, others through a shift in their mindset or outlook. While some experienced an "aha" moment of realizing they had achieved expertise—a dramatic change in a client; positive words from an expert who observed their practice—more often this sense developed gradually.

Challenges to development of proficiency were both external and internal. Tension between practice guidelines and the process of MI, lack of support from and in some cases active opposition by supervisors, isolation, and difficulty finding teachers or supervisors were noted; but so too were difficulties with specific aspects of MI practice (e.g., finding the balance between client-centeredness and direction, or knowing when to move from a more exploratory / preparatory process into a more focused, planning and problem-solving one), putting what one knew intellectually into practice, and frequently, the difficulty of changing a familiar, existing style of working to one that contrasted with it in important ways.

Perhaps most surprisingly, a common response to the questions of how long it had taken them to become "competent" in MI, or when they realized they had really "gotten" it, was demurral from this self-description. In some cases this seemed to reflect simple modesty, in others members' sense that they had not yet reached a level of skillfulness they they could feel satisfied with, and in yet others a sense of MI as a method that one could keep growing better at indefinitely, and thus an aversion to sounding (or feeling) complacent about the level of expertise attained

MINT members frequently described teaching MI as an important part of learning MI

It's often been said that the best way to learn something is to have to teach it to someone else, and this was true for many who responded to the questionnaire. For some, being given a teaching assignment motivated them to develop their understanding more fully; for others, it was the process of teaching itself, including observing and learning from students and having to develop answers to the questions they asked, that strengthened their own knowledge and abilities. MB

What Can MI Do for HIV Prevention and Care?

Sylvie Naar-King, Karen Ingersoll, Merav Devere, & Sharon Zang

The Horizons Project

Sylvie Naar-King

The Horizons Project, a comprehensive continuum of HIV services for youth from HIV prevention to counseling and testing to HIV care. The program incorporates MI for HIV prevention with youth in detention, for HIV outreach to encourage HIV testing among young African American men who have sex with men, for youth engagement in HIV care, for medication adherence and secondary prevention. It is also initating computer applications for adherence and sexual risk using using the Motivational Enhancement System (adapted from Ondersma and colleagues). The structure of these sessions includes:

- Opening statement
- Elicit client's view
- Elicit change talk – readiness ruler and decisional balance options
- Feedback (not normative but based on baseline assessment)
- Summary and Key Question
- Option for change plan

The training protocol included:

- 2 day training
- Weekly group supervision
- Review of audiotapes
- Review of MITI Coding

The individual projects include:

Project 180: Prevention for Primarily African American Adolescents in Detention

Two MI sessions in one week in the facility delivered by peer outreach workers. Data pre to post-intervention show immediate improvements in readiness to change. Three month follow-up data show reductions in substance use and unprotected sex. MITI coding suggested difficulties in reflection to question ratio and for the ratio of complex reflections to simple reflections.

Brothers Saving Brothers: MI to Encourage HIV C&T among YAAMSM (16-24)

Youth were randomized to a single brief MI session conducted in the context of street outreach versus a traditional outreach session. A significantly greater percentage of youth agreed to an HIV test following the MI session compared to youth who received traditional outreach. MITI coding suggested difficulties in reflection to question ratio and for the ratio of complex reflections to simple reflections. It was noted that we do not have data on MITI coding validity for brief interactions and for interactions outside of traditional mental health/substance abuse services.

Get Here Get Down: MI for Youth Engagement in HIV Care

HIV+ youth received an MI session at baseline and at 6 months. Youth were randomized to receive the sessions from a masters level provider or a peer outreach worker. MITI coding from peer sessions were equivalent or better than those from masters level providers. The effect size for improvement attendance to HIV appointments was larger for the peer providers than for the masters level providers. Data revealed equivalent scores between an MI session at baseline and at 6 months. These findings suggest that peer outreach workers can be effectively trained to provide MI.

Healthy Choices

A pilot study suggested that MI in a 4 session MET intervention, can be used to improve viral load, unprotected sex and substance use in HIV+ youth (Naar-King et al., 2006). This intervention is currently being testing in a multi-site clinical trial with 186 youth.

Participants in this breakout session discussed the appropriateness of MI for adolescent populations. A majority felt that few modifications were needed. Adolescents do not get "bored" with reflections, and love affirmations and emphasizing personal control.

Improving Medication Adherence and Reducing Cocaine Use with a Motivational Intervention in HIV+ Adults

Karen Ingersoll

Sporadic and consistent cocaine use increases non-adherence to HIV medication. Adherence must be extremely high to achieve suppression of HIV virus. Better adherence relates to lower morbidity, disease progression, and lower mortality. Because there have been no interventions available to address both cocaine use and non-adherence among HIV+ persons, we set out to develop and test a new therapy.

The Cocaine and Adherence Readiness Treatment (CART) intervention was revised from a 4 to 6 session MI counseling intervention. The following outline describes the CART intervention:

- Opening Session: Cocaine, HIV and Self-Monitoring
- Social Support, Stigma, and Disclosure
- Decisional Balance, Goals, and Personalized Feedback
- Confidence and Temptation
- Goals and Coping Skills
- Progress and Plans

The following outline describes the video control intervention (matched for dose and timing):

- Positively: Adults coping with HIV/AIDS
- Taking Control: Adherence

- Substance Abuse and HIV Care
- Stress, Nutrition, and Exercise
- Substance Use, Safe Sex, and Spirituality
- Portrait of Addiction

Seven participants (5 African-American women and 2 African-American men, all cocaine dependent) enrolled in the CART study pre-pilot trial. No attrition observed. Results were promising; with improvements in adherence and days using cocaine noted.

In the pilot study so far, 26 HIV+ nonadherent patients in HIV care have been recruited; 12 have been randomized to Video, 14 to CART counseling. Most characteristics were equivalent across groups. All participants were cocaine dependent by SCID/MINI criteria. Fifty percent are female, 72% African-American, 77% unemployed, 50% heterosexual. They were immune health compromised: mean baseline CD4 count = 365, mean viral load 37,434. At baseline, the mean adherence rate = 65%, mean proportion of days using cocaine = 27%. Common comorbidities included Major Depression, Anxiety Disorders, and Alcohol Use Disorders.

Regarding retention, 18/26 completed all 6 treatment sessions; 20 completed 5 treatment sessions; 19 completed 2 Month (post-treatment) Follow Up; 12 completed 5 Month Follow Up. Preliminary outcomes are positive. Participants in both groups are improving their medication adherence, having a positive impact on biological markers of HIV disease including viral load and CD4 count. Additionally, they are reducing the percent of days using cocaine from 29% of days to 12% of days. Both intervention conditions seem promising at present, but the sample size is still too small to have adequate power to detect group differences. Using MI to target two behaviors among patients with HIV not seeking treatment appears to be a promising method to improve the health of people living with HIV.

Incorporating MI into an Infectious Disease Medical Unit

Sharon Zang

Training staff and providers to adopt brief motivational assessment, strategies, and skills benefited patient outcomes of treatment compliance and decreased risk taking behaviors. Staff training was completed in a three day session. Physician training was on-going with 1 hour trainings per month and on-site supervision. This adaptation of training for the physicians and their on-site, real-time supervision allowed physicians to improve their application of MI assessments; strategies and skills.

Action Research and Reflective Practice: Exploring and Negotiating the Way Ahead in Developing MI and MI Supervision Service at Somerset Bay

Merav Devere

Somerset Bay (SB) is a small HIV organisation that was established in 1992 to provide residential care for people dying of AIDS related illnesses. In 2003 I was approached by SB regarding delivering MI training and MI clinical supervision training. We agreed on 6 days MI training x 4 to be taken by all nurses and support workers and 15-day MI clinical supervision course.

Why MI?

- Genuine wish to provide clients with the best care: The changing nature of HIV following the introduction of antiretroviral therapy has changed the type of support they need to manage their life and medication better. In addition different clients seek residential support; more chaotic clients who present with multiple issues.
- New director who wants to bring something new and sees MI as an approach that will give SB the edge when seeking funding in a competitive field.
- MI is seen as an alternative to the medical model presented by the NHS HIV referring unit. MI seems to be more in line with SB's ethos and values.

The MI training started in January 2004. The MI clinical supervision training, which was meant to be delivered in parallel to the MI training, started in Feb 2005, more than a year after the first MI batch finished. It finished in October 2005. The action research started in November 2005 and finished a year later in November 2006.

Action research was undertaken as a collaboration between myself and the supervisors with the aim of improving the way in which MI and MI supervision is introduced into the workplace, following the classical spiral of: planning – action – observing – reflecting – re-planning – action – and so on. This action research, however, started in the middle of the process in reflection after the supervisors observed that the practitioners were not using MI in the unit, which they interpreted as resistance.

The research focus centered on the question: How can an organisation improve the way it introduces and manages a significant change, i.e., the introduction of MI and MI supervision, in its approach to its own service?

This is divided into sub-questions:

1. How does Somerset Bay's staff, including management, supervisors and supervisees, understand the main reason/aim of introducing MI to SB? Do they agree with it, and how appropriate do they think MI is to reach this aim?
2. How might MI and MI supervision be introduced to the organisation most effectively in light of the responses it has received so far? What went well? What went wrong and what can be learned from it?
3. How effective is MI supervision with regard to staff development including development of MI skills and confidence in using MI? How can it be improved?

The research was conducted in collaboration with 7 MI supervisors in SB and myself, using qualitative methods of data collection and analysis including questionnaires, interviews, peer group supervision meetings, process notes and other relevant written materials. The data was analysed

using discourse analysis.

Question 1

There seems to be some consensus over the value of MI and its philosophy of care as well as an understanding of the reasons for introducing it. There also seems to be an agreement that at least some aspects of MI are congruent with the values and culture of nursing in general and SB in particular. However, not surprisingly, the director of services and the supervisors seem to express a much more enthusiastic response. The nurses and support workers, although supportive, express more reservations:

> "With my nursing hat on, I think they are very, very similar. I think it is about empathy, and about supporting and about giving information...I think where some of the uncomfortable sits is where the perception is that it is being prescriptive if you are goal setting. With my MI hat on, it is actually not my goals, it is the client's goals."

Points to consider:

- Is there a conflict between person-centred ideology that acted as the driving force in British nursing (Kitson, 1996) and the dominant managerial ideology of health care with its emphasis on efficiency and productivity?
- In this context is MI a 'compromise' or a 'mediator' between two conflicting ideologies?

Question 2

> "I think there should be more consultation with the clinical team, with the nursing team. To me personally it all felt a bit rushed and it all felt as there wasn't enough discussion and enough planning. Because of that there has been some resistance from the clinical unit. Understandably ...cause they are quite stressed at the moment. They see it as more work on top of heavy workload. They also feel from my discussion...they also felt it was quite monolithic, large new kind of way of working coming in and that they didn't feel confident that they have the skills to be applying to what they do." (Supervisor and team leader)

This quote demonstrates some of the problems that the supervisors identified. However using the framework of the action research and the principles of MI the supervisors managed to turn things around. They did it by rolling with resistance and involving staff in finding solutions and compromises.

Question 3

Starting the MI supervision groups took much longer than originally anticipated and by the time this action research finished there had only been 3 supervision sessions. The data however suggests that the MI supervision has played a vital role in the process of using MI. In fact I believe that without it the project would not have survived. This is in line with research that suggests that training on its own is not enough. An ongoing support in the work place is necessary to allow the implementation of what had been learned in training. The following quote from a supervisor's reflective journal demonstrates this point:

> "I feel there was a definite shift this week in the nurses understanding of the application of MI with clients in specific situations...By focusing on looking at the situation from the client's perspective and how the client may view what his needs are, which could be different to how the nursing team view the client's needs, the supervisees managed to identify that the client was in pre-contemplation, so explored what MI skills they could utilise...We discussed rolling with resistance and working with challenging the client's behaviour. W. identified that empathy and support was key to the client's needs at this point."

Some additional points:

- Analysing the discourses reveals differences in perspectives and emphases between senior management, the supervisors and the practitioners. Generally speaking it seems that senior management is more occupied with issues of cost, survival in a competitive field and control; the supervisors are concerned with how to implement the change in the most effective and least resistance-provoking way; and the practitioners are concerned with practical questions of: how is this going to be used? Is this going to affect my levels of autonomy? Will it involve more work? Will I be able to do it?
- These action research findings are consonant with other studies of attempts to introduce organisational change through top-down decrees of empowerment, where such attempts were regarded as an attempt at direct control by management (McDonald and Harrison, 2004).
- Generally speaking, the supervisors in the context of providing MI supervision seem to prefer to steer away from managerial functions like monitoring or evaluating supervisees' use of MI. They prefer to focus on the supportive, educational and motivational functions. This is consonant with other research findings that suggest that some clinical supervisors feel uneasy in particular around the task of evaluating supervisees' work (Carroll, 1996).
- One aspect that is missing from the texts is the expression of emotions. Supervisors seem to feel more comfortable talking about practical issues than expressing anxiety, disappointment or any other emotions. One of the supervisors explained it as follows:

  "You have to go with the flow and not get too emotionally involved, cause it is too upsetting to get too involved, or you start having negative thoughts about it thinking 'oh it shouldn't be taking that long. You know personal failure rather than maybe that's just the way it has to be."

Doing this action research has taught me great deal about the organisational dynamic and processes in relation to their specific context. I have a greater understanding of the resistance I sometimes experience in training and of the role of the trainer (and

the action researcher) as someone who is expected to meet the different and sometimes contradictory needs and expectations of not only management and staff, but also funders and referrers.

Researching MI in context has also helped me understand the appeal of MI to both management and staff. I believe that the integration of person-centred principles and short-term directive goal oriented techniques has the potential perhaps of meeting both staff and management expectations and cultures. The action research and the creation of an MI supervision group have proved to be very effective by providing the space for reflection and negotiation between the different perspectives and expectations. It is reasonable I believe to assume that even more effective and long lasting results could have been achieved if all stakeholders, including service users and funders, took part in the process.

In summary, MI provides an approach which is short term and directive and therefore suits the culture we live in, alongside offering empathic and respectful attitude to clients. This research I believe demonstrate how MI principles can be mirrored in an organisational level to help practitioners and managers alike deal with the demands that rapid changes in the external circumstances bring about. MB

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Development of a MINT Peer-Review and Certification Process

Tom Barth

This breakout session explored possibilities for establishing a peer-review system for ensuring quality of MI practice.

The presenter began by summarizing initiatives that are already underway, including community college and university certificates in MI, recommendations arising out of MITI, and the MI campus. He also referred to a model developed by MINT member Kathy Goumas, indicating that she was available to provide details of this model later in the session.

As a way of exploring the desired attributes of an MI practitioner, the presenter introduced the analogous question: "What do I want my dentist to have?" The discussion generated the following list:

- A certificate
- Participation in a shared practice
- Engagement in continuing education
- Membership in some kind of specialized body
- A patient probably wouldn't be interested in the details of any qualifying procedures
- A patient would want to know that dentist values quality assurance activities

The presenter moved on to share some thoughts about the MITI, observing that it's a good, reliable instrument that captures part of the complexity of MI as a skillful use of a guiding style of counselling. However, experience has shown that a practitioner can "produce" good MITI scores without achieving an optimal outcome. So, although the MITI may provide part of a solution, limitations—such as applicability of the tool across languages and cultures—indicate that other factors should be considered. The presenter provided an example to illustrate the latter point: in Bulgarian, "Do you mean…" and "You mean…" are indistinguishable.

Next, the question of what a peer review system might look like was discussed. The presenter suggested that there are many possibilities, including a panel of experienced MI practitioners reviewing a recording and providing written feedback to an applicant. Points of clarification arising from this approach include: (1) Would this involve an acceptance vs. non-acceptance judgment? (2) What role would advertising and marketing play in the process? (3) Would there be a renewal date attached, for instance, two, three or five years? The presenter put forward the idea that a "keep it simple" approach would probably be best, emphasizing a mechanism that allows practitioners to demonstrate they are making an effort to get feedback on their practice.

As far as possible next steps to further the thinking on this topic, the presenter suggested that MINTees could start with themselves, putting out the invitation: "Anybody want to come and play?" The advantage of trying out some relatively straightforward approaches to providing MI practitioners with feedback on their practice is that this process would generate some practical experience, as well as some draft materials, that could be reported back to the MINT community. Subsequently, the community could discuss whether MINT could be involved in the process in an official way.

Kathy Goumas was then invited to share her ideas on a system for providing MI practice feedback. She explained that individuals could be put through short cycles of a process described by the acronym "PDSA": **P**lan, **D**o, **S**tudy, **A**ct.

In summary, the presenter observed that the MI community doesn't yet have a way to measure acceptable practice standards but there is merit in continuing to explore practical ways of providing feedback to see where this leads. Anyone interested in participating in an ongoing discussion about this topic is welcome to email Tom at tom.barth@allasso.no MB

"You Can't Make Me!"

Using MI to Improve Rehabilitation for Persons with Chronic Disability

Linda Ehrlich-Jones & Trudy Mallinson

This breakout session discussing the use of MI to promote health behavior change in persons with chronic disabilities began with a role-play highlighting a typical interaction of a physical therapist (PT) and a client. The PT was trying to convince the client that she should get rid of her wheelchair based on goals the client had set for herself in coming to physical therapy. The client protested and requested the PT contact her physician for reassurance that she should continue using the wheelchair. The PT "pushed back" trying to get the client to comply. The role-play ended with neither the PT nor the client satisfied with the outcome.

In processing the role-play, issues of what was driving the PT or what was she thinking were discussed. The concerns of a health care professional who knows the bad outcomes that can ensue, such as pressure ulcers or atrophy of muscles, when a client remains in a wheelchair or does not actively participate in muscle strengthening activities were highlighted, but it was felt that the manner in which the PT expressed these concerns could have been approached in a much more MI adherent fashion.

The workshop continued with information about the types of clients seen in a physical rehabilitation setting, such as stroke, brain injury, arthritis, joint replacement, spinal cord injury, multiple sclerosis and Parkinson's Disease. The kinds of challenges that our clients face including the struggle of everyday activities, environmental barriers, personally meaningful activities that are no longer possible, loss of identity or role, loss of independence as well as the challenge of communicating with others were described. Examples of application of MI in a physical rehabilitation setting were given.

The focus of physical rehabilitation is predicated on the cooperation of the client. Health care clinicians may find their interventions met with resistance or ambivalence to change. Comparing and contrasting a standard medical approach to one using MI was given using the work of Belinda Borelli (a MINTIE). In a standard medical approach, the clinician will focus on fixing the problem, prescribing goals, providing advice, and "laying on of hands" to treat the client. We assume clients are motivated to change because they are here to see us. We warn and persuade them trying to get them to change. In a standard medical approach we view ambivalence as an expression of denial and resistance is usually met with correction or argumentation. Our clients see us as the expert and look to us to fill their genuine knowledge gaps. In an MI approach, the clinician is focused on the client's concerns and perspectives and we try to match our intervention to the client's level of motivation. The relationship between clinician and client is seen as an egalitarian partnership and goals are collaboratively set using a menu of options. In MI ambivalence is seen as a normal part of the change process and resistance is seen as an interpersonal pattern influenced by the clinician's behavior. In a physical rehabilitation setting, an MI approach includes "doing with" the client and enabling the client to question and/or modify the rehabilitation strategies. We also examine our client's perceptions, fears, values and expectations rather than just focusing on the education process.

The workshop continued with a re-play of the role play allowing the participants to break into pairs and replay the skit in a more MI adherent fashion. Participants seemed to really get into their roles and we had the opportunity to discuss how their interactions went. It was an opportunity for those with and without health care backgrounds to experience physical rehabilitation issues.

The second half of the workshop focused on arthritis and the physical activity promotion program we developed as part of an NIH funded grant. The goals of the physical activity promotion program are to increase physical activity in persons with rheumatoid arthritis and knee osteoarthritis, building individual strengths as well as overcoming barriers while developing an individualized and targeted intervention. The physical activity promotion program has six steps: (1) an interview to identify supports and barriers to physical activity called the Arthritis Comprehensive Treatment Assessment (ACTA); (2) identify goals for physical activity; (3) develop an action plan; (4) establish an agreement in writing; (5) develop strategies for recording progress; and (6) plan for future meetings with the physical activity advocate.

MI was incorporated into our physical activity promotion program using OARS and elements of the changes to the ACTA interview and the program were highlighted. Challenges to teaching health care professionals to use MI such as time constraints, billing/reimbursement/documenting progress issues, medical model dominance, the need for a certain amount of didactic information sharing, goal setting written in ways to satisfy provider and insurer needs, sense of control for the clinician, and getting students to break the cycle and not follow what they see clinicians doing were discussed.

For more information regarding this session, please contact us at lehrlich@ric.org or trudy@northwestern.edu. MB

Mint Bulletin Live Symposium

Goal-Directedness in MI

Allan Zuckoff

Welcome to this morning's *Mint Bulletin* Live Symposium on the topic of "Goal Directedness in Motivational Interviewing." The inspiration for this session came from—as so often is the case—discussions on the listserv at various points related to what the role of directiveness is in motivational interviewing and how to understand that. We define motivational interviewing as client-centered and directive, of course, and yet there has always been a range of ideas and understandings of what it means to be directive within MI, and to what extent that's a necessary part of MI. Does that vary in different settings in which we might do motivational interviewing, different time frames from brief to long term? Is there a clear line between client-centered therapy and motivational interviewing? And how firm is that line? And how do we understand that relationship? These sorts of questions, of course, have been discussed at various times. So I thought that it would be—actually Tom Barth thought it would be very interesting to have a session to focus on these questions. I agreed and agreed to facilitate it under the heading of the *Bulletin.*

The way this going to work is, we're going to hear from each of the five speakers you see in front of you. It will be—oh, they've actually gotten themselves into the order. Wow. So, actually we will move from right to left across the table. I've asked each of the panelists to speak for up to ten minutes on the topic, giving them no clear instructions or guidelines other than what I've essentially just summarized to you. The idea was for each of them to take up this question of goal directedness in MI in the way that made sense to them and that they felt would be of interest to the group. After each of them has spoken for ten minutes, we'll have comments from Bill and Steve, and then I'm going to offer each of the panelists another two minutes or so to respond either to Bill or Steve or to things that panelists have said. Then we'll open up the floor for discussion, questions, comments, and that should take us all the way through. I think that's all that needs to be said in introduction, and I'll turn it over to Tom.

Tom Barth

Allan says, "Do whatever is comfortable," and, there's no way. [laughter] I was asking Denise, "Why do we do this? Why do we do this?"

Actually, Allan says I suggested it, and he might be right in a sort of a way, but it wasn't in a place like this. It was, I think, far up in a mountain somewhere in Norway and everything was very different. Anyway, when you ask me to do things, Allan, I find it very difficult to refuse because he is so helpful with everybody else. So there's no way one can turn you down.

I just have one point for today, and I sort of slowly will wind my way towards it, and hopefully I'll get there within ten minutes. Just to remind you, of the definitions—MI is client-centered and directive. Steve says it's a refined form of guiding. I think for today, my working definition would be the skillful use of OARS, or microskills, in order to reach certain strategic goals. And as we all know, one of these goals could be certain kinds of change talk.

I'd like to give you a case example. This is a man who came to my private practice a couple of months ago. I'm a psychotherapist, also. He's about 40 years old, and he's a very, very successful and wealthy international business man. He travels all around the world and does contracts, legal stuff, and that kind of thing. He's married—twice married, and with his second wife he has a little daughter who is—what do you say in English—the pearl of his heart? [audience member: Apple of his eye.] Little daughters usually are. He was referred by his GP because of a drinking problem. His drinking pattern at this time is that he usually doesn't drink for weeks and weeks, even months, and then he drinks. And sometimes that works out fairly good, and sometimes it doesn't—he doesn't stop drinking when he should have stopped drinking, and the consequences for his business aren't very good. You've heard about this before. He wonders why this happens, and has commented and is very upset over it. He says it's when he feels good. It's not when he feels bad. It's a combination of feeling good and the opportunity. So, if he's been in Japan and done a contract and is on his way home in a very first-class kind of thing and will be home on Friday. So he has the weekend, and then he starts with the champagne, and the, you know. His drinking history—he started drinking heavily when he was 17 years old. You know the kind: first time they drink they pass out, and then they do it like that every time. Then he got through the university, so there has been some other way of adjusting.

At some time point, five years ago, he was diagnosed by his psychiatrist who told him that he had major depression, and they put him on medication. That helped. And he has been trying to get off the medication, and he can almost do it, but for the last five milligrams—when he tries to take

Goal-Directedness in MI ¦ continued

them away, then he gets uneasy, so he goes back on. So now, he's on inadequate medication. Thinking about him, perhaps the diagnosis isn't correct. When I think about what he's telling me, it might be bipolar disorder. And it might not be, it might not be strong enough to be real bipolar. So I could figure out that if I wanted to. He has the issue of stress, and management of stress, of course. And he's been sort of sloppy. He loves playing guitar. He had been good at playing guitar. He has many guitars: electric, acoustic guitars. So, he isn't spending as much time with that as he did earlier. He also is fond of exercise. He has two dogs, and he goes hunting in the mountains and wants to spend, could spend more time walking his dogs. And he has a wife. The way he describes her—well there's a name for that kind of thing also. If she gets very angry with him, which happens quite often, she could go down to the basement and smash one of his guitars. Then he doesn't know what to do about it, so he tries to ignore it, sort of. The only time she's happy is when he takes her shopping, he says. Then she's happy, and then they come home, and then they make love. So, there might just be a name for that kind of personality.

And then he comes to this MI therapist, that's me. And I think I'll see him for 20 or 40 sessions or something, and there's a mix of goals. There could be some behavior change. He wants very much to understand, to make this make sense. He's been to treatment once for his drinking problem, and he's learned all the cognitive behavioral stuff and he can identify high risk situations. He uses Antabuse every now and then when it absolutely mustn't happen, so he knows everything he needs to know. A goal could be acceptance. He cannot divorce his wife, he thinks, he feels, because he's too involved because of a lot of legal matters and the way they set up their contract, and also because the pearl of his heart would be with the wife, he thinks. And goal could be developing a stronger, fuller understanding of himself, and feeling he is in charge of his life.

So, talking to him every session, he comes, and we have different kinds of focus. Some of these could involve behavior change. I want him to exercise more. I want him to. This isn't very high on his priority. He wouldn't be very eager to talk about this all of the time, but every now and then he could. So that would be sort of a goal-directed little bit, like five minutes. And other goals aren't behavior change at all, like accepting that perhaps his life and his marriage is going to be the way that his life and his marriage is.

And I guess my point is that when I'm working, I have a goal, I think, the goal of accepting his life and his marriage. I think there are certain faults and certain affects he needs to get in touch with in order to get that. I have a very clear idea of what kinds of faults and affects. So whenever we're talking about that, I can hear in my head, "Oh, now there's a place it would be good for him to move to." If he's close enough, I just ask an open-ended question: "What do you think about …" and I reflect, and so on. If he's not really close to it, I ask if I can give him an idea: "I've been thinking there's this idea. Do you want to hear it?" He says, "yes." And I say, "blah, blah, blah … what do you think?" And he says, "Doesn't make sense to me," or "I never thought about it before." So I'll be handling resistance or I'll be…

Directiveness: I'm not directing him except for the exercise and also a little bit with the medication. But who's the directive one? It's me. And I am—at all points, I am strategically using the OARS in order to reach certain goals that I have set. And I think it's good for him, and I use all my expertise as a clinical psychologist to find the goals. And looking at this from the outside, I think you can't see the difference between when I'm working behavior change directively, and when I'm working other kinds of directions. I think they might even be the same. And my point is—I think you all understand—that it doesn't make sense to me that in one session, Tom, you are doing motivational interviewing, talking about this running up and down a mountain and in the next session or the last part of the session you are doing something different, when I think I'm doing just the same thing, with just the same tools, and in just the same kind of rhythm, and my plans are just the same. So, why shouldn't that also be motivational interviewing, and in my head it is. Thank you.

Denise Ernst

Well, I always think following Tom is one of the hardest things that you can do. [laughter] Actually, Tom and I were talking last night and this morning, and just thinking, reflecting on what he had said last night and this morning has really shaped my thoughts, too. There are a couple of different things. One is I think he's probably right about the MITI, that it probably would pick it up the same, although we'll see with the new directiveness global whether or not we get anything different in that regard.

But one experience I think is important to share, that I think has kind of triggered much of our conversation about this is that—I do a lot of coding, I listen to a lot of sessions—and what I can say from my experience is that, in the majority of sessions that I have listened to, there is no evidence of the strategic use of OARS. We talk about it a lot. We discuss it. We think it's really important. And when I look at my own practice, or if I were to listen to Tom's tapes, or I would listen to someone who really is using the strategic use, you can pick it up. You can hear it. You can sense it. You listen to it. You go "Oh!" You can tell where they're going. But this is a highly—it seems to be a pretty advanced skill that we haven't quite figured out how to teach people. We think it's important, and we haven't gotten there yet. And so, I think that's driven in a way how we think about being directive. Part of this

discussion is, how do we help people understand how to be goal oriented? So, you listen to sessions, and it's oftentimes pretty aimless. You really don't have any idea about where the therapist is going. Now, they may, in fact, have a goal in their mind, but it's not very evident from listening to it. So it seems like somewhere along the way, we need to figure that out. How to help people—because I believe we owe it to our clients to participate in that and to carry a goal and to move towards that goal. So part of the way we've done that is in all the coding that we've done. The focus has gone to target behavior and behavior change because, I think, largely because we can measure it. We can actually recognize it, and it's a marker for us. We can see—we can say yes, you can tell what the target behavior is, and that's one goal that's certainly legitimate and has come along with motivational interviewing from the very beginning of moving towards a target behavior. And, we can measure change talk. I also believe that there are other forms of talk—even if we we're looking just at talk—other markers. There are probably other markers that we will be developing that will help us recognize when the conversation is moving towards a goal. I think we'll be recognizing more of those and learning more about those. But this is where we are right now—where we're starting, with the concept of focusing on change talk. And, it clearly—Tom's story really provides a sense that our notion of goal has to be broader than just focusing on the behavior, because people are so much more complex and have so many more things going on, and there are so many other changes that would be of value for them. There are so many other non-change targets that would be really useful to seek, such as the acceptance that he was talking about.

Just as a way of illustrating that—what I really got thinking about on the plane, you know when you're traveling and you just get kind of in the zone, whatever zone that is. I was flying over here and I was thinking about my own self. I've made a decision to make a move. But even though the decision is made, I am incredibly ambivalent about this move. And I run up against my ambivalence everywhere I go. I think "oh..." There's all kinds of stuff rattling around in my head about it. And I found myself saying that I wish somebody would do motivational interviewing with me, that would really pick up and hear that this goal is important to me, even though it may not make any sense to them. But it's a goal of mine, and it's something that I need to resolve—and will resolve eventually on my own, but I could do it a lot faster if one of you guys would do this for me. Actually, I've been getting lots of good help with this since I've been here, because I've been talking about using it in this Forum. But would be able to systematically hear, even though it doesn't make sense to them, that I have indicated that this goal is important, and that will help me actually flesh it out and say, "Why is this important?" And "What is it about this? Why would I want to do this? What is the ambivalence about?" Even though I'm not there, and recognize that this requires a complete change in me about how I view myself, what I think is important and actually allow that to happen. So, on the surface it looks like this really simple thing. Oh yeah, you're going to make a move. Oh yeah, that's ok. And there's so much more to it. But I want somebody to systematically and strategically pick up on my strengths, my goals, my values, my reasons for doing this, and help me move towards that. Now, there's a lot of behaviors in there. They're not all target behaviors, but there's a very strong goal. And I want to know more about it for myself. And I don't think that's that much different from our clients. They may have goals that we don't even hear, and I think we need to train ourselves to hear what their goals are, and maybe help shape those goals, participate in them, and help guide them to a clarification about what the goals are. It's not strictly about behavior, but when we're working with behavior, there's a pretty good marker when the person starts talking about it. And maybe we need to look at some alternative ways of recognizing when the client is really talking about a goal. But I do think it's important for us to pay attention to their goals and to the ones that we bring—just like Tom said—my goal is to help bring acceptance. Well, we need to bring our goals into it and negotiate with the client about those and keep moving in that direction. But it definitely seems like we need to have a goal. We owe it to our clients to do that. Thanks.

Gian Paolo Guelfi

Good morning everybody. I'd like to start with a Peter Prescott letter. A few days ago he wrote,

> *MI has dual natures. At the same time it is both spirit and technique, a style and a manualized treatment, a short intervention and a way of being, supporting and influencing, strategic and empathic, confrontational and accepting, patient-centered and counselor led.*

This is an interesting way of getting to the issue. Remember that the first definition of motivational interviewing, and the subtitle of the book was, *Preparing people to change addictive behavior.* The definition we find in the second issue is not that way. It's a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. And compared to the early view of motivational interviewing, this definition drops "behavior," and turns "behavioral change" into "change," and goes beyond addiction. And we know that this is a major revolution. And I've seen the outline of a book that is coming out by Bill Miller and their coworkers—it's completely beyond addiction. Conversely, the new one is client-centered, that is, non-directive, and still directive is reconfirmed, is maintained. So motivational interviewing is founded on two pillars:

acceptance and direction for change. And I wonder if this is oxymoronic. I think there is wisdom in oxymoron. Contradictions are enriching.

As a matter of fact, I think that reflective listening can be thought the skill, the motivational skill that reconciles client-centeredness and direction. Webster's *New World Dictionary* says that there are two meanings in the verb *reflect*. One is a transitive meaning, reflect something as a mirror, as mirrors do. And *reflect* is an intransitive verb: reflect as mind, that is, to think seriously, contemplate, take into consideration. So, reflection is an act of acceptance. It is also an act of direction, because the clinician makes a choice of what part of the talk or the speech of the client to reflect, and it's not meaningless—the choice. Reflection can emphasize a point in the speech of the client that in her or his view requires particular attention, as in amplified inflection, for example. Or he can invite the client to consider the fact that in her or his speech is a possible dissonance, as in double-sided reflection. So, working reflectively is a brilliant combination of acceptance and direction for change, for enhancing intrinsic motivation to change. This is a change in the behavior problem and possibly in the underlying mental state, mental attitude, mental problem. That is something very close to what the people who spoke before me said.

The problem is: do we need a behavior target, problem behavior, maladaptive, addictive, pathological? Do we need a behavior to do motivational interviewing? Isn't it enough to have an existential condition of psychological pain or distress?

Here, let me show you. I'm going to present briefly a session with a neurological patient with an age of 36, living with her intrusive and overbearing parents and two younger twin sisters in their 20s. She is of normal intelligence. She experiences strong sexual urges and romantic longings. In the enmeshed family there is a lot of rivalry, jealousy, and worrying concerning the sexual activities of the older sister. She has no major pathology, no substance abuse. The overwhelming client feeling is that she is a prisoner in her handicapped body. The patient has been sexually active through a number of encounters, which she arranges with remarkable resourcefulness.

At the beginning of the present session, the clinician is called on the phone by the mother of the client who relates an event a few weeks ago when she was found by the railroad tracks with her male friend. The doctor informs the client.

Client: I nearly ended up in jail. We were private. They treated me as if I were a criminal or a drug addict.

Doctor: What happened?

The event is clarified. Police found her almost undressed. The boy escaped. The woman found refuge in the toilet at the station, but she was summoned out, and harassed, threatened, shamed, and her family was called on the phone, violating her privacy, and so on.

Client: It was a terrible shock. I was also very frightened.

Doctor: For you, it's a state of war. You feel you are a prisoner in your body with this limitation and those of your intrusive family. And on the other hand, you feel the need to do these things you deem important to you, and you are willing to run the risks.

Client: I'm very determined when I get something in my head.

Doctor: For you, it's a kind of survival. It's a constant struggle. You're trying to find space while they run interference. They check on you. They report you. They threaten you.

Client: This chain. This hell. I take it with me wherever I go.

Doctor: Yes. On the other hand, you have your jailbreaks.

Client: Yes. I do (laughing). Fortunately, my mind is able to create all these situations (laughs again), but sometimes I feel like jumping out of the window.

At this point, the issue of possible suicide and impulses is explored fully. She is afraid of her impulses. She lives on the third floor. She commented that she might not die from jumping, and end up in a worse prison, confined to a wheelchair.

Doctor: So these intrigues, these jailbreaks allow you to live with your difficult situation.

Client: Yes, a little. I also pray. I ask God how long I will have to stay down here.

Doctor: What is that like for you, praying?

Clarification of the experience of prayer: She takes part in a prayer group once a week. She also goes away on retreats. Prayer is comfortable and peaceful to her.

Doctor: So there is more to break from your prison life.

Client: Oh, right. When I go away to the annual retreat, I come back different each year. Changed.

Doctor: You go. Every year, more gifts, more breaks. And then, in your weekly prayer group, you continue to cultivate these seeds.

Client: I also like music a lot. And I like these stories in TV. My mother says, "Why are you always looking at that TV?" But I like it. I see myself in all these characters. The love stories. So, I have these three things: sex, television, and prayer. God! I can't do without any of them.

We see that the jail climate has changed. She's aware of a more complex and complete picture of her situation, which includes her talent, her determination, and many gratifying aspects of her life.

I think what has happened through reflective listening and open-ended questions is that a less partialized and catastrophic representation of her life has been reached. This will possibly allow, eventually, and I would add a second layer, also the determination of whether she is doing the right thing with her sexcapades or if this is, indeed, the best she can do given her circumstances. Thank you.

Christina Näsholm

Thank you. Some basics: MI is a professional conversation method. All professional conversations are about the other. It uses a method and has a goal. Thinking about MI as a professional conversational method, I am thinking we're really trying to—the spirit of motivational interviewing anchors us to listen to the other person, elicit from the client, to use OARS as powerful tools. And why worry about the directiveness of MI?

Listening to Tom makes me concerned. What drives a therapist to have all these desires, reasons, and needs to use OARS in such a skillful way to reach certain goals. The main part of what I'm thinking about directiveness is—I think we need more than we do today—to discuss, to help ourselves be aware of all the directiveness we have within us. Motivational interviewing is a very effective method, and skillful use of its tools—I love the way Tom uses it, but at the same time, I'm not sure I would like everyone to use it in that skillful way, depending on what drives them to help the client in that certain direction. So, I think about desires, reasons, and needs that we, as practitioners, have on behalf of our clients that will steer us in certain directions. Of course, it's OK to have aspirations—as Steve is talking about—for your clients. Of course it's OK, but to what degree are we aware of why we have those aspirations as we have?

Yesterday I attended a wonderful workshop when we were talking about factors that could influence the desire I have for my clients. The goals I have. It could be organizational, time limits, insurance company regulations. I'm also thinking about personal background reasons, desires, and needs. So, where is the reflective room for the practitioner to have a chance to self-explore, discuss, reflect upon in what way I'm using the directiveness I have within me. And who's helping me to become more aware of some of them and when I'm using them because it's more my need than the client's need, and because I want to fulfill a goal more on behalf of myself than the client. And I would like us to spend more time on this in training trainers, and I would like us to spend more time on this in training practitioners because there are people in our workshops that, maybe I'm happy they don't learn to be that strategic as they could maybe be. [audience chuckles]

Some of you know that I have a certain interest in exploring ambivalence. And I'm really hoping that we will be better in, that we will develop our skillfulness in exploring ambivalence, strategies for exploring ambivalence, so that they will be more helpful for the clients because even an exploration of ambivalence is always goal-oriented: oriented towards solution of ambivalence in a certain direction or mainly to take a stance, make a decision, whatever the direction.

Well, more awareness of the directiveness we have within us, and I would love us to be training ourselves for a more strategic use of the tools in MI and also having the room, the space and the time for reflecting upon its use. I think I'm stopping there.

Grant Corbett

Pleased to be here this morning. Goal directedness—I want to highlight that there are two forms: automatic and intentional. When we as counselors ask questions, we are "priming" concepts. Research shows that following primes, people engage in associated behaviors, without being aware (for example, subjects primed to think about the elderly, walked more slowly to the elevator after the experiment). Evoking change talk is a form of priming. We know that the strength of change talk predicts behavioral outcomes, but clients don't know that when we evoke it. So there's an automatic directedness in priming concepts and change talk.

Then there is intentional behavior, which is what most of us think about when we think of goal-directedness. This is a person's propensity to set conscious and fairly well-defined goals, meaningful to themselves.

Allan wrote to presenters on the panel today, and proposed questions we might answer. So the three I chose were: Must MI always be goal directed? What is the nature of the directiveness in MI? (I love that question. Allan asks good questions, don't you think?) And, should the therapist always be going somewhere, i.e. pursuing change talk?

In answer to the first question ("Must MI always be goal directed?), I'm going to suggest: yes, in summary of what everyone said.

I propose that we are being goal directed even when we simply reflect feelings. That is because a person's affect is connected to the content, effect and difficulties of the situation. Let's start with content. This is the story that the person tells us. Let me use an example: a man, who comes in with an alcohol problem, says his wife is always on his back about his drinking. That's the content.

Feelings. If a client said to you, "My wife is always on my back," what emotion would come to mind for you? Anger. Sadness. Hurt. Unresolved content usually has feelings attached. Meaning is inferred from the relationship between content and feeling. The man in our scenario could be feeling anger, but it might be sadness. So you have to connect the two.

Then there's the "effect" on him of the situation. How does his wife 'being on his back' affect him? Perhaps he is left feeling distant from her. A situation has an "effect" on us, to the extent that there is a difficulty that we cannot manage. If we turn his difficulty upside down, we have his goal. For example, if he can't talk to his wife about feeling distant from her, his goal may be to be able to talk to his wife about this distance. In MI, the next step is the evoking of commitment language. And then there is taking action steps.

Goal-Directedness in MI ¦ continued

Now, I don't know if anyone recognizes this list without the evoking commitment component. These are the skills of helping defined by Robert Carkhuff. So I think all he missed was commitment.

Now, why is the foregoing goal directed? If we reflect just feelings to a client, would that be goal directed? Yes. Because reflecting affect is engagement in goal directedness whether we know it or not. Feelings about a situation are a pointer to the "effect" of the situation on a person. What do I mean by pointer? I was influenced by the early work of Nico Fridja. He wrote a paper in the 80s called, "The Laws of Emotions" (he published a book by the same name more recently). He proposed that our emotions have meanings.

So, for example, anger has two meanings: 1) the belief that we've been harmed, or 2) that our expectations have not been met. So, when a client expresses anger, they are saying "I have been harmed or my expectations have not been met." When we reflect affect and meaning, we are participating in a goal directed process.

How many of you have had a client say to you the same thing over and over and over again? Only three people, ok. [laughter] The reason is that clients are saying, "You're not hearing me." We're not connecting to their goal through their affect.

Now, the focus on change talk is being goal directed. I want to quickly list the central components: Desire, which is what they want. Need language: I have to, I must—very goal directed. Activation: what are you ready and willing to do—definitely goal directed, or taking steps or what have you already done. When we evoke these in MI, we are being goal directed.

So what is the nature of MI directedness? There is much that the broader research says about what we're doing in motivational interviewing. I will speak to four here. First, evoking desires and giving affirmations. All of you would identify with evoking desires as goal directed. In a paper, just recently published, Aarts and Custer propose that the accessibility of the goal state (in MI language, that's evoking the person's desires), and it's detected affective valence (positive feelings) work together to produce motivational goal directed behavior.

I want to highlight their mention of positive affect, as one of the strengths of MI is its use of affirmation. When we affirm a client, when we affirm anyone, when someone affirms us, how do we feel? Positive. So, by affirming people's desires, in a sense, we're being goal directed. Evoking desires and giving affirmations are ways that we're directive.

Evoking and reinforcing commitments is goal-directed. We know about that from research by Amrhein and group, and Terri Moyers has a new paper coming out in November, 2007 with additional data.

Future-oriented questions. Let me point out two areas of the research around the importance of these questions for goal-directed behavior. What future-oriented questions do we have in MI? When we ask the "Looking forward" question? The "Extremes" question: what if the best thing were to happen? There's a body of research that talks about distal goals, goals that are further away, and proximal goals, goals that are closer. It appears that distal goals energize behaviors. So by being future-oriented, were being goal-directed.

There is a second body of research that is relevant here. A distal perspective enhances something that we often talk about in MI: the preference for identity over instrumental benefits, which is by way of saying that distal goals (i.e., desires) helps us focus on ourself, rather than on just immediate reinforcements (such as an addictive behavior). So, future-oriented thinking is critical to having the person focus on the self, which is directing goals. That's from a paper by Kivetz & Tyler (2007).

Last, evoking if-then thinking—what would that be in each of your languages? In MI, what "if-then" thinking do we evoke? The rulers (also called scaling questions)? You ask about importance and confidence: "On a scale of one to ten, where are you now?" Whatever, the client responds, you might ask: "If you were at an eight or a nine, then how would things be different?" Evoking "If-then" thinking is goal-directedness.

A recent piece of research adds support to this. The ability to plan is associated with greater activation in the ACC, the anterior cingulate cortex. The ACC seems the most likely area activated by conditional reasoning tasks, which is what "If-then" thinking is.

To answer Allan's last question, "Should the therapist always be going somewhere?" I would recommend always going to MINT Forums. [laughter]

Allan Zuckoff

Thank you, then, to each of our panelists. We'll now have comments.

Bill Miller

Well, there's an awful lot of intelligence and therapeutic talent up here. It's been impressive to listen to a presentation like this. As a cautionary note, I found myself this morning remembering the late Joseph Wolpe, who used to stand in front of the Association for the Advancement of Behavior Therapy every year and denounce the encroachment of cognitive therapy into the domain and say, "This is not behavior therapy. This should be cast out from the behavior therapy organization. It does not belong here." And I in the audience found myself thinking what does it matter if it's behavioral or cognitive? We're trying to find therapeutic approaches and empirically validate them. And the outcome of that after Wolpe's death was that it's now the Association for Behavioral and Cognitive Therapy. So, I lean

toward inclusiveness.

So, let me just kind of go through the presentations and reflect a bit.

First of all, Tom. No one—including me—has a longer history with motivational interviewing than Tom Barth does. He was in the same room at the same time when these ideas were being birthed. And I love the focus on the strategic use of OARS toward a goal. That's very consistent with how, certainly, Steve and I have been thinking about motivational interviewing. And if I were to add anything, I would say, well probably it's more than OARS also that's being used toward this goal, but certainly strategic use of OARS is a skillful piece of it.

It is easiest to demonstrate motivational interviewing when there is a clear, single goal—when there is a behavioral focus. So, if I'm asked to demonstrate motivational interviewing, so that people can see what I'm doing, it's clearest if there's one particular goal that I'm moving toward, because it's just plainer what's happening. And, it's easier to code motivational interviewing. In fact, it's challenging to code change talk unless you have a goal to reference. And, what Tom really raises, I think, is the multiplicity of goals, and the agenda setting that Steve talks about that are present, usually, in therapy, and the shifting among goals and the fact that goals change as you get further into therapy. And so, one can deal with that somehow, and you certainly do in health care. When a physician talks to a diabetic patient there may be an underlying goal of glycemic control or even further than that of quality of life—and toward glycemic control, one could be changing exercise, one could be changing medication adherence, one could be changing stress levels, food intake. There's a whole variety of things, so that talking about any of those behaviors that would contribute to glycemic control would be moving in the same direction. It gets more challenging to code, but that's the reality of this kind of enterprise. So, what I took from Tom's presentation is this challenge of having multiple goals that one is pursuing at any given time and trying to understand how the method of MI fits into that constantly shifting terrain.

Denise affirms it's not motivational interviewing yet if there's not a clear goal, and I think that's consistent with the way we talked about this from the very beginning, and she asserts that we owe it to our clients to have clear goals. It then begins to touch on the ethical issue of, well, whose goals are we talking about here? Because sometimes in motivational interviewing, we're pursuing a goal that is not the client's current goal. And sometimes we're pursuing a goal that the client has brought. Sometimes we clarify that and are sharing a goal. I think there are different degrees of discomfort depending upon the degree to which the goal is shared. But I began in an area where I was working toward a goal which was change in problem drinking. It was not yet the clear, formulated commitment of the client, and, indeed the purpose of the counseling was to bring the client to the place where they had decided to move ahead with that.

Gian Paolo—first of all, whenever I listen to Gian Paolo, I'm amazed at his mastery of English, to differentiate transitive and intransitive verbs, and coming up with phrases like "sexcapades" [laughter]. It's truly wonderful.

I did, very much, like Peter's description of the paradoxes in motivational interviewing, because it's true. It's both acceptance and direction, and both of those things predict outcomes, by the way. In Terri's research she's finding that spirit, the global measures, acceptance, empathy, are good predictors of outcomes, just as Truax and Carkhuff did. And also strategic things, like there was something as specific as the reflection to question ratio is predicting behavioral outcomes and is predicting change talk. So, these things flow together, and I think it doesn't even make sense to try separate them and say, "Well, this piece by itself does this percent of the variance." So yes, it's both.

Christina is worried about the ethics of goals, also, because MI works. If it didn't work, we wouldn't be concerned about the ethics of it. It wouldn't be a problem, but it does seem to work, and calls us to be aware of our own ABCs, our own aspirations for behavior change—our own DARN aspirations for our clients and why we have those, and the ethical issue involved. And worries about MI seeping out into the world where people aren't bound by the same ethical restrictions, and so begin using motivational interviewing to sell products or to get signatures on informed consent forms or as one detective told me two months after coming to one of my workshops, "This is a great way to get confessions." I don't know that we could do too much to prevent that except keep talking about the underlying spirit of it and emphasizing that. Also, she raises the situation where you encounter ambivalence, and you have equipoise about it. You don't really have an opinion, and you shouldn't have an opinion about which way it goes. There, your job is to help the person resolve ambivalence, but I would maintain you're not doing MI at that point. You're doing good, careful reflective listening, but since you don't have a goal—other than perhaps the resolution of the ambivalence itself—if anything you try not to influence the direction of change inadvertently, but to help the person take a look at both sides of the ambivalence very carefully, which is something that I would not do ordinarily in motivational interviewing where I'm wanting to move the person more toward looking at the pro-change side.

And then finally, Grant, the encyclopedic mind of motivational interviewing, says again, "Yes, MI must be goal oriented." And it's just one tool. It's not a comprehensive approach to psychotherapy. It's not the only thing that any therapist does. It is a tool that is particularly useful when you have

a goal and ambivalence seems to stand in the way, and you need to get over that in order to make progress. So, he reminds us to keep that perspective of, it's a tool within a much broader perspective of therapeutic endeavors. Interesting material on distal vs. proximal change—in a way it reminds us to keep those distal goals in mind and to ask the client about their values. And if-then questions about the long-term impact of what's happening and how that relates to their values. Therapy itself is not always goal oriented, but motivational interviewing, by definition, has been.

Finally, I want to add that the goal of motivational interviewing is not eliciting change talk. Change talk is just a pointer for us. It's just an indicator of where things are going. I mentioned on the listserv recently a series of interviews that I did, demonstrations on video tape, where during the interviews there wasn't a whole lot of change talk. Certainly during a couple of them there wasn't a whole lot of change talk. And so, we feel like, well those were not successful interviews. But we had the idea for Terri to sit afterwards and ask the person, "What was your experience during this interview with Bill?" And all three of them, in what they said, revealed some internal struggle and asking themselves questions about why they weren't changing, and thinking about moving in that direction, and talk about a kind of uncomfortable reflective process that hadn't been going on before. So, even in the absence of change talk, things are happening. It's just a pointer. It's not our goal to elicit change talk. I do think it's a good indicator to help people learn motivational interviewing along the way, but it's not the ultimate goal. It's simply a means to an end. And there are other things in motivational interviewing—including, I think, the spirit of it—that themselves invoke change, apart from this particular mechanism. So, those are my thoughts.

Steve Rollnick

Thanks very much, Bill. I'll be brief, Allan. I started off writing some quite clear, reasonably strident and perhaps provocative statements, and then a couple of things happened to me. First of all, he mentioned an uncle of mine, Joseph Wolpe, and echoes of genetic dogmatism came filtering down. He was a great uncle of mine, and I don't know much about him, but I thought I'd better just genetically tune myself down a little. And secondly, I wasn't at the magic show last night, but my glasses have disappeared. So all the stuff that I was writing [laughter] is too difficult to read. Instead of just being grumpy like my uncle, I'll just say a couple of things—and really they're feelings I have—which is that I'm really delighted that we're moving beyond oversimplified discussions about dichotomies, or we either direct people and influence them or we make them make their minds up for themselves. I feel liberated listening to the discussion— feeling that it's more subtle—a wee bit more complicated, and that's a good feeling.

I'm also inspired by the possibility of helping practitioners who might entertain these oversimplified notions, because it's one thing for a group of us to have thoughtful convergence around certain issues. It's quite tough to talk to people with less experience and avoid then entertaining oversimplified ideas, which is what I'm excited about the potential for through clarifying with them what their aspirations are for changing someone else. These vary on a number of dimensions, and I think we're just touching the surface of this. We talked about strength differences. I put that up yesterday, but there are other ways in which these aspirations differ and can manifest either constructively or less so in the navigation with the patient or client about what *their* aspirations are.

And I'm thinking of two stories, very briefly, both involving the same person that I told you about yesterday. I think it's clear that, when I worked with her with a group of people who were out in the township and she and I stood back and asked the question, "What was the effect of this workshop on motivational interviewing?" our conclusion was that the effect of the motivational interviewing wasn't that their patients were going to get better, but that they felt better about themselves because they didn't feel that they had to solve every problem. They said it released them from a sense of responsibility, which is interesting. So, I suppose it amounted to the constructive use of their aspirations. I can aspire to some things, but the way I respond to this might not have to mean that, "I've got to get them to change." So, that was very inspiring. On the negative side, the flip side, of that is the well intentioned, but misdirected use of direction because people's aspirations are so high. They're well intentioned, but they're misdirected, and they're extremely destructive for the atmosphere in the service, I think for the patients many times, and particularly for the mental health and well being of the practitioners. So I think this stuff is all opening up now, and I have nothing more to say. I hope I've avoided the Wolpe trap. [laughter, applause]

Allan Zuckoff

Everyone, it is almost 20 after ten, and so I'm faced with a decision. I had promised to give the panelist each a minute or two—good, that was what I hoping you would say. And so we have a little bit of time for questions or comments from all of you. And again, the key is to be sure that you are going to be speaking into the microphone so that we can pick up your comments and questions as well. I'll just be the runner here for that, so it can be a question to one of the panelists or commentators, or it could simply be a general comment or expression of your own thoughts.

Sandy Downey

This is a really important discussion for me personally in the work that I do with MI and my clients. I'll try to be really brief, but for me, the most important part of what we do is help our clients discover the goals that they have for themselves. Although I may have very important goals in my mind that I would like my client to reach so that they improve themselves and their lives, I believe that there's a place in my clients in that they also have similar aspirations for themselves. And I believe that what I try to do is help, sort of journey to that place together within them where they discover what the goals are for themselves and get clarity around that and become more confident in themselves so that they can reach those goals. I believe it's all within them. So I get a little bit uncomfortable when I keep hearing so much about clinicians' goals, and I just heard less about our clients' goals, and I really believe that they have these goals for themselves.

Cathy Cole

I guess I wanted to talk about the issue of the "soft goals". I'll talk about that in terms of people talking about acceptance, and is that measurable, because as Sandy said, I believe very much that I'm in the process of helping people that I work with figure out what for them will be meaningful in their lives and what will help feel like they have a better quality of life despite the issues. So whereas I might want them to do exposure therapy on their trauma, that might not be what they want. They may believe that learning to cook is a way that they'll feel better in their lives about the effects of things. For them to establish that is very important, and for me to realize that I think of aspirations as my righting reflex, and I teach it that way. It's just what I think is best because of my desire for clients to have something better in their lives. So I'm always having to rein that in, particularly these days when I'm dealing with people coming back from Iraq.

So, about the acceptance piece, for me, I find that easy, and that if somebody says to me—I'll go back to Tom's example—it might be better for me to accept that this is the current state of affairs with my wife. And so, my response to that might be, So how will you know when that's happening for you? What will feel different to you in your life? How will you act differently, feel differently, perceive differently? And that, then, becomes measurable in some way, because the client can say, "Well, maybe rather than agonizing about thus and so, I might want to take that walk up the mountain that you thought might be a good idea for me." So, I really think that those things that we might consider "soft"—and I really appreciate Grant's comments and as well as Gian Paolo's comments about that—that we help our clients operationalize what that will be. And that, to me, is the real value that comes in this process of motivational interviewing.

Merav Devere

I'd just like to very briefly, if I can, share with you my own ambivalence about directiveness. When I did my psychology degree back in 1976—many years ago—it seemed like cognitive behavior therapy and short-term, goal-oriented therapies generally were considered inferior because they didn't take into account the whole person. This was the philosophy then. Now society has changed dramatically since. The way I see it, the business world—including business language, like *target* and *goal*—has taken over, and they are the sort of main philosophy nowadays. And it's not as if they're really a bad thing, but it also concerns me because I think it's important to remember that the person is more important than the goals. And I think for the majority of my clients—the majority of people—finding their own goals or working with my goals work very, very well, but it doesn't work for everyone. And my main concern is with all this sort of target culture is that some clients are excluded or will be excluded from services because they don't conform to the target or the goals that the organization or society puts for them. Recently I took part in a multidisciplinary meeting where a client was referred to as "dead wood". And she was referred to as "dead wood" because she doesn't—she can't, or she wouldn't, or whatever, adhere to her HIV medication or stop taking drugs, or whatever it is. So, no one wants to know about her. And this is what concerns me very much about targets. It's important that we remember that some people are not ready. And this is the most important part of motivational interviewing. Thank you.

Giovanni Biondi

I would like very briefly to say that if you do a coordinated use of OARS, it's impossible not to go somewhere. You don't necessarily have to know where you're going—unless you sort of row [with one oar], it's impossible not to go somewhere. So we don't have to really worry. You always will go somewhere. And it's probably better not to have a really clear idea of where you should go and all that, because it will emerge.

Pip Mason

This is more of a question or an issue to raise, rather than a thing I think you ought to know. There's something for me about how far can we trust—that if we allow people to, clear away the rubbish from people's decision making, clear away the pressures that they're under, clear away the hassle they feel from everybody else and make sure they've got and understand the information they need to make a decision, how far can we trust that they will make the decision that is right for them? When I'm feeling that I can trust that, I can be very laid back about not having my own goals. So, for example somebody was drinking in a destructive way; I can trust

that eventually they will decide they want to drink in a less destructive way. And then we'll have a plan for that. Now I'm aware that there are some obvious exceptions to that. For example, someone who's clinically depressed may not at that time be able to make that sort of decision, and there may be much more. That's more of an obvious area. There may be much more gray areas, and we'll probably not all come to a consensus as to where to draw the line between the people that can make good decisions for themselves and not. But that seems to be an issue when I'm teaching people. It seems that some of them actually don't have any faith that people will make good decisions for themselves, and therefore they get put in a position—put themselves in a position of having to make the goals for people. And others have an enormous amount of faith in people's general drive toward self actualization and that people will grow the right way.

Dee Dee Stout

Two things really came to mind, and one of them I want to thank Grant and Gian Paolo for because I'm talking on solution focused and MI later, and so the questions that I'm hearing are exactly that, which is why I've been doing that as long as—I've trained both of those at exactly the same time. So, I had to find a way to make it work in my own head. And I think it does, because that's the gentle way or the soft goals, maybe—Cathy—helping people to reach their own goals, whatever those are. Now, three things, because now—Giovanni—when you mention OARS—that you have to go someplace, it reminded me that one of the things that I wind up teaching so many of my students who are addiction counselors or trying to get there is that first they need to know how to tread water before they start going someplace because they're too anxious to go someplace. And so, we start with treading water in the pool first and getting an idea of how to use OARS and just sort of hang out for a while before moving somewhere. And lastly, Steve, your comment about getting excited around the idea of how this MI—this thing that we were talking about here relieves some of the pressure for clinicians around having to have the answers. It reminds me, because I came to—one of the ways that I came to teaching MI was through counselor wellness. And, so groups of people who were unwilling to talk about it in terms of clinical use of MI when I would say, "Well, how about if I could show you a way that might help you to alleviate the stress of your job for which you get paid squat—at least in the United States—as addiction counselors, so don't work so hard anyway, because you're not making money, would you be interested?" And they would all say, "Sure!" And so I'd say, "Well, let's talk about this, because it allows you to not have to have all the answers. You don't have to be the expert anymore. And we can collude with that."

Allan Zuckoff

Our time, unfortunately, is up, and I'm going to keep myself to the same discipline that I've tried to enforce on others, by not extending my own session, as much as it interests me and I'd like to continue the conversation.

The world of client-centered counseling, which we sort of partake of, but don't directly interact with in many ways, has been struggling a long time with this question of, to what extent is any form of directiveness allowable, appropriate, acceptable within a client-centered framework. Even within that world, there are camps of experiential, process experiential versus pure client-centered, and they have these kinds of either/or, dichotomous disagreements. I think that the content and the ideas expressed here this morning, really have a lot to offer to that world as well in terms of beginning to think more subtly about some of these issues. One of *my* goals and aspirations is to—in a way—to try to build that bridge.

So, I want to thank the panelists, Bill and Steve, and all of you for your thoughtfulness and your attention. We'll go ahead and take our break and follow up with break-out sessions. MB

Editor's Note: I am deeply grateful to David and Louise Prescott for their transcription of this symposium.

What is a Motivational Interviewing Group?

Chris Wagner & Karen Ingersoll

In this session, Chris Wagner and Karen Ingersoll facilitated a lively discussion about doing MI in Groups. The session was attended by more folks than the room could comfortably hold, and many participants had been doing MI in groups in a number of interesting settings, including mental health and substance abuse, criminal justice, domestic violence, and medical/health behaviors settings. Participants identified many benefits of doing MI Groups, including reduction of feelings of isolation, opportunity for observation of other members' successes, and the opportunity for planting seeds of change when members hear positive messages about change from other peers in the group. Some challenges were also identified, including the need for skills in group facilitation and MI, the need to attend to varying levels of readiness among group members, and the desire for co-facilitators which seems unfortunately rare among those currently doing MI Groups. Most participants in the session expressed the view that using the group format can be a powerful therapeutic tool, and that MI spirit and techniques can be adapted successfully in that format, with special attention paid to building on commonalities among group members. Thanks to all who participated in this session. MB

Have a Heart

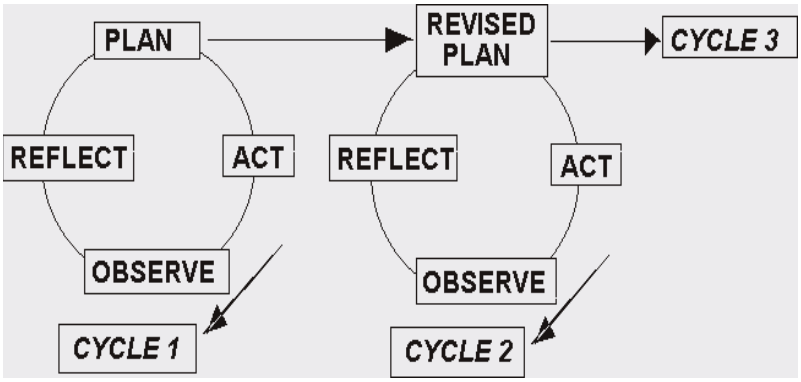
MI in Cardiac Rehabilitation: An Action Research Project

Claire Lane & Lyn Williams

This presentation aimed to give an overview of action research as a methodological approach, and to illustrate how this could be employed to study MI (and indeed wider issues) with an example of a piece of action research conducted in South Wales.

Action research (AR) is "Social research carried out by a team that encompasses a professional action researcher and the members of the organisation, community or network [stakeholders] who are seeking to improve the participants situation."[1] It aims to address dissatisfaction with the existing service and/or current practice by finding local-level answers to on the job problems. It is flexible in its approach—practice changes as the project develops through constant cycles of data collection, reflection, and evaluation (see figure 1). Changes are implemented during the course of the study, rather than at the end of it.

Figure 1 The Process of Action Research



AR encompasses a number of different methods, which can be both quantitative and qualitative. There is a mutual relationship between the 'researcher' and the 'participants', in that the lead action researcher takes on the role of facilitator, and the research participants assume the roles of co-researchers. The participants are seen as the experts in changing their situation, and ideas about what could be tried are elicited from them by the lead researcher.

It is striking to see the similarities between MI and AR in their spirit and approach. Both are collaborative, evocative and person/people centred. The participants are seen as the experts in how and why to change. Both employ facilitators to help guide the participants through growth and change, and are context specific.

Healthcare professionals often find it difficult to implement MI skills into their everyday practice following training in MI.[2] The project presented in this workshop aimed to assist a group of cardiac rehabilitation professionals to integrate MI into their clinical practice using an action research approach.

Cardiac rehabilitation in the UK incorporates four phases:[3]

- Phase 1 – Hospital in-patient following cardiac event
- Phase 2 – Post-hospital discharge follow-up
- Phase 3 – Outpatient sessions
- Phase 4 – Long term maintenance of lifestyle changes

There is no uniform way in which these four phases must be delivered across the UK, and cardiac rehabilitation service delivery varies from NHS trust to NHS trust. Most programmes however tend to be education and exercise focussed, and phase 3 is normally delivered to groups of patients.

At the start of the project, cardiac rehabilitation programme in the Bro Morgannwg NHS trust (South Wales) was already a little 'unusual' in comparison to other programmes operating in the UK. The head of service is a clinical psychologist, whereas most services are nurse led. Phase 2 is delivered by local health visitors conducting a home visit, whereas in most services phase 2 is delivered by a telephone call. The outpatient group sessions at phase 3 are conducted in closed, rather than open or 'rolling' groups, and are not purely education focussed. Finally, cardiac rehabilitation is delivered across two sites, by two teams. There were some political problems associated with this. When staff were employed at the newer of the two sites, they were told to devise a cardiac rehabilitation programme for that site. Following much hard work, they were later told to mirror what the 'other site' were doing. The trust considered the two teams to be one team based across two sites. However, following this experience, there was understandably some professional discomfort in the relationship between the two sites.

These health professionals had already established that cardiac rehabilitation patients often find it difficult to make and maintain lifestyle changes to prevent secondary cardiac events, and that these issues were often quite challenging to talk about with patients. This is where the project began.

The team were invited to attend four half day workshops in MI. From the second that the trainer and the lead action researcher arrived for the workshop, it was clear that the atmosphere did not taste that good. Firstly, there appeared to be an air of distrust,

Have a Heart ¦ continued

despite the fact that letters had been sent inviting the team to attend (some had chosen to opt out in fact), and informing them about the aim and content of the training. Secondly, there appeared to be team division—not just by the team from one site sitting on one half of the room and the other team sitting on the other side. The nurses sat with the nurses, the dietitians sat with the dietitians, and so on. They all objected to the fact that they were asked to conduct a consultation with a simulated patient to assess their skills before and after training and provide them with feedback—even though they had been given the option to opt out before the training—and all were highly suspicious of the lead action researcher (well, that was Claire, maybe they had a point....).

The first session was a little uncomfortable. The participants seemed a little interested, but not really engaged in the content. Claire vividly recalled having a 'crisis chat' with Steve Rollnick (the trainer) in the car between Cardiff and Bridgend, and thinking about how to take this material down a level further to help the participants relate to it better in session two. It was through training this group, and attempting to engage them with MI, that the three styles model of directing, guiding and following evolved, very much as a result of these practitioners' input.

Needless to say, it worked well. The teams seemed happier with what they were learning and why, and between sessions even started implementing changes to their practice.

Following the training, Claire attended a number of external meetings and conferences alongside the participants. She got to know the team quite well—not just socially over dinner, although that of course helped to develop their relationship somewhat. They were there to see her present the project's findings so far with regard to the before/after training evaluations (BECCI[4] scores, post training evaluation questionnaires, semi-structured interviews), and could see for themselves that her 'motives' were genuine. Most were surprised to see how their comments had been taken on board and incorporated in later trainings, and were also surprised to see how much their practice had improved. This is when their suspicion of Claire seemed to evaporate. They became more engaged with the project—in fact, they took ownership of it. They stepped willingly into their roles as co-researchers in the project.

Something else happened following the training. The team identified that there were a number of barriers that they felt prevented them from using their MI skills in practice. When Linda Speck (head of cardiac rehabilitation and PI on the project) explained that there was scope in the project to help them integrate MI into their practice, the team were very keen to take up this opportunity. They had an initial meeting with Steve and an organisational psychologist to discuss how they thought MI could enhance their service, and what things appear to be hurdles to implementation.

Following this initial meeting, the team had further meetings over an 18 month period. They asked Claire to facilitate, but in reality, Claire knew that the team were the experts in how and why to change, and gradually took a back seat as they did all the hard work.

Initial meetings were tough. Despite identifying that pre-phase 3 assessments were not that MI consistent, the team seemed hesitant to wanting to change them ("There's nothing wrong with assessments. We're doing MI when it fits—what's wrong with that?") The psychologists on the team did not agree, but did not want to be perceived as 'inflicting their grand visions on the team'. It became clear through the dialogue in the first meeting that the team were not resistant to change—they simply could not envisage how things could be different.

With a little encouragement from Claire, the psychologists prepared a presentation on how they thought assessments *could* look, and presented this to the rest of the team as a piece for discussion. This led to a process of interaction with the team contributing additional ideas, and discarding others. They would go away from each meeting to try out new ideas, then come back and discuss what appeared to work and not work, and then made further amendments to their plans. Ultimately, this led to the redesign of the assessment form as the team felt this was making the integration of MI into assessments difficult. They also designed a 'crib sheet' to help remind them to use their MI skills during assessments.

Following on from this, the team also decided that trying to implement MI with the phase 3 groups was not as easy as with individuals, and they wanted to try to find a way of doing this. In their monthly meetings, the team would come up with ideas of how they could adapt MI for use with groups, try out ideas, and them come back and discuss/amend them as they saw fit. They gradually developed an adaptation of MI for use in phase 3 sessions.[5]

The team then decided they wanted to focus on ongoing development, and asked for information on using the BECCI to reflect on their own practice, and 'mini workshops' on MI skills, which were facilitated by Claire, and other members of the team who had become minties.

In reflecting on the project, there were a number of things the team valued:

- The improvement in team relations—both between sites, and between professional disciplines. This was facilitated by learning a new skill and creating a new service together.
- Learning about MI in practice—by having a supportive team environment, and learning to accept that change to practice was not going to happen overnight.
- Changing the assessment for—which made it easier to incorporate MI into their practice.
- Incorporating MI into their

phase 3 groups, in a way that really worked for both them and the patients. They agreed running groups in this was harder, and quite terrifying at first, but they all found it so much more rewarding.

- Learning to be flexible in practice, and knowing when to switch styles.

Of course, there were a number of things they hated, too:

- The initial training —they felt it was thrust upon them, they hated the simulated patients, and would have liked more say in how they were trained.
- The fact that their skills were assessed—they felt this was not a fair way of reflecting all the hard work they had done.
- The initial lack of structure of the team meetings—although they were more able to say what they wanted from them nowadays.

There were a number of things that had occurred during the project that actually surprised the research team:

- Members who did not attend the initial training also developed new skills and made changes to their practice in line with their colleagues, as they were so impressed by the responses of the patients.
- The clinicians on the team still maintained their MI skill level 2 years post training.
- The team's enthusiasm to engage with MI, and to regularly reflect on their own practice.

The funding then ended, so Claire's involvement in the project stopped at this point. The team continued to evaluate their practice beyond the scope of the project funding.

However, it is important to note that things are not left static, and things have not been 'perfect' since the end of the project. There have been changes to the team—members have left and new members have joined. There has been extra pressure on the team, including two team members on long term sick leave and administrative matters. As a result, some services have had to be cancelled, and at times, MI skills have been a little 'lacking'. The regular team meetings where they focus on practice have also had to take a back seat for a few months.

Despite this added pressure, although MI skills are sometimes questionable, MI spirit is still very much alive. The team are still keen to reflect upon practice, and have recently decided to re-launch their meetings to reflect upon practice and clinical governance. They have taken on board the concepts of constant cycles of implementation of new ideas and evaluation, drawing closely on the skills they acquired as action researchers. MB

Acknowledgments

Big thanks to the other people involved in this project from Bro Morgannwg NHS Trust and Cardiff University: Linda Speck, Adrienne Cook, Nick Brace, Michele Gray and Stephen Rollnick. This project was made possible through funding from the British Heart Foundation.

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Exercise Demonstration

Reflect on Me

Cathy Cole

This exercise is used as a way to gather the group after a break in training such as lunch or an evening break and is designed to let participants practice forming reflections in a less pressured situation. Generally, I do it in a small group with everyone being able to hear the reflections. Basically, each participant is asked to speak 2-3 sentences on something that has happened in their lives in the last 24 hours (or any recent time period), not necessarily a matter of ambivalence. The listeners then deliver either simple or complex reflections and check for accuracy. The time allowed is generally no more than 15 minutes.

The debriefing in a small group generally takes place right then by my asking about the experience of the listener; I then do a reflection. At the end of all of the reflections, I summarize what I have heard about the experience which has always been a positive one thus far. I note that the experience of being heard and understood is what clients experience when we accurately attend.

This was my first time doing this in a very large group and I was pleased with how it went. I could only hear from a sample of participants but this did not seem to take away from the exercise. I needed to 'roam' more, and attend to whether side conversations were developing, but the richness of the reflections and the ability to summarize remained the same. MB

Five Phases in MI

Christina Nasholm & Tom Barth

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

Once again, our Scandinavian colleagues have given us some wonderful new ideas to ponder. As always, Christina and Tom presented some alternative ways to think about how we apply the skills and define the tasks of motivational interviewing.

The presentation was based on a new book that Christina and Tom have written wherein they outline five phases that they purport should be addressed in a motivational interviewing consultation, whether it is a single brief or long session or even if it is over a series of meetings.

In writing their book, Tom and Christina decided to include a case example based on a transcript of a lengthy MI consultation. The case study transcript depicts the "trees," or individual tasks and skills of doing MI, but Tom and Christina thought it was also important for readers to realize that these skills and tasks contributed to a larger whole, being the "forest" or raison d'etre (reason for being,) of the MI consultation.

The authors described their view that a typical MI encounter has a structure, a rhythm, or a number of issues that need to be addressed. As they pondered this structure (the forest,) they actually described five stages / phases / tasks that together make up the whole.

Five phases in MI

What is the structure of a MI consultation/treatment ?
Five stages/phases/tasks

1) Establish a working relationship
Creating the "psychological safety" the client needs in order to accept help.

2) Neutral exploration
Creating a common understanding of the starting point of a potential change effort, mainly based on the client's point of view.
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3) Expand understanding
Exploring alternative viewpoints
and widening the narrow or limited understanding of the situation or available options that keeps the client stuck.
Preparing the ground for those not (yet) ready to change.

4) Build motivation
Narrowing the perspective, focusing on decisions.
Selectively eliciting and strengthening motivation for change.
Turning attention towards the future and actual behaviour change.

5) Decision and commitment
Exploring the nature of the client's decision, and strengthening it by eliciting commitment.
Helping to make a change plan if necessary.
Arranging follow-up.

Phase 1 – Establish a Working Relationship

In the first phase, the clear goal is to establish a working relationship in order for the client to be willing to proceed. The establishment of this relationship may take a short amount of time, as in a brief session or may take a longer time in psychotherapy where establishment of the relationship is a very important first step.

A number of variables must be addressed in this phase. A spirit of empathy and a sense of credibility allow the therapist to establish herself as a helper in the client's eyes. The authors also referenced the work done by Allan Zuckoff which points to the need to establish psychological safety for the client in the first part of a session or perhaps an entire first session.

Phase 2 – Neutral Exploration

The second phase is focused on a neutral exploration of "What is this about for you?" or allowing the client to tell their story. The point of this phase is not to change anything but to explore via the use of open-ended questions and simple reflections. Complex reflections, which are potentially more confrontational in content, are not used during this phase as the therapist is aiming to avoid eliciting resistance. The main goal in phase 2 is to help the client to explore his situation and to allow the therapist to demonstrate listening. Of

course, as the client tells his story, he also hears himself expressing it and the stage is set for moving on to the next phase.

Phase 3 – Expand Understanding

This phase focuses on discovering alternative viewpoints or perspectives. Using the OARS, the client is assisted to explore ambivalence and develop the capacity to see things in more than one way.

The therapist is following but may also challenge the client's perspective by skillfully helping her to listen to herself. Techniques that develop discrepancy are used and, in so doing, resistance may be elicited and the therapist must deal with it skillfully. The therapist is also listening for desire, ability, reasons and need to move forward as expressed by the client. As the client hears herself expressing ambivalence or identifying desire, ability, reason or needs, the therapist wants to help her enter this state and stay there with a view to moving forward and not backward.

Some of the strategies noted by the authors as helpful in this phase are:

- Exploration of the other side (i.e. the less good things)
- Inviting the client to take a step back and view himself as an observer. Questions like, "What do you think of this guy and his situation?"
- Looking at the third track (no change.) For example, the client might be asked to imagine what will happen if she decides not to change anything at all
- Establishing menus of possibilities or choices
- Use of more complex reflections

Phase 3, in essence, prepares the ground for the next step.

Phase 4 – Build Motivation

In this phase the practitioner changes pace and helps the client to narrow perspective and begin focusing on decisions. At this stage the therapist may once again be reflecting more simply but also more strategically. The practitioner is skillfully reflecting change talk as well as selectively eliciting and strengthening motivation for change. "Future talk" is more common in this phase and Tom points out that he often finds it helpful to ask the client, "to think about this guy who is expressing these change thoughts."

Phase 5 – Decision and Commitment

The last phase focuses things and makes them simple for the client thereby helping him to hold on to a decision. It is helpful to explore and strengthen the client's decision and his commitment to it. Once the client has made a decision, he is often more ready to use the therapist as a helper. Creating menus, offering information, asking permission to give advice and helping to make a change plan are all helpful strategies in Phase 5.

Points for Use in Your Practice

1. In the beginning of the therapeutic relationship, it may be wise to avoid making the client tell you about specifics. If the client does not feel safe, she may be unwilling to give correct information, which makes it more difficult to move forward together.
2. The MITI profile will be different in each of the five phases. For example, the question-reflection ratio or the number of simple or complex reflections will differ. When discussing MITI scores, it may be helpful to explore where the therapist is at in terms of the phases.
3. In brief interventions, agenda-setting and asking for permission may be all that you have time for in establishing a working relationship. Expanding understanding may be limited to only one thing.
4. Sometimes a client is more ready to move forward and the therapist may not need to do Phase 2, for example.
5. In other cases, stopping halfway may be helpful, allowing the client to "finish" making the meaning on their own. Of course, the client would not be left in chaos but it may be helpful for her to explore further and make a decision on her own. This might be true in an instance where the therapist has no reason to support a specific decision (i.e., should I have a third child, or not?)

Points for Use in Training

1. The phases might provide a structure or visual map. The trainer could use exercises that are helpful to each phase as the workshop progresses.
2. The trainer might ask trainees who are using a particular skill, "What phase are you working in now?"
3. The trainer could allow learners to see that they may be more skilled at working in some phases and may need to work on developing skills to work in others.
4. In more advanced training, trainers could help learners to use specific tools or strategies in different phases.
5. When trainees are observing videos, the trainer could ask them to identify phases, transitions between phases as well as asking them to identify what tools the therapist is using in each phase.

Why I Appreciated This Presentation by Christina and Tom

As a practitioner who has been using MI for many years, this helped explain the "itch" that often occurs for me when I both see and feel the disconnects between my best intentions and the client's reactions. Although I feel like I have already learned the importance of working effectively with resistance and understanding the client's confidence,

Five Phases in MI ¦ continued

importance and readiness to change, I was able to identify that I might sometimes misread the client's phase and, out of zealousness to be helpful, select MI strategies that are not matched to the client's momentum as s/he explores ambivalence and begins contemplating making a change.

This new way of looking at the "forest" works so beautifully with Christina Nasholm's presentation from last year, where we explored the concept of multivalence. In both cases, I am reminded to slow down and work at expanding understanding before focusing on change talk and building motivation.

As a trainer, I have already tried the concept of using the five phases as a meta-structure, or map, for the training process and it worked superbly. Trainees got the "spirit" so much better when we focused on the first two phases and talked more about why we choose MI as our preferred approach. In fact, we spent a whole day talking about the spirit and following Tom's advice of having our first day focus only on establishing a working relationship and neutral exploration. I noticed that when we began working on OARS on day two, participants were using the techniques much more skillfully and practicing patience as they progressed. As a result the number of reflections increased substantially over what I had witnessed in other workshops that I delivered.

I am excited about working more with the phases map and am now encouraged to learn Norwegian so that I can read the new book! MB

Helping Workshop Participants "Get the Drift" to "Prevent the Drift"

A Model for Teaching MI

Barbara Kistenmacher

Motivational interviewing is often well received by addictions practitioners. When a skilled trainer conducts a workshop, participants often leave the experience feeling rejuvenated and excited about practicing their new skills. However, like any worthwhile model of change, MI is not as easy as it looks, and practitioners often return to old habits. I began this breakout session with a discussion of 3 main challenges faced when hired to teach a MI workshop, followed by a demonstration of the method I use to teach MI to a counseling audience. The discussion was focused on how to prevent "practice drift."

The challenges I have encountered over the past decade of teaching MI can be classified into three categories: 1) Who you teach; 2) What you teach; and 3) How you teach. These areas are, of course, intimately related. Regarding the first challenge, it is essential to tailor your workshop to your audience. Although one might think this goes without saying, I have encountered more resistance by workshop participants because I neglected to completely adjust my approach to their needs. Simply changing a few case examples does not necessarily suffice. What starts off as a simple endeavor (i.e., to deliver "pure MI") becomes a frustrating experience for all parties involved. I suppose this a similar to what happens in a therapy session when the therapist fails to match his/her approach to the patient's stage of readiness for change.

Some practitioners take to the MI model more readily than others. The discussion that came out of this workshop revealed a range of experiences re: who is most suited to learn MI. Most participants agreed that psychiatrists and analytically trained clinicians have the most trouble accepting or grasping MI. Psychiatrists are trained to diagnose, ask lots of questions, and to educate; therefore, the empathic skills are usually quite challenging for this group. Analysts, on the other hand, don't typically agree with the idea of guiding a patient toward a healthier behavioral choice and therefore are less motivated to use the directive aspects of MI. I have also found that participants who don't actively do counseling in their work with clients (e.g., caseworkers, child welfare workers, etc.) do not connect with the model as much as those who are in a counseling role. Prior to every workshop, I ask participants to complete a brief questionnaire with the following questions:

1. What is it that you "do" with your clients that works well?
2. In what context will you be using Motivational Interviewing? (client characteristics and specific function you will perform)
3. Tell me a little bit about your clinical training in general (e.g., psychologist, social worker, CASAC, bachelor's level, etc.) and your MI training specifically (e.g., 1 MI workshop, etc.).
4. What would you like to accomplish by the end of the workshop?

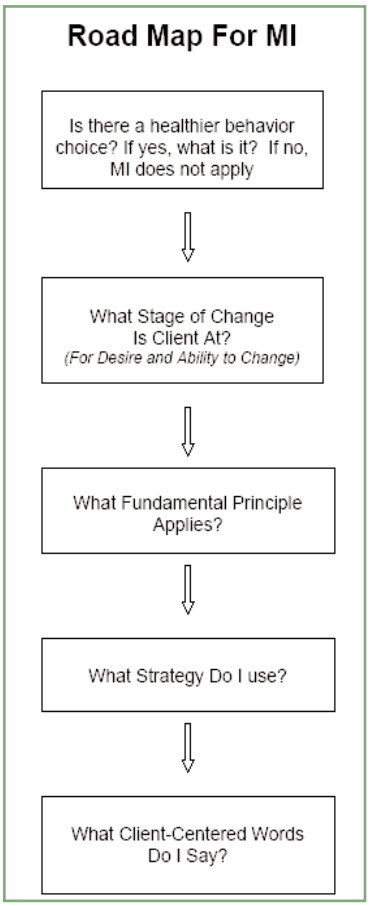
Participants' answers help me develop a workshop that will meet their needs. An added bonus is that the questions are written in an MI-consistent manner, so participants are exposed to MI even before the workshop begins.

Regarding what you teach, "pure MI" is not always a good fit, particularly for organizations whose clinicians are less likely to do counseling (e.g., child welfare agencies where case investigation and case management are the primary activities). Some organizations don't understand MI enough to know that "pure MI" is not what they need. I have found that there are many ways to handle this including: 1) suggesting that "pure MI" might not be the best fit for their organization; 2) adjusting the

A Model for Teaching MI ¦ continued

MI workshop to suit the type of practitioners I am training; and/or 3) allowing for ample time at the end of a workshop for practitioners to engage in exercises around how MI could best fit into their work. At this Forum, Stephen Rollnick discussed the difference between "pure MI" and "behavioral change counseling." I found this distinction to be helpful in the context of determining what an agency might need. Organizations with less counseling staff seem to benefit more from MI-informed behavior change counseling.

With regard to the third challenge, I discussed the difference between teaching MI with "spirit " (e.g., rolling with participants' resistance during the workshop, listening for change talk regarding participants' ability to learn MI, and supporting self-efficacy by reflecting it back, etc.) and teaching MI with a method. The current workshop was focused on the latter, although teaching with MI spirit is equally as important. I shared with the audience shifts I have made in my teaching method over the past 10 years. The best way to define this shift is to say that I give away the punch line before the joke. In other words, I provide a brief, yet thorough summary of the MI model coupled with a road map, a brief description of the fundamental principles, and a video demonstration using the pot-smoker on Tape B and Handout 1a.



Participants were surprised, even skeptical, about exposing participants to "too much" material early on. I have found that exposing participants early on to type of listening and thinking an MI therapist must engage in provides them with a better sense of what is involved in practicing MI. Then, when I cover the concepts more thoroughly later in the workshop, participants have a sense of how they all fit together.

The workshop ended with a discussion of participants' experiences teaching MI. Many agreed that a 3-day workshop is much more reasonable than 2 days. Others shared tips for convincing organizations to allow for a 3-day workshop (e.g., provide journal articles that support the need for more training). Beyond ensuring that you are an expert in MI, the key to helping others get the most out of their training experience lies in your ability to teach from a model that makes sense. I hope my model is helpful to you and, at the very least, adds to what great work you have already been doing. MB

MI Overview

MI is indicated when:

1. There is ambivalence (note: resistance can often represent one side of "the coin")
2. There is clearly a healthier behavior choice (there may be more than one behavior)

MI combines 2 approaches to client change:

1. Client centered (Carl Rogers)
2. Directive (through the use of open-ended questions that guide the client to explore the "DARNs" of change)

MI seeks to:

1. Decrease Resistance (by "rolling with it")
2. Increase "Change Talk"

Motivation consists of two basic components:

1. Desire to Change
2. Ability to Change

Readiness Coding Sheet

Not at all									Extremely
1	2	3	4	5	6	7	8	9	10
Precontemplation		Contemplation			Preparation			Action	
MI Phase 1					MI Phase 2				

Based on the client's first few responses, judge the initial level of readiness. Then, whenever you perceive a change in the level of client readiness for change during the session, indicate a new readiness rating and note what the counselor said or did just before the shift occurred. Remember that client readiness can shift in either direction. Next, chose from the 4 fundamental principles (e.g., express empathy, roll with resistance, develop discrepancy, and support self-efficacy) the counselor was most likely following. Finally, label the strategy (e.g., reflection, open question, etc.) the counselor used to support the fundamental principle.

1 or 2	Initial client readiness rating
New rating	What was the counselor doing/saying?
1.5 or 2.5	**"And so it doesn't affect your work, as far as you're concerned. This is something that's apart from that. It happens in your private life and really, the company has no reason to be concerned about this."**
	Rolling with Resistance (fundamental principle) — Simple or Amplified Reflection (strategy)
2 or 3	**"So, really, it's not something you've worried about or wondered about at all. It sounds like there are some other people who have worried a little bit." ....."You smoked together"**
	Developing Discrepancy (fundamental principle) — Double-Sided Reflection (strategy)
4	**"So, let's suppose that you were planning to have children in the near future. I know that's not what you want, but suppose you were. How might that change your own sense of your drug use?"**
	Developing Discrepancy (fundamental principle) — Looking Forward/Goals and Values (strategy)

Handout 1a - Answer

MI and the Transtheoretical Model

Mary Marden Velasquez

I have worked with the Transtheoretical Model (TTM) for many years and I find many of the constructs very useful. So, I have a real interest in the TTM and it is near and dear to my heart. Yet it is important to look critically at the various components of the model and see what parts of it are most useful and what parts of it need to be further developed. I'm grateful for this chance to think through some of the issues surrounding the use of the TTM, particularly the stages of change and how (and if) they fit into training in MI.

Many folks have asked how MI and the TTM are related. Bill says they "grew up" together as cousins, which is a great way to put it. They were both developed at around the same time, but the TTM was developed as a framework for understanding change and not as a specific intervention. MI was developed as a way of facilitating behavior change. So, the TTM, particularly, the stages, provided a way for researchers and clinicians to think about how people change and it first described the process as a gradual one that happened often in baby steps, and it suggested that it was OK (and even gratifying) to work with clients who were not yet ready to change. The stages of change provided a language that captured this.

So, the TTM's stages of change seemed to suggest that you could develop interventions that were more targeted to where an individual was in the change process than just providing programs that were action-oriented. That's where I became very excited about Motivational Interviewing. It is apparent that MI is a great way and maybe one of the only effective ways to work with precontemplators. It also became apparent that MI could perhaps be used effectively (but differently) with people who were in the later stages of preparation and action—and that the MI spirit was critically important throughout.

In the early days of MI trainings, it sometimes seemed that people saw the stages of change as being synonymous with MI. If you asked audiences what they knew about motivational interviewing, they would start describing the stages of change—and that often still happens. I think it was brilliant of Bill and Steve to teach us how to use MI to move people forward and that slipping back wasn't a negative thing but could be seen as a learning process, and to provide the field with some practical tools for helping people in the early stages of change as well as those who seemed more ready for action.

More recently, though, there has been a shift away from using the stages of change in MI trainings, in part as a response to a number of critiques about the stages—many of them warranted (and many of them not—but that's another presentation. I think a lot of it has to do with the ways in which people are using "stage based" interventions")

At any rate, I think that we as trainers need take a look at the parts of the TTM that might be useful and discuss what, if anything, we would like to retain in our trainings. I do use the stages in trainings and plan to continue to do so. I make it clear that it is not MI, but I use them to help people understand about change, as others have also described. I think that there are some issues involved in accurately measuring the SOC and that a lot depends on the population and the setting. Yet, it is a valuable heuristic and offers a tremendous amount in terms of helping clinicians think about change.

So, given that there are a number of important questions, how am I currently using the stages of change? In our work with groups I use our manual, *Group Treatment for Substance Abuse: A Stages of Change Therapy Manual,* which is actually more focused on the processes of change as identified by the TTM. It is designed to be somewhat stage-based in that we start out with sessions that are designed for early stage clients. We call these “Precontemplation-Contemplation-Preparation” sessions but they are not distinguished by stages within this categorization. Each session focuses on one of the TTM's experiential processes of change and we use MI throughout. These early stage sessions include what you might expect: a focus on values, relationship concerns, decisional balance. The later sessions are more geared toward Action and Maintenance, and those sessions are more focused on skill building and relapse prevention strategies—things that, according to the TTM, are more behavioral process-oriented. Again, we use MI throughout as a way of delivering the sessions. Our MI groups are clearly delivered using MI and that seems to be MI done well, given that our therapists are MINTIES and that a number of the group tapes have been MITI-coded.

One thing we do in our first session for each component is to teach clients about the stages of change. And I think this is where the TTM is very useful clinically. The stages are descriptive and they facilitate clinicians and clients talking about the process of change and how to address it at different points. People often see the stages as a useful way to describe what they are going through. It's a valuable way to help clinicians understand change and discuss it with their clients.

We have some evidence in a recent study that MI might be most useful to folks in the early groups but when clients are ready for action the use of MI might even hold them back. That is, when it's time to do more CBT-oriented stuff, it's time to do it and not continue to try to build motivation. But, that's another topic—one about which we're working on a manuscript now. MB

Using the Eight Stages as a Roadmap in MI Training

Bill Miller

In a recent article (Miller & Moyers, 2006) we described a developmental process by which people may learn MI. In particular, we outlined eight steps of skill development by which proficiency in MI can develop. We hope that these descriptive "stages" can be helpful in conceptualizing and designing MI training from beginning to advanced levels, and how to do that is the focus of this article. Before setting out on this journey, however, some caveats are in order.

First and foremost, don't take these steps too seriously. After all, we just made them up, based on our experience in helping people to learn MI. They are certainly not meant to be prescriptive—that everyone must go through these steps, and in this sequence, in order to learn MI properly. They aren't true "stages," although for better or worse that is the term we chose to use. They don't have a definitive ending, and they overlap. They don't have to occur in this order, and for some, learning will focus on just a few, not all of these components. There are surely some important elements in learning MI that we didn't think of in writing this description. We aspired only to take a step forward in thinking about how to help people learn MI.

Within these limits, we have found this conceptual model to be helpful in thinking about how to structure MI training, what to emphasize and why. Let me begin with a brief summary of the article. We started by coming up with places where clinicians seem to get stuck in learning this complex method, a series of plateaus that can occur along the way. Eight of these are:

1. **Letting go of the expert role.** This has to do with the basic spirit of MI. If one is not willing to entertain at least the possibility that clients hold important pieces of the puzzle, that there is gold to be found within each client, then there is little point in listening to the client's perspectives. It would seem a waste of time. A beginning in learning MI is at least a "willing suspension of disbelief," a willingness to suspend the expert-didactic-prescriptive role and try something else.
2. **Using complex reflections.** A second place where people can get stuck is in developing skillful reflective listening. If one relies too much on simple reflections, stays too close to what the person has already said, movement may not occur. "I tried reflection, and it didn't go anywhere," usually means that the reflections were too simple. Complex reflection involves taking a risk, making a guess, continuing the paragraph, reflecting what has not (quite) been said yet. This is itself a skill that one can keep refining throughout a lifetime. It is a skill that is fundamental to MI, a *sine qua non*, I believe, without which one is stifled in developing MI skillfulness.
3. **Missed opportunities.** In listening to tapes, we often notice missed opportunities—doors that the client opens a crack, but the clinician bypasses and fails to open wider. This has to do with knowing what to listen for. The "missed opportunity" that we are usually hearing is change talk, or the potential thereof. If you don't recognize change talk when you hear it, you don't know where to dig.
4. **Insufficient direction.** We have heard plenty of sessions that were very good examples of client-centered counseling, but not MI. The reflections are there, but the session does seem to be truly nondirective, not moving in specific direction. Here it is the goal-oriented aspect of MI that is missing. The clinician should be leading in the dance, systematically discovering and exploring the client's own motivations for change.
5. **Opposing resistance.** In the Albuquerque airport, one passes through a revolving door when entering or leaving the secure hallway to the gates. The door turns on its own, and in big letters there is the warning, "Do not push - Door will lock." It's a nice metaphor. Sometimes clinicians get the basic idea of evoking and exploring change talk, but then revert to old habits when resistance or sustain talk arise. They take the bait to defend the pro-change side of the argument. This involves learning how to use an MI style to respond to sustain talk and resistance, rather than pushing against it.
6. **Failing to move on to Phase 2.** The time comes when there is enough apparent motivation to warrant testing the water and moving on to a discussion about the when and how of change, a change plan. Sometimes clinicians don't seem to pick up the signs of readiness, and keep on using Phase 1 strategies focused on the why of change. Of course it's possible to make the opposite mistake as well—to move too soon and press too hard toward a change plan.
7. **Not consolidating commitment.** Paul Amrhein's research, along with studies in cognitive psychology on implementation intentions, emphasizes the importance of commitment language as a special form of change talk. When developing a change plan, there is also a closure step of getting to "yes," of committing to at least a first step. I think it's not the language itself, but helping the person get to a clear intention. Something is still missing if the person resists

committing to a step in the right direction. Again, it is also a mistake to get ahead of the client and push for commitment too soon.

8. **Not letting go of MI**. Finally, in the COMBINE study, we had therapists in the Combined Behavioral Intervention (Miller, 2004) who were excellent at MI, but couldn't seem to let go of it and move on to the more action-oriented cognitive-behavioral components. MI is just one tool that can be intermixed with other treatment methods.

These were the plateaus that led us to describe eight corresponding "stages" of learning MI:

1. Getting the spirit of MI
2. Developing client-centered skills (OARS)
3. Recognizing change talk
4. Evoking and reinforcing change talk
5. Rolling with resistance
6. Developing a change plan
7. Consolidating commitment
8. Integrating MI with other interventions

Using the Model in Designing Workshops

We find this to be a useful heuristic in deciding what to include in workshops of various lengths, and at different levels. Steve and I began emphasizing the spirit of MI over a decade ago, and that is something I now include in most any introductory talk or workshop. For beginners, it makes sense to focus on the early steps. We used to put rolling-with-resistance right up front, and there may still be populations where that is appropriate, but I have found that when the first four steps are in place, resistance is no longer much of a problem. The fifth stage is a matter of learning to keep the same style in responding to sustain talk and resistance. I also used to assume that professional audiences already knew client-centered counseling skills, and would skip over these lightly, usually to find that I was wrong. A 2-day introductory training might provide an overview of the whole picture, but I tend to focus time on the early steps.

This also has implications for more advanced training workshops. In these, one might assume (even screen for) familiarity and proficiency with early steps, and spend more time on the places where people tend to plateau after they have got the basics and have been practicing MI for a while. After checking on complex reflection skills, this usually involves a focus on change talk: recognizing, evoking, and responding to it, forming it into MI-consistent summaries and such. I also give emphasis to Phase 2, evoking a change plan and moving along to consolidating commitment.

Individualized Training

When working with one or more individuals over time, the model can help one think about what the person needs to do next. What steps seem to be fairly solid, and which ones need work? Rather than trying to teach all of the skills at once, it makes sense to focus on those that logically come next as building blocks on MI skillfulness. Thus the model can guide assessment of current MI skills. If you pre-screen candidates for a more advanced training, the model can help you think about what skill prerequisites you want to have as a beginning foundation.

The MISC, MITI and other coding systems provide indices related to some of the specific stages. For the first step, the global MI Spirit measure is an obvious choice. At step two, the ratio of complex to simple reflections and of reflections to questions would be informative. At step three, one ought to be able to identify change talk, to pick it out of multiple choices, or identify the change talk components within ambivalent speech. Step four gets more challenging. There are so many different ways to evoke change talk that we have never been able to reliably code how well a clinician is doing this specifically. It turns up in the MI Spirit global rating, but we can't seem to get it down to a countable category. Reinforcing change talk would be reflected in a sequential code like Terri Moyers' SCOPE system, where it's a conditional probability question. When the client gives a change talk statement, what is the clinician's NEXT response? In general, it ought to be one of the EARS: asking for Elaboration or Example, Affirming, Reflecting, or Summarizing.

Sequencing Training Over Time

In the desirable situation where training is not a one-shot affair, but occurs over a span of time, the model can also help in thinking about how to sequence components of training. You can start with the early steps and work on those until your trainee(s) come up to competence criteria, then move on to a next step. I encourage training to criterion, rather than devoting a fixed amount of time to each step. Better, I think, to help people really get down three steps than to do a little of everything.

This suggests the possibility of stage-specific training strategies. When one wants to teach the spirit of MI, for example, what are some good training methods? When we started doing training of trainers, Steve and I prescribed a particular sequence of training methods. In the mid-90s we shifted over to offering a menu of training methods that can be mixed and matched to training goals. Each MINTie has favorite exercises to use for particular training tasks, and that's part of the fun of it. There are many ways to achieve an MI training goal. The eight stages we described are, in essence, a set of specific training goals to which trainers can apply their own creativity in designing approaches. MB

References

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Exercise Demonstration

Affirmation Card Sort

An Exercise in Self-Discovery

Sandy Downey

In this session, participants experienced first-hand a training exercise designed to engage trainees in a process of self-discovery and affirmation. Utilizing a card sort developed from the listing of Shelby Steen's *"Characteristics of Successful Changers"* located in MI2, page 115, participants formed dyads and took turns facilitating in an MI manner the exploration of their partner's inner strengths and personal qualities that may be used in reaching towards identified goals. Participants were also provided with instructions for several clinical applications of this exercise for use with individuals and therapeutic groups.

Rationale for Clinical Use

In my experience, one of the most powerful aspects of motivational interviewing is the focus on eliciting and affirming our clients' personal characteristics that make up who they are as individuals. Many people who struggle with substance use and mental health concerns also report painful feelings of shame and guilt and often describe a lifetime of repeated demoralizing experiences that sometimes include interactions with treatment professionals. On top of all this, many clients have frequently endured battling a negative social stigma that is associated with addiction and mental illness. By providing an experience that instead reflects the true essence of each person and illuminates the positive qualities they inherently possess, clients often begin to experience a sense of hope. I have found that eliciting and exploring our clients' positive attributes with regard to their own goals, in turn, helps them to recognize and value their strengths, increase self-worth, and begin to realize all they can become. This affirmation process allows our clients to further develop self-efficacy as they consider meeting new life challenges and stimulates increased motivation for behavioral change.

Rationale for Training Use

When training practitioners, I find that seizing every opportunity to have them directly experience various aspects of MI is an effective way of engaging trainees and helping them to better understand the spirit behind MI. This training exercise engages participants in an MI consistent process of exploring their own strengths and valued behaviors. As a result, trainees can better appreciate how keeping a strength-based focus with their own clients is an effective method of facilitating positive behavioral change.

Pre-selected Card Sort Used in Exercise

Accepting	Optimistic
Ambitious	Loving
Determined	Intelligent
Forgiving	Sensible
Imaginative	Thorough
Adaptable	Visionary
Adventuresome	Organized
Clever	Persevering
Courageous	Spiritual
Creative	Unique
	Wise

The Affirmation Card Sort Exercise

Participants in this session were taken through the exercise as if currently in a training. The purpose of the exercise was explained: To gain an understanding of what it may be like for our clients to explore their strengths and to further practice our use of OARS. The instructions for using the card sort (see below) were given to each person. Participants were also given a set of 21 cards, each listing a personal quality that was pre-selected from the complete set of 100 characteristics in order to work with a more manageable number. (Additionally, this particular selection of 21 cards reflected my perception of some of the strengths I believe are true of MINTies in general!) Participants were then invited to break into dyads and take turns in the "practitioner" and "client" roles. They used *real play*, and engaged in an MI facilitated discussion by selecting one *clinical* application from the instructions provided. Participants were given eight minutes per interview with a two minute notice to summarize for one's partner, before switching roles.

Debriefing

At this point we ran out of allotted time for this training exercise. In an actual training, it would be important to engage participants in a discussion of their experiences in the "client" and "practitioner" roles. I have observed this exercise as having the potential to evoke a strong emotional reaction for some trainees and sensitivity to this possibility is needed.

A copy of the of the 100 *Characteristics of Successful Changers* that may be used to pro-

Affirmation Card Sort¦ continued

duce the 100 card sort is located in the MINT members' section of the MI website. An older version of the instructions for this card sort is also located in the members' section, although the most recent update is presented here. I recommend using a subset of the 100 cards (20 works nicely) that may be adapted to suit the individual, therapeutic group, or training setting that you are working with.

Following the session, several participants shared variations for additional uses of the card sort, to further help trainees notice positive qualities and convey affirmations in their work with clients. So be creative and have fun using the affirmation cards! MB

Instructions for Affirmation Card Sort Using *Some Characteristics of Successful Changers*

Clinical Use Variations

1. Practitioner invites client to read through card sort and select several qualities that describe him or her. Using MI communication skills, facilitate a discussion with client regarding why he or she selected particular qualities, how they are important to him or her, and *how they may be used in reaching towards goals or in his or her change efforts.*
2. Practitioner invites client to address the following question: Name or select from the card sort one strength you have and tell about how you use it in your life.
3. Practitioner invites client ot choose five qualities that best describe him or her right now, and explain in what way they characterize him or her. Then invite the client to choose five qualities that client would like to work on or further develop in him or herself. Using MI communication skills, facilitate discussion regarding how developing such qualities might help client in reaching towards personal goals or in efforts to change.
4. Practitioner invites client to choose one quality and tell about a time *in the past* when he or she best upheld that particular characteristic. Using MI communication skills, facilitate a discussion regarding this time in the client's life, and the positive difference having this quality made at that time.

Group Therapy Variations

1. Each group member selects a card randomly. All group members describe how that quality characterizes them and how they use it in their life.
2. Group members select a number of qualities that describe them and take turns in a facilitated discussion exploring themes as stated above.
3. Evenly distribute the cards randomly to every group member. Then, invite members to categorize the cards in the following ways and discuss:
    a) Select qualities that are true for you now—that best describe you.
    b) Select one quality and tell about a time *in the past* when you best upheld that particular characteristic.
    c) Select qualities that you would like to work on or further develop in yourself.

Training Use

Trainees are instructed as to how to use card sort in an MI adherent manner. In dyads using *real play,* pairs take turns in "practitioner" and "client" roles and engage in discussion as described above by selecting one clinical use variation.

MI and the Use of Telephone Supervision

Sylvie Naar-King & Dee-Dee Stout

We presented on two different uses of MI and supervision. Sylvie discussed and presented evidence from her research with telephonic supervision of MI-trained therapists working with youth in the Detroit area. Dee-Dee discussed the use of telephonic MI supervision in a private consultation practice and with individual supervision to workers in an agency setting (also youth-oriented).

Sylvie presented on qualitative interviews from 10 therapists across 5 cities. They received a 2 day face to face training followed by a face to face booster 3 months later. They received individual phone supervision approximately twice per month based on case load. DVDs of sessions were reviewed by supervisors before supervision. MITI coding was sent to therapists and supervisors once per month. There was also a listserv for therapists and supervisors. Therapist comments suggested that supervisors' use of MI was most helpful and enabled them to feel supported and not criticized. Review of DVDs was extremely helpful, but they would have liked to review DVDs with supervisors over the phone. The availability of supervisors via email or phone was important. They requested an additional booster at 6 months, occasional group supervision by phone, and information about study outcomes. Supervisor comments suggested that what helped in learning MI was having basic counseling skills but not a psychodynamic background, having a commitment to ongoing learning, and having system support so that MI was not an additional burden. Supervisors also would have liked an additional booster and occasional group call. They felt that the support of other supervisor and project directors was important. They noted that the listserv was underutilized by participants but helpful for distributing affirmations.

Sylvie then presented on a phone supervision program within a community mental health program. Therapists and case managers received a 2 day training followed by 6, 1.5 hour group phone supervision sessions with 6 therapists/case managers per group. Providers were expected to bring audiotaped sessions to supervision and play tape over phone. Providers received 3 MITI codings—one early in supervision, one later in supervision, and one post-supervision. Providers reviewed coding independently and had opportunity to discuss with supervisor via email or phone. Supervisors reviewed MITI sessions globally in supervision. A general outline for the 6 sessions was:

- Session 1
  - Affirmations for participation
  - Elicit-provide-elicit supervision purpose
  - Explore ambivalence around audiotaping
  - Readiness ruler, Pros and Cons
  - Discuss experiences since training; round table so that all participate
  - Review of audiotape; supervisor uses MI skills (e.g., EPE, OARS)
  - If time or if no tapes first session: role play activity, incorporating MI into current format (e.g., Typical Day, MI not a format but an approach)
- Sessions 2-5
  - Round table discussion
  - Review of audiotapes
  - Skill activity
  - Based on participant elicitation
  - Based on MITI coding
  - Examples - Global Markers, Drumming Exercise
- Session 6
  - Individual Change Plans

What would we do differently next time? We would consider at least one face to face meeting with the supervisor if they did not provide the training or videoconferencing. We would consider an individual session to discuss MITI coding or issues not brought up in group. A face to face booster would also be helpful to ensure continuation of skill acquisition.

Dee-Dee's work has been primarily with individual supervision after a 1-3 day basic training in MI. She has also supervised a local MD with MI training and expertise in smoking cessation for nearly 1.5 years. All of these supervisory sessions have been conducted over the phone save the initial contact, which was done in person.

We discussed some of the challenges and surprises in telephonic work. Among them was how to deal with typical room distractions —movement outside, door bells, and other interruptions; staying focused without visuals; music vs no music in the background, and more. Participants at the Forum session had great ideas and questions regarding this subject!

Dee-Dee stated she had found the telephonic work freeing in some ways: she is able to fully concentrate on the telephone conversation without the distraction of viewing the person, though it can be useful to imagine the person sitting in front of you. Clarity in voice and speech is another important aspect of telephonic work discussed. As tone and timber can make listening challenging at times, it is also important to literally speak into the telephone, and to say when you don't hear something the speaker stated. This can also be useful to build rapport through the skillful use of reflections to clarify constantly throughout the conversation.

Another important part of telephonic work is clarity on goals and structure of the sessions. Having preset goals—the supervisee's of course—can lend some structure to the conversation, helping minimize the distractions discussed earlier. Informing the supervisee of the use of role plays and other learning tools can help to avoid unpleasant surprises and keep both the supervisor and supervisee on task. Using Bill Miller & Terri Moyers' Goals of Supervision form from MIST (Motivational Interviewing Supervisory Training), Dee-Dee walked through a typical initial session's discussion with a supervisee using this form. Later,

MI & Telephone Supervision¦ continued

in a mock session, she demonstrated its use.

Lastly, the teaching aspects of telephonic supervision were discussed. Again drawing on the MIST, Sylvie and Dee-Dee conducted a mock telephonic session in which they sat back-to-back to capture the essence of what it is like to not physically see each other via telephonic work. This scenario proved to be enlightening to both those conducting it and to the audience. Sylvie commented on the surprise she had at finding herself becoming distracted by not being able to see Dee-Dee, yet later seeing how this changed for her when Dee-Dee, acting as the supervisor, asked her to role play a client during a supervisory role-play. Sylvie noted that distractibility increased when Dee-Dee had long verbalizations. Dee-Dee mentioned that she found she had better focus by using the form's structure than at times in the past when she has not used it, or not had it. A question was raised whether there is a need for the videoconferencing or face to face meeting at all; e.g., someone who is visually impaired would never have "face to face" supervision. Rituals that bring together the team—for example, themed parties over the phone—were also suggested.

In conclusion, we feel that telephonic MI and telephonic MI supervision are important parts of the equation to having regular, accessible supervision and learning of MI for our trainees and others, which we now know is crucial to learning MI well. More research and information is needed to show how to best use this supervisory and learning tool to its best advantage—and to prepare us better for the unique challenges in MI telephonic supervision and learning. MB

The Swedish Coding Journey
An Update

Kerstin Forsberg & Denise Ernst

The Swedish coding journey started June, 2004, when I (Kerstin) went to Santa Fé, New Mexico to attend a three day workshop about the Motivational Interviewing Treatment Integrity instrument (MITI) conducted by Theresa Moyers and Denise Ernst. I thought that I would deepen my understanding of motivational intervewing by learning how to code behavior and globals according to the MITI.

When back in Stockholm I was asked to train some coders, who were involved in three different studies where counsellors were using MI. The training consisted of 5 days, 6 hours each day spread out over a 2 month period starting February, 2005. We had 8 coders: 6 University students ages 21–23 studying law, political Science, gender science and philosophy, and 2 experienced socal workers ages 60 and 62.

To test agreement between coders all coders coded tapes independently. The first test during the training period revealed that the coders were acting as two different groups. In the second test two tapes coded by all coders were used and the average ICC were 0,76 and 0,62 respectively. In the last test three tapes were independently coded by all coders and the calculated average ICC were 0.78, 0.83, 0.94. Thereafter the coders training continued with 3 hours once a month with ongoing coding of real tapes in between.

Six months later, following regular laboratory coding with continous training, reliability was assessed again, coding 15 sessions. This time 5 available coders coded all 15 sessions. Five sessions were randomly selected from a prison study, 5 from a tobacco quit line study and an additional 5 from a study on gambling. The internal consistency between the 12 variables in MITI was calculated. The average internal consistency was high, but could have been slightly higher if the coders had agreed more on Empathy, MI-spirit and behaviors coded as MI-Adherent.

Conclusions:

- The MITI in Swedish proved to have good inter-coder reliability.
- The reliability proved good in quite different settings—drug using prisoners and telephone coaching of smokers as well as among problem gamblers—suggesting good generalizibility.
- Significant variations between tapes and coders indicate that some tapes are difficult to code and that reliability may be further improved by enhancing coder skills in identifying MI-Adherent behavior as well as "MI-spirit" and Empathy.
- The validity of the Swedish MITI needs to be further investigated.

During the presentation several related issues about coding were raised and discussed. The group consisted of MINTies with an interest in using MITI coding to facilitate skill development or assess treatment fidelity. Several present had been actively coding themselves or were using coding done by others to provide feedback and coaching to clinicians. A lively discussion ensued about the value of coding, the limitations (including demoralization and discouragement) of "using the numbers," strategies for delivering more easily acceptable feedback, and enhancing motivation to continue learning and improving MI skills. These are common problems experienced by coaches and coders in using the coding results and the group supported the idea of continued training for MINTies in these activities.

Finally, there was a brief presentation of MITI 3.0 including the changes and reliability results. The primary change from MITI 2.0 is the breakdown of the MI-spirit global measure into three separate globals to measure evocation, collaboration, and autonomy support. A global measure of direction was also added. In addition, the global scales were reduced to a 1-5 scale with verbal anchors given for each level. The MITI 3.0 can be downloaded from the CASAA website at htpp//casaa.unm.edu. MB

Thoroughbred or Mongrel?

Practitioner Modifications of MI

Guy Undrill and Claire Lane

This workshop looked at how people change their practice from classic or textbook MI and what the consequences of the modifications are. Guy started with asking whether practitioner modifications mattered, and argued that they did for broadly three reasons.

Firstly, MI has a good evidence base, sometimes stronger than other approaches. In designing MI, what has been left out is as important as what is put in: mixing in other approaches can sometimes serve to 'dilute' MI. This is important as the intervention being offered has less evidence for it than 'pure' MI.

Secondly, MI has a very explicit set of values, partially codified and taught as the 'MI spirit'. Bringing in other values can serve to undermine the value base of MI much as bringing in other techniques can undermine the evidence base. MI also differs from other approaches in that it is a theory of solutions rather than a theory of problems: this is very different to other approaches like CBT or the medical model which (at least in theory) depend on an accurate formulation at an early point in treatment.

Thirdly, the way values are treated within MI as both ends and means functions to create a virtuous circle. Practicing reflective listening techniques brings you closer to MI values; holding MI values in mind enables the core techniques to come easier. This is one of the things that makes practicing MI self reinforcing—but it is possibly a fragile process if there is too much movement away from the core techniques or values.

Guy went on to suggest that there were two broad groups of modifications to MI.

The first related to the difficulty practitioners have in changing what they do, particularly where this has previously brought them success. Many of us come to MI having done other things—CBT, SFT, dynamic therapy, medicine, nursing to name just a few. If you perceive the interventions you have made within those models as successful, then changing what you do is going to be hard. There is an extent to which success is corrupting in the way it makes change harder than behaviours which on one level or another are unsuccessful.

The second group is the deliberate, conscious and mindful modification of MI for use in a particular setting or situation—often a creative response to a challenging problem(for constant examples of this on a daily basis, see the listserv).

After this brief introduction, participants were invited to share their own modifications of MI. Participants were variously blending in techniques from solution focussed brief therapy, psychodynamic approaches, neurolinguistic programming, 12 Step and dialectical behaviour therapy. Other participants commented on how they simplified reflections with psychotic patients.

There was then a wide ranging discussion. Key themes emerging from this were:

1. There is a difference between blending MI with other methods and moving in and out of MI to other methods. MI is not a panacea and skilled practitioners will use other approaches. Perhaps a model of stepping in/out of MI is more helpful than a model of blending MI with another approach (is stepping in and out in itself a modification of MI?). In this scenario, knowing what you are doing (when and how you are transitioning in and out of MI, and what to) is crucial, and qualitative work around this complex process could give us valuable insights as to how MI is implemented in these situations. Some people also felt that MI was transformative on other practices (e.g., CBT therapists 'could not go back' to pure MI, feeling that although a mixed CBT/MI approach took longer it achieved better outcomes).
2. Participants differed on the importance of the role of the MI spirit. Most thought it was crucial: that adaptations should be made within a framework of the MI spirit, and that a degree of flexibility in working with clients / patients embodied that spirit. A minority questioned the value of MI spirit as merely treating someone with respect and politeness.
3. There are some important ramifications of the thoroughbred / mongrel question for research. Research relies to some extent on standardised interventions coupled with standardised outcome measures. Modifications of MI make it harder to do research—they add to the issues of intervention standardisation and treatment fidelity, as well as uncertainty of the degree to which outcomes are related to the MI components of the intervention. However, this is connected to a wider question about using standardised, researcher-led outcome measures: RCTs use an outcome measure that is by definition researcher defined, not user defined, which in itself conflicts with MI spirit. How could we do research that looks at patient/client generated outcomes? MB

MI and Acquired Brain Injury

Challenges and Possible Solutions for Working with Clients with ABI

Tim Godden

This breakout session provided an overview of the clinical considerations in counselling people with an Acquired Brain Injury (ABI) as well as an opportunity for participants to explore some themes related to using MI with this population.

The first activity involved establishing the participant group's areas of interest, which included:

- How MI could be most effectively used among war veterans with Traumatic Brain Injury (TBI).
- How the assessment process could be adapted taking TBI into account
- How to address the loss of confidence clients experience after brain injury
- Exploring how the therapeutic alliance can move from being a "holding relationship" to a relationship based on change
- Application of Harm Reduction principles
- Overview of the clinical considerations of brain injury, including a definition of Acquired Brain Injury (ABI).

Early in the session, the presenter defined ABI as an injury to the brain that occurs after birth, is caused by trauma or illness and results in altered brain function. It was further explained that ABI covers TBI—caused by falls, motor vehicle accidents and assaults—as well as non-traumatic brain injury, caused by health conditions such as stroke, encephalitis, tumours or aneurysms.

Subsequently, there was discussion about the importance of being able to recognize people with brain injury presenting to a clinical setting, incorporating effective screening and assessment procedures. The presenter shared his agency's experience around building in a few simple screening questions to the intake process. As a result, about 24 per cent of clients presenting to a substance use setting over a three-month period were identified as having an ABI history, with almost 30 per cent of this sub-group reporting cognitive impairments.

The presenter went on to explain that clients who have both a brain injury and substance dependence are subject to a "double-whammy," since a history of heavy substance use increases the risk of having one or more brain injuries and even a small amount of a substance, such as alcohol, can compromise a client's recovery from a brain injury. This observation means that counselors practising fro a Harm Reduction platform face a significant dilemma, weighing respect for a client's short-term decisions about unhealthy behaviours—such as heavy drinking— against the cousellor's professional responsibility in achieving the best possible outcome for the client.

Although the presenter's review of the literature had yielded very little about the utility of MI in the ABI population, he explained that his agency's experience in working in partnership with a brain injury service provider had generated much reason for optimism. In one-on-one work with clients, as well as in a preparatory support group for clients with ABI and substance use, the presenter and his colleagues had found MI principles very helpful in enhancing client engagement in counselling and circumventing counter-change behaviours.

The presenter and his colleague, Carolyn Lemsky of the Community Head Injury Resource Service of Toronto, had found that their clinical work had supported the idea that adaptations of MI described within the Concurrent Disorders population—clients with both mental health and addiction issues—were also useful in the brain injury population. For example, Dr. Lemsky had reinterpreted the "FRAMES" acronym (**F**eedback, **R**esponsibility, **A**dvice, **M**enu, **E**mpathy, **S**elf-efficacy) to produce a guide for counselling with the brain injury population. The new acronym is "PRIMER":

- **P**ace communications (one concept at a time)
- **R**epeat important concepts
- **I**llustrate concrete examples
- **M**emory aids for use in session and outside of sessions
- **E**nvironmental modifications (including the involvement of caregivers)
- **R**e-direction sometimes necessary to move client to problem-solve or address tangential speech

Discussion highlighted a number of challenges in working with clients with ABI, including problems with executive functioning - such as setting goals, learning from mistakes, thinking before acting and making abstractions—and problems with memory, including forgetting information, events and items on to-do lists, as well as confabulation. The presenter commented that the latter phenomenon has contributed towards some brain-injured clients being perceived as untruthful in traditional addiction programs because these clients' stories didn't seem to "hang together."

Participants in the breakout session also shared examples of challenges. One participant spoke about the difficulty of explaining to a person that he has a brain injury when the client lacks the capacity to remember and appreciate his condition. Another participant spoke about how counselling with brain-injured clients can be com-

promised when practitioners become frustrated at the slow pace of change and lose hope that change can happen. On this latter theme, the presenter introduced the concept of the "Fundamental Attribution Error," defined by Gilles and Manchester (2006) as "the tendency to attribute another's unpleasant behavior to an internal disposition and to view that behavior as under the person's control." The presenter suggested that counsellors who are too heavily invested in this concept may be less likely to operate from the spirit of MI, since they would tend to favour more aversive treatment options, rather than focus on how therapist behaviour could be contributing to the lack of progress.

Another challenge covered during the discussion was that for many brain-injured clients, emotions no longer serve an educational purpose. For instance, clients with ABI often don't retain the "oh my gosh, what was I thinking..." embarrassment produced by negative consequences of a target behaviour in clients without ABI. To further complicate matters, ABI clients often don't remember the content of a therapy session but they generally do remember if they leave a session angry or frustrated—a potential disincentive to return for the next session.

This latter observation provided a bridge to a further discussion of potential solutions in working with ABI clients. The presenter related that he and his colleagues had discovered that if each session with a client could be concluded on an affective high note, then the client would retain the memory of leaving the session feeling more optimistic and more inclined to come back next time. For example, the counselor can conclude sessions with discussion that supports the client's self-efficacy.

As a vehicle for exploring more solutions and applications of MI principles in the ABI population, the presenter introduced a case study:

> *Larry (not his real name), a 61-year-old white male, who was referred by his spouse and community health care team to the presenter over concerns that the client's alcohol use was compromising his physical health, including liver damage and exacerbation of diabetes. The client had experienced a traumatic brain injury about 14 years before, resulting in a significant short-term memory deficit. Larry initially stated that all the concerns raised didn't seem real to him because in his view, his drinking wasn't "really all that bad."*

The presenter reported that he used MI in the early sessions to build the therapeutic alliance and establish the client's goal for therapy: no alcohol use until his physical health concerns resolved. After about three months, progress in the sessions stalled, even though the client had demonstrated a significant number of signs of readiness, including a clearly stated goal and resolve about meeting it. The presenter responded by returning to a phase 1 style exploration of ambivalence around goal. The presenter wondered whether the client's lack of follow through with coping strategies generated in the sessions was due to enduring ambivalence about the goal or was a manifestation of cognitive deficits based in Larry's brain injury. As a means of checking with the client about whether a Phase 2 shift was appropriate, the presenter introduced the concept of the "holding pattern"—namely that one of the contributions a therapist can make is to share observations about factors that appeared to be stalling progress in the course of therapy. Larry agreed that this was a useful idea and that he would welcome this sort of feedback. He responded by affirming his commitment to his goal and clearly signaling his openness to begin to discuss a change plan. The writer suggested that introducing the holding pattern concept to clients was one useful way for ensuring that progress with an ABI client doesn't entirely settle into a "holding relationship."

The presenter concluded the break-out session by relating some ideas on how Larry's spouse was included in the process. In providing individual counselling to the client, the presenter made his best attempt to strike a balance between respecting the client's decision-making authority and optimizing spousal support. At the first session, the therapist initially met with the client alone, bringing in the spouse only after the client had consented to it. Throughout the course of therapy, the presenter consistently followed this practice, so that the spouse's feedback —whether delivered directly in person or indirectly through a memo —was only brought in through the client choosing to do so. When the spouse began to withdraw from her day-to-day efforts at cajoling the client to stop drinking—as a result of her interpretation of messages from family counselling—the therapist motivationally opened up the option of the spouse supporting the client in implementing compensatory strategies, once he had decided this was a good idea. The approach seemed to yield positive results, perhaps because the client consistently valued the spouse's support and welcomed her feedback, in spite of their difference of opinion over how much a problem the client's drinking represented. MB

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Thanks to Tim Van Loo for his help in preparing this report.

Surprises in Sofia

Some Personal Reflections from the Session *Action for Change: Motivational Interviewing & Drama in Domestic Violence and Abuse Work*

Mark Farrall

In Sofia I presented a workshop entitled "*Action for Change: Motivational Interviewing & Drama in Domestic Violence and Abuse Work*, which considered the group-based intervention programme (*Action for Change*) developed by my company for work with non-convicted men who have been behaving abusively and/or violently.

I first became involved in formal group work in the early 90s, in the context of Theatre in Education, presenting theatrical stimulus and then facilitating discussion and experiential exploration of the issues raised (Third World development, Fair Trade and environmental questions). I then spent seven years facilitating groups in probation and prison, again using experiential techniques, and for the last five years have been formally training in Psychodrama, a group-based experiential psychotherapy.

I would describe myself as a 'group worker' and the group modality (especially experientially based) is my preferred modality, so it was a surprise when presenting in Sofia to see what seemed to be some huge gaps in knowledge around 'groups' and the MI crossover. I realised that I have embedded assumptions and conclusions, from years of group practice, which are not shared by others, however obvious they seem to me.

For example, in Sofia, I was present at a workshop where the question was raised, "Is it even possible to do MI in a group?" Admittedly, Walters, Ogle & Martin (2002) suggest that this question has not been answered, but to me it was obvious—of course you can! And it felt like I have been doing 'group MI' since I first trained in MI in the middle 90's. So that was one surprise—that it was not as obvious to everyone as it was to me that you can do MI in a group setting.

The second surprise from Sofia was what seemed to be a gap in knowledge around groups per se. I spend a lot of time around other group workers and group psychotherapists; so again, I had assumed a common understanding because most of my colleagues share my own.

From discussions in Sofia, it seemed like there was some degree of lack of awareness that a 'group' involving eight people is not the same thing as a collection of eight individuals in the same room—to state (what seems) the obvious, groups have a collective dimension which makes them special, and have special properties and dynamics which can both aid and impede 'group work'. Hence I would argue that group work is not just one-to-one work, multiplied by the number of people present.

The third surprise was around experiential work. Again, coming from a theatre background my preferred style of group work is active and experiential, involving a lot of 'getting off the chair' (by leaders and group members) to literally *do* something. In the light of past Listserv discussions around people's reactions to such work, I hasten to add that while I accept there are some special demands and possible disadvantages around such techniques, I continue to assert that there are also some incredibly powerful advantages.

In this session I was describing briefly how *Action for Change* uses experiential techniques, but trying to focus mostly on the 'MI bits'. So it was interesting that the elements which seemed of most interest was the active work—in retrospect I would have spent less time talking and more time doing, sharing and demonstrating techniques.

The final surprise was that ever since Sofia, I have been thinking about 'MI group work' and trying to clarify what I (thought I) understand by it. *Action for Change* is an entire intervention programme, one to one and group work, for domestically abusive men, which I think is 'built around MI'—but what does that mean for others? Is it just using MI skills and techniques, so more reflection, summaries and affirmations etcetera, but still within a—for example—mainly didactic psycho-educational model? Or is it a translation of the 'pure' MI process found in one to one, but done in a group? Or is there still more, something distinctively different about an 'MI group' as opposed to a 'group which uses MI' or is 'MI consistent'?

Walters, Ogle & Martin (2002) suggest in their conclusion that the development of MI in groups will be one of "next directions that MI will take" (p. 390). Certainly I think there is huge scope for such development and that of course, it has been happening for some time already, as the work of Chris Wagner and Karen Ingersoll demonstrates. MB

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