Motivational Interviewing Newsletter: Updates, Education and Training

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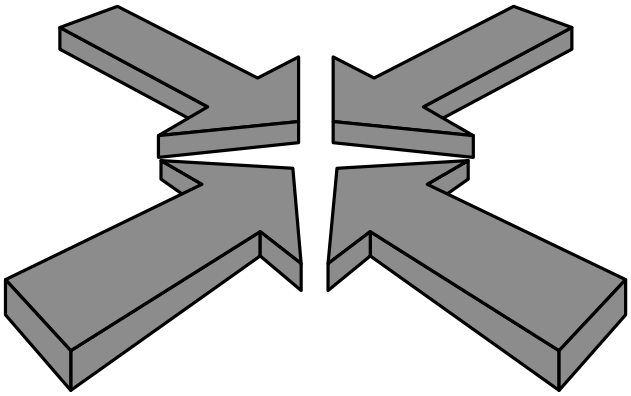
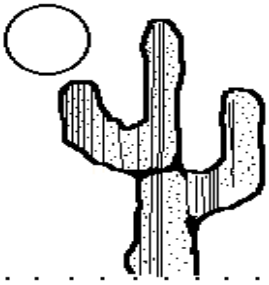


New Perspectives



Notes From the Desert

Bill Miller

From the Desert

News. It's already been a lively year as we move toward Y2K (2000) and Y2M (2001 - the beginning of the second millennium). I'm really enthusiastic about the start-up of MINT's motivational interviewing web site for the general public and professionals. We'll have our work cut out for us deciding how best to communicate MI through such a disembodied but powerful medium. I receive regular requests for our website address. MINT-7 (hard to believe!) is coming up in September in Spain, the first side-by-side bilingual training of new trainers. As of July, we already have over 30 approved applicants for the 40 English-speaking slots. We have officially grandparented and welcome several senior colleagues who chose to accept IAMIT's offer to become full-fledged MINTies, at least one of whom (Allen Zweben) plans to join us in Tarragona. ICTAB-9 in Cape Town in September of 2000 will give us an occasion to further communicate MI to colleagues in Africa, where Angelica Thevos has already been doing "MI in the bush." Steve and I are moving out of contemplation and into preparation for the writing of a second edition. At CASAA we are setting up a MI quality assurance service through which therapist tapes can be coded with the new MI Skill Coding (MISC) system. We hope that this will help investigators studying MI to document the fidelity of their interventions, and there are some exciting training applications possible as well. We're starting to analyze data from MIDAS - our NIDA-funded clinical trial of Motivational Interviewing in Drug Abuse Services, actually a series of four randomized trials of MI as a prelude to drug abuse treatment. The MINT email network (one of only two I subscribe to) just keeps on humming with interesting new developments.

Project COMBINE. One of the projects occupying a lot of my time these days is Project COMBINE, NIAAA's latest multisite collaborative trial. We are now in the process of refining and practice testing the Combined Behavioral Intervention (CBI) that is planned as a state-of-the-art treatment for alcohol problems, for which CASAA is serving as the trial's training and monitoring center. At the training helm are MINTies Nancy Handmaker and Judy Arroyo. The trial will test two medications against placebo - naltrexone and acamprosate - alone and in combination with each other. Half of those receiving medication will also be given CBI, and a ninth group is receiving CBI without medication. CBI as currently designed begins with a session of straight motivational interviewing, then proceeds to assessment feedback (MET), functional analysis of drinking, an evaluation of social functioning, and development of an

individualized treatment plan based on all this information. From there CBI draws on a menu of cognitive-behavioral modules much like CBT in Project MATCH, with an additional encouragement for all clients to sample mutual-help groups as a support for change. We are also experimenting with ways to include a supportive significant other through most of the 4-month treatment process.

Tidbit. In the far back corner of a large poster session at the Research Society on Alcoholism was an unstaffed poster, which caught my eye as I rounded the corner. "A Brief Intervention for Reducing Alcohol-Related Problems Among College Students," by C. Cronin, Saint Leo College, St. Leo, Florida 33574. A professor had surveyed students about their alcohol use over the course of a semester. They were also randomized to receive different survey forms. One survey had additional questions asking students to predict how much they would drink, and which negative consequences they would experience from their drinking during the next two weeks. The surveys were repeated for four consecutive two-week periods, so that the intervention group made these predictions four times. The control group made no predictions about their drinking or consequences. Students in the intervention group showed significant reduction in their drinking, relative to the control group. An "explicit priming" hypothesis was referred to as the conceptual basis for the intervention, but from an MI perspective it resembles eliciting SMS. This suggests that one could devise a set of written exercises to elicit SMS outside the context of an interview, and still have a suppressing effect on drinking. The students in Cronin's study were unaware of receiving an intervention; they were only aware of completing a survey. Gina Agostinelli's research also indicates that mailed personal feedback suppresses heavy drinking. Maybe one *can* draw on an MI model to produce printed or computer-administered materials that will effectively alter addictive behaviors!

Toward a Theory of MI

Much of my career I've run afoul of colleagues for being too atheoretical - a pragmatic dustbowl empiricist. When pressed I can usually come up with a reasonable theoretical rationale, but the truth is that I usually start from curiosity and experience, and from a general interest in finding what works best for people in pain. With enough experience, I start coming around to theory development.

Thus I have devoted perhaps too little time and attention to developing the theoretical underpinnings of motivational interviewing. As you know, MI did not evolve from a theory. It was drawn out of me. In a style much like that which I would be writing about, my Bergen colleagues had me demonstrate what my clients had taught me, and then helped me to unpack the unspoken assumptions and decision rules behind the method so that it could be communicated to others. As I wrote the resulting descriptive article that was published in 1983, I tried to ground the method to behavioral science findings and constructs, as well as a few metaphors. (This was long before Jeff Allison's elegant dancing-versus-wrestling.) I drew on Festinger's concept of cognitive dissonance, which eventually gave way to the broader and less baggage-encumbered concept of discrepancy. I used what Hal Arkowitz had taught me about Daryl Bem's self-perception theory. There was a natural fit with the then-new transtheoretical model of change, and with health belief models. I even threw in a wacky electrical wiring diagram that with a little tweaking could now grow up to be a structural equation model, complete with mediating and suppressor variables.

Since then I have been busy doing, developing, testing, and teaching MI, and haven't contributed any further steps toward a theory to understand it. I may not even be the right person to wrest (or dance) a theory from the data. I am getting curious, though. We seem to have a method that works with surprising consistency across problem areas, contexts, therapists, and cultures. Two decades ago it would have been hard to convince me that a single session of anything could reliably trigger a change in stubborn addictive behaviors. Yet it seems to happen - not always, of course, but with enough statistical reliability to be replicated by numerous investigators in reasonably small samples, with effect sizes averaging somewhere around six tenths of a standard deviation. We seem to be able to show other therapists how to practice MI, so that they can replicate its effectiveness. We're even training trainers!

Yet with all of that we do not have, in my view, a satisfactory explanation of *why* and *how* motivational interviewing works. I've taken to asking MINTies how they explain it. Perhaps that's the nominal group brainstorm topic with which we will start off MINT-7 this year. If we stick to our style, what we will do is eventually *elicit* the theory from each other, and I hope that MINT-7 will be just such an opportunity. As a small step forward, I offer the following findings, which I think, need to be accounted for and incorporated into any theory of motivational interviewing.

1. MI seems to work. Behavior patterns that have been stuck for some time seem to get unstuck. How/where was behavior "stuck" before MI (this is where Steve and I have speculated about ambivalence), and what unsticks it?

2. It works in relatively small doses. There are numerous demonstrations of single session interventions (not all of them explicitly MI) being a reliable catalyst for change. Whatever it is that happens, it doesn't take much.

3. The effect is relatively large. It's enough to produce large effect sizes from a single session *added to* an outpatient program or a 21-day inpatient program. In Project MATCH, MET held its own against two 12-session outpatient treatment methods. Whatever is happening in MI, it seems to be *enough* to produce change.

4. The efficacy of MI seems to be enhanced by (or at least is most evident in the presence of) negativity. If anything, its relative advantage is with less ready, less motivated people. In MATCH, it worked better with angry people. Client attributes often regarded to be markers of poor prognosis seem to be less serious obstacles with MI.

5. It seems to work by reducing negativity. In Miller, Benefield and Tonigan (1993), we found that what predicted change was not a high level of clients saying the right thing (though that did happen with MI), but rather a low level of client resistance. If the therapist behaved in a way that did not elicit resistance, change followed. It is also noteworthy that client resistance was a relatively low frequency behavior; small numbers of occurrences predicted a lack of change.

6. If Paul Amrhein's reported psycholinguistic findings in MIDAS hold up to replication, self-motivational statements (SMS) do make a difference. What he is finding, and what may have eluded us before, is that it is not the absolute *level* of SMS that predicts outcome, but rather the *slope* of commitment language during an MI session. If commitment language (what we call SMS) is going up over the course of the session, the client is likely to show behavior change. If the slope is flat or negative, the client is unlikely to change.

7. Therapists differ in their efficacy using MI. Even under intensive training and monitoring conditions in Project MATCH, designed to minimize therapist differences, therapist effects on outcome persisted after removing variance accounted for by sites, treatments, and client characteristics. MET was the one condition where we could not account for such differences by eliminating outlier therapists.

8. Accurate empathy, defined as reflective listening, seems to be a strong predictor of therapist efficacy. I am enthusiastic that in MISC we have a research tool with finer resolution, which may let us get closer to identifying process determinants of change.

Straying further from the data, I would add these intuitive observations.

9. There is something about this *Menschenbild*, the underlying positive assumptions about human nature, the living-as-if seeing of possibilities in the other. This may be harder to measure, but I believe that the efficacy of MI has something to do with communicating - even taking for granted - hope, profound respect, esteem, possibilities, faith in the

person, freedom to change. "Other-efficacy," perhaps.

10. There is something about self-esteem. The literature doesn't show up self-esteem, as usually measured, to be a strong determinant of outcomes, and perhaps it's because it involves interactions. In my original wiring diagram, self-esteem has the potential to drain off motivational juice at the point where both discrepancy (importance) and efficacy (confidence) are present. If I am doing myself in with my behavior, and there is something I could do about it, I still might not take action if I think I'm not worth saving. Self-esteem in itself doesn't seem to drive change; it may even do the opposite in some circumstances. Yet I think there are conditions under which it is the missing ingredient. Lacking self-esteem, our clients borrow our esteem for them.

11. There is something about acceptance. The paradox that Rogers highlighted is that when one feels unacceptable in one's present discrepant state, one cannot change. When one feels accepted or acceptable, then it becomes possible to change. Against the reflexes of the heart, the motivational interviewer does not insist or even believe that a client *must* change. I also agree with Rogers that this is a reciprocal process - not that the client accepts the therapist (although I think it happens, and that Monty Roberts is onto something here) - but that one's ability to extend such acceptance to others is related to and enhanced (or limited) by the extent to which one experiences that same forgiving acceptance of self. The good news is that practicing one seems to enhance the other. The very act of listening reflectively to another also changes the listener.

12. There is something about love. In America it is out of fashion for psychologists and researchers to talk about love. We also mix up its multiple meanings. I have found particularly helpful a little C.S. Lewis book called *The Four Loves* in which he distinguishes among four ancient Greek nouns, all of which are rendered in English as "love." One (*eros*) is erotic, sexual love. One (*storge*) is attraction love, like my own love for chocolate. One (*philia*) is familial, close-bond loving. All three of these are things that therapists are not supposed to do with their clients. Then there is *agape*, a kind of selfless, other-directed, encompassing but nonpossessive love, likened to God's love. Its sole interest is in the well-being and growth of the other. There is a mystical sense of oneness with the other, as though at least for this moment we were not separate beings.

Twelve. That's a good number, a good place to stop for now. You take it from here.

Meeting Monty

It was Saturday afternoon. We were relaxing in a hotel room at Santa Barbara, California, the night before the opening of the annual Research Society on Alcoholism meeting. Kathy was reading tourism brochures about the area, while I was enjoying Monty Roberts' autobiography, *The Man Who Listens to Horses*. I had been watching videotapes of the original horse-whisperer working with horses, and was immediately struck by the fundamental parallels with the processes of MI and the addiction field. The field even chose the same verb, "breaking," to describe what one "has to do" to get through to an alcoholic or drug addict. In April I had mailed him a copy of *Motivational Interviewing* and our training tapes, with a long letter of appreciation for his work, and some reflections on its similarities to MI.

"Listen to this," Kathy said. "There's a little Danish village called Solvang just half an hour up the road from here. They have shops and restaurants and Danish bakeries. Want to go?"

Solvang. . . . Solvang Where had I heard that name before? Kathy reminded me about a friend's parents who had once lived there, but that wasn't it. I read another two chapters before it hit me. Solvang is the postal address of Monty Roberts' ranch.

The operator had a telephone number for a Monty Roberts in Solvang. It turned out to be the answering service for Flag Is Up Farms, his

ranch. I self-consciously explained to a young woman that I am from Albuquerque and had sent Mr. Roberts a book and some tapes, and might it be possible to meet him. She had heard it all hundreds of times before. "Can I put you on hold please?" I waited on hold for several minutes listening to a local country-western station. Then another voice: "Just a minute, I'll get Monty."

The next morning we were sitting in his living room, with a stunning view across the sunny valley that had caused Danish settlers to give Solvang its name. "I've watched all your tapes," he said. I see thousands of tapes, so I don't remember that many of the specifics. I do remember two doctors talking to a man who had had a heart attack. One didn't really listen to him, tried to crowd him and move him out quickly. The other gave him lots of room to move, and found out what it was that he wanted. What I remember most, though, is that I felt like I didn't need to remember the specifics at all, because what we are doing is the same thing. It was all familiar, and I felt right at home with it."

Before long we were talking about mustangs and alcoholics as though they were interchangeable. "People hear me talk about my work with horses and say, 'What a great metaphor for education, or management, or people!' What they don't understand is that it's *not* a metaphor. It's all about relationships, and preventing brutality and violence With horses it's blatant. The whip is still the single biggest-selling item in any tack shop. Jockeys are fined if they don't whip their horse. Sometimes it's blatant with people, too. In white collar jobs it's usually more subtle and civilized, perhaps, but the process is the same. It's control by fear and coercion, rather than rewarding the positive and helping people to want it instead of the alternatives."

We talked about the 47 foster children he has raised, and our own adopted children. "You could spend all of your time and tire yourself out just reinforcing kids for all the positive things they do right. But what a way to go!" We talked about corporations and prisons. What I came away with most, however, was the powerful sense that we really *are* talking about the same fundamental processes. Horses were his teachers; alcoholics were mine. They taught us a nonviolent alternative to treatment as usual.

Horse Sense. In reading Monty Roberts' second book, *Shy Boy*, I kept encountering little gems, words that would jump off the page at me with their parallelism to MI. *Shy Boy* is a beautifully-written (and photographed), fascinating, and inspiring book. Its seeming main story - the wholly nonviolent taming of a wild mustang on the open range - ends halfway through the book. There is a moving chapter on parallels to child abuse. MINTies will identify with the story of his most horrendous training experience - the horse from hell. And then, in an unexpected final twist, the central true story returns, winding its way to a new conclusion.

Here are some Monty Roberts gems:

> If all learning is zero to ten, then the most important part of learning is zero to one. (p. 173).
>
> If you can use your skills as a trainer to open a door that a horse wants to go through, then you have a horse as a willing partner instead of your unwilling subject. (p. 158)
>
> It was up to me to listen, to read the signals, and to show that I understood his language by the speed and accuracy of my response. (p. 80)
>
> [describing his response to a horse's sudden outbreak of violent "resistance"]: There should be a complete lack of urgency in any situation like this. Horses need patient handling. Act like you've only got fifteen minutes, it'll take all day; act like you've got all day, it might take fifteen minutes. (p. 108)
>
> [describing what he observed that told him a horse was ready for change]: I saw "a dramatic change in demeanor: he was still wary . . . but he seemed possessed of a new calm. (p. 76)
>
> I would tell the world that the gentle way is the better way. (p. 135)

It is ironic that in the film, *The Horse Whisperer*, Robert Redford insisted on inserting scenes at the end involving violent treatment of a horse. The message seemed to be that this gentle stuff is all

well and good, but when you really encounter tough cases you ultimately have to show them who's the boss. Tying up, walking on, and generally subjugating horses is precisely what Monty Roberts has spent his life working against, not primarily through denunciation, but by showing that there is a better alternative that renders violence unnecessary.

He writes, "My goal is to leave the world a better place, for horses and people, than I found it." That's a rather straightforward life mission statement. I believe he has already done so.

MI in Zambia

Angelica Thevos

Work with MI as it applies to the encouragement of safe water treatment practices in the developing world is continuing. Water treatment and safe storage play an important role in the prevention of diarrheal diseases, a lead killer of children throughout the world. The first studies done in Zambia in 1998 resulted in much higher purchase rates of water disinfectant (chlorine) in the MI group, as compared to a comparison group of health education only. Due to these promising results, the Centers for Disease Control and Prevention has funded another two studies there in an attempt to replicate and extend the previous work accomplished.

The studies will be conducted in a different part of the country, this time with the assistance of the Tropical Diseases Research Centre. One study will evaluate MI's effect on the use of chlorine, as delivered to community residents by Neighborhood Health Committee workers (volunteers from the community). Another study will investigate the effect of several MI interventions with community opinion leaders (traditional medicine practitioners, women's group leaders, priests, etc), with the goal of influencing their decision to utilize safe water treatment in their own personal households. Sales of chlorine in the opinion leader study community will be compared with a comparison community as a measure of the effectiveness of the opinion leaders to influence the diffusion of the adoption of safe water practices within their spheres of influence. The comparison community will be exposed to social marketing alone.

It is hoped that these new investigations will further the support for the use of theory driven behavior change interventions in developing countries. Work accomplished to date indicates that MI is very promising in this regard, deserving of more thorough scientific investigation and refinement of training and delivery methods.

Editor's Note –
Addended to the MINUET is an edited series of email missives from Angelica describing this research, first hand. Again these emails were sent in real time and describe her experience, the research process and the implementation of MI in this setting. The first few dispatchs cover general background information, while the sections dated July 15 and 19 discuss the specifics of the MI training. These emails provide some interesting twists on provision of MI training and what represents an adequate dose of training. Hat's off to you, Angelica. Great work!

Important MINT Dates

Submission	Publication
8/1/99	9/1/99
12/1/99	1/1/00
4/1/00	5/1/00

Regional MINT Meetings

Please let us know if you are holding a regional MINT meeting.

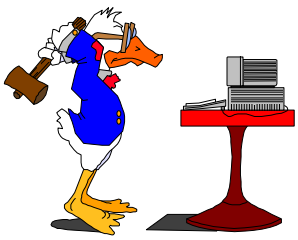
A Fresh Cup

Denise Ernst

I have agreed to take a role in editing and compiling the Minuet after David moves on to other things. I see it as a way of staying in touch with a great group of people and facilitating the sharing of our very diverse and exciting work. The group has not finished the discussion of the purpose of the newsletter, how we are going to distribute it, and how we are going to support it. Unfortunately, I will not be able to be in Spain to participate in those discussions. But I am confident that the group will provide me with the guidance and direction to bring the newsletter into the 21st century. During the years 2000 and 2001 I will be traveling around the US (mostly), Canada, and Mexico. I will be continuing to work in research, providing training where called, and dancing (as opposed to wrestling) with the MINTies for articles for the newsletter. In addition, I would like to propose meeting with many of you individually and doing "profile" pieces as a way for us to get to know each other and our work better. I know that my training has been enriched by the willingness of the MINTies to share ideas, experiences, and thoughts. I look forward to meeting with many of you and would appreciate any thoughts or ideas you have regarding the newsletter. I can be reached at denise.ernst@kp.org or (503) 499-4672.

MINT Contributions

As a reminder, MINTies, subscribers (and others interested in MI) are invited to submit pieces for the MINT. Remember that it doesn't have to be perfect. MINTies consistently state that hearing from other trainers is one of their greatest desires for this newsletter. So, send it on in.



Messages from Cyberspace

Chris Wagner

MI Website

The MI website is now up on the web! I think we have a good start on it, although there are numerous additions & changes needed for it to really be whole. Before announcing it more broadly to the public, I'd like for MINTies to take a look at the site and provide me with feedback & suggestions on additions, deletions and alterations needed in the content or format of the site. Don't be shy in giving feedback, even if you really dislike something! Now that it is up, I expect that the site will change and grow rather rapidly. I am currently reviewing the MINT newsletters for articles to post on the site (the full set of newsletters are already available for downloading, but please suggest articles I could pull from them to feature). I am also working on updating the trainers' list, which is already rather outdated, and doesn't yet include MINTies from the 1999 training. If you notice that your address, contact info, or specialty areas are incorrect or incomplete, please drop me an email at ccwagner@vcu.edu with updated info and I'll upload it as soon as I am able.

I'd really like this to be the MINTies' site, so, again, don't be shy about suggesting changes or submitting pieces you'd like to see on the site - it's really just an outline of what it could be....

The site address is www.mid-attc.org/mi/

Listserve

The Listserve is intended to provide an easy means for MINTies to share information, discuss issues, ask questions, organize symposia and other plans, and generally keep in touch. It is a place to notify one another of new training events and techniques, current or future research projects, journal articles, book chapters, etc. It is intended to be a resources for increasing the

quality of Motivational Interviewing/Enhancement training. The Listserve is archived, so members may request a copy of previous messages from the server on which the list is kept. The list is limited to members of MINT and messages sent through the Listserve should not be shared with non-members without permission. To subscribe to the Listserve, email a request to Chris Wagner at ccwagner@vcu.edu

European Blend

Peter Prescott, European Co-editor

I have one short thing for MINUET. Nice summer weather and vacation time doesn't seem to enhance motivation for writing about MI and training. But since I sort of promised Tom to send something, I have to muster the necessary discipline....

I sometimes wonder, or to be more precise, I am sometimes filled with doubt, about the impact of MI-training. I feel I need a steady stream of positive feedback to keep my spirits up. Actually I need a constant flow, rather than a steady stream. And it seems to get worse. Positive evaluation of workshops isn't enough; I need more "proof". Sometimes stories from the trainees give me hope that I'm doing something meaningful:

This spring I did a 2-day MI-workshop for community nurses in primary health care and a 1-day follow-up with the group about 6 weeks later. As usual with these 2+1 day affairs, I started the follow-up inquiring about their experiences in using MI. I expected the usual: Touchy conversations were easier to have and that they felt more secure talking with patients about behavior change. That was the case this time too, however one school nurse told us about a 3rd grader, Kari, who had a problem. Kari's problem was that just couldn't walk to school on her own. Every single day since starting school, her mother or father had accompanied her. They had to take her, not just to the school grounds, but all the way to the classroom. As you can imagine, everybody was pretty fed up with this routine. The school nurse told us about her first conversation with Kari. She decided to explore the good and not so good things about walking to school with mom or dad. Kari was willing to do so, and it became very clear that there were a lot more cons than pros. So the nurse asked, "Would you like to try to change all this?" Kari couldn't wait to answer, "Yes!".

They then talked about other ways to walk to school. Kari decided that she would ask one of her friends if they could walk together. And that's what happened. The next day Kari walked to school with her friend. And after that she had no need of her parents to help to get to school. During the next two weeks, the school nurse made short appointments with Kari to check on how things were going.

Even though there is a taint of "the miracle cure" in this story (I think Kari had done a lot of change-work already.), it gives me a nice feeling. I also think about the applicability of MI to behavior change in general.

Peter

Steve Rollnick, MI Innovator & Listserve Miscreant

A bad experience

The higher you fly, the harder you fall. We got right up there in a training recently, among family physicians in sessions on how to deal with patients "demanding" antibiotics for minor illnesses. We met most of the criteria set out in

recent reviews of effective postgraduate training (see for example Cantillon and Jones, 1999).

- The learning experience was centred on real-life situations, not subject matter units!
- The trainees requested it.
- It was an "outreach event", in their own work environment.
- They brought their own material into and out of the training.
- They were encouraged to try out new strategies between training sessions.
- I used a high quality actress, with child, to be a simulated patient in role-play consultations.
- Small group, good food, good turnout, no interruptions, well prepared trainer, lots of handout material and critically, good rapport (I had worked with them before, hence the request for more training)

And then? It fell flat. They didn't like the role-play as a teaching method. Maybe I could have made it more attractive as a learning device, but I honestly tried. I concluded that not enough choice was given to them that suited their learning styles. I managed to recover some ground, when we subsequently used a critical incident analysis as a platform for individual supervision between trainings. This really worked well with those practitioners who chose this approach to learning.

Why do I ruminate so often about congruence and flexibility in the counselling session, and sometimes forget this with a group of trainees? Can anyone help me with a descriptive account of learning styles? Has anyone done this? Let's start from the bottom up, and see where this leads...

PS: We have re-designed our training programme. We did this by spending half a day discussing a different approach. We chucked out the concept of training almost completely, and started with a different question: how can their everyday experience be supported by the work we do with them (training)? This was like putting on a set of spectacles with a different colour lense. I'll leave the description of the process and outcome to another time.

Useful Reference: Cantillon, P. and Jones, R. (1999) Does continuing medical education in general practice make a difference? BMJ 318, 1276-1279.

"Health Behavior Change: A Guide for Practitioners"

This is the title of our new little book, in which we put together our experiences of training, method development and research on the subject of health behavior change in medical and other consultations. The idea is to present conversations about behavior change as involving a particular set of consulting skills, with a few guiding concepts and principles. When used well, this will approach motivational interviewing.

The details, for those interested, are:
Rollnick, S., Mason, P. & Butler, C. (1999) *Health Behavior Change: A Guide for Practitioners*. Edinburgh: Churchill Livingstone. ISBN: 0-4430-5850-4

If local bookstores can't help, amazon.com will, or one can order it direct from the publishers: Europe/Africa: Harcourt Brace, Tel 44-(0)181-308-5700 Fax: 44-(0)181-308-5702 USA: W.B. Saunders, Orlando, FL Tel 1-800-545-2522 Fax: 407- 352-3445 Canada: Harcourt: Tel: 1-416-255-0177 or 1-800-387-7278; Australia: Harcourt: tel: 1800-263-951 or 6-12-9517-8999

Conversation analysis of motivational interviewing

I might have mentioned this in a previous newsletter. I have established a solid working relationship with Clive Seale, a sociologist from Goldsmith College in London. He has agreed to have a look at a transcript of a motivational interviewing session. He would prefer to use a real one. He knows little about our subject, which is an advantage - we will get a fresh view of the very subtle meanderings of conversation about change. I'll keep you posted about this.

Conversation analysis of a difficult consultation

I recently asked this sociologist to examine a set of audiotapes and transcripts of common and difficult consultations in general practice. Without any background in motivational interviewing he came up with the observation that the most common pattern of interaction was *expressions of concern from one party*, followed by *minimisation from the other*. Familiar? It sounded like the

confrontation-denial trap in traditional addiction counselling.

But the roles were reversed! These were consultations about coughs, colds and sore throats. The patient expressed concerns ("I've been up all night, cleaning up the child's vomit"; "I rushed straight down because the little one's temperature got higher and higher"), and the doctor minimised "Its just a bit of cold"; "Let me have a quick little look ... I see, his ears are a little red... It's probably just a virus…"). Dr Seale described these consultations as very skillfully managed by the doctor - trying to avoid prescribing antibiotics. He describes a series of "pre-emptive strikes" employed to warn the patient that antibiotics will not be necessary, followed by the final "verdict": no! The problem we are faced with is that no matter how skillfully this is managed, doctors prescribe inappropriately and too much (they cave in to perceived demand) and both parties are frequently dissatisfied with the consultation and the outcome.

This analysis confirms my suspicion that we tend to view consultations in an oversimplified way. We focus on change in the patient, yet quite often the pressure comes in the opposite direction, or both directions at once. We also tend to caricature what happens in the everyday consultation, by imagining or even suggesting that it have an unskilled or dysfunctional quality. This qualitative work has been immensely valuable in helping us to develop new concepts and descriptions of processes, and to construct training on the basis of what actually happens in routine care.

For those of you in the addictions and other fields, surely the lessons here are also applicable? For example, how often is the pressure for change coming from the client ("I'd like help with housing"; "What I really need is a prescription of this drug to keep me going....")? What *actually* goes on in the conversations of the practitioners you train? What skills and strategies do they use well? How do they and their clients feel about these meetings? Since so little qualitative, descriptive work has been done in the addictions field, do we run the risk of suggesting solutions like motivational interviewing which are not grounded in adequate knowledge of everyday practice?

I saw someone just do it!

I asked a medical student to do an interview based on advice-giving with a simulated patient. He negotiated instead. It looked a lot like motivational interviewing. When I asked him how he did it, he said that he was just trying to empathise with the patient (the self-motivating statements were tumbling out of the patient's mouth). So what more did I need to teach him? And his colleagues? What concepts and methods did they really need? Thanks to Tom Barth here, our MINTie colleague from Norway. When I asked the students how one empathises with a patient, most had remembered what they had been taught three months previously: "use short summaries", which was what Tom suggested to me, and which I had placed in their curriculum for their tutors to teach them. Simple. Thanks Tom.

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Tarragona TNT and MINT Meetings

The final plans for the TNT-7 and the parallel MINT meeting in Tarragona are being made. The English-speaking TNT is now full. There may still be openings for the Spanish-speaking TNT. Carolina Yahne is asking for MINTies willing to help with the Spanish-training to contact her at cyahne@unm.edu. If you are interested in the MINT meeting, please contact Delilah Yao at: dyao@unm.edu.

MINTie News, Comments & Info

Bolivian Training

The Pan American Health Organization and the Bolivian Ministry of Health have invited Angelica Thevos (Medical University of South Carolina) and Carolina Yahne (University of New Mexico) to conduct an MI training in Cochabamba, Bolivia during the month of November. Their interest is to use MI to promote healthy behavior change, particularly as it applies to water and sanitation practices. The participants will be community health promotion workers. Time will be devoted to a weeklong MI training and then direct supervision and guidance in the field.

Thanks and A Request

Dear Colleagues:
I deeply appreciate the good thinking and writing and communicating being done about our role in Tarragona in September. Antoni Gual i Sole from Barcelona and I will be co-facilitating the parallel training for trainers in Spanish while Bill and Steve are training the English-speaking trainers. Antoni and I would like to coordinate with both other groups. For example, if you speak Spanish, could you visit our group and demonstrate your most successful training method? Even if you don't speak Spanish, but have materials to share, please contact Antoni and me. I have just returned from Spain where he and I conducted our second MI training to an enthusiastic audience of professionals from many Spanish provinces and from the tiny country of Andorra to the north. Over 40 of those participants indicated they were hoping to come to Tarragona.

Warmly, your friend in Albuquerque,
Carolina Yahne

On-Line MI Course

Short on time, low on budget, but in need of innovative treatment approaches? The Addiction Technology Transfer Center of New England, funded by the Substance Abuse and Mental health Services Administration, Center for Substance Abuse Treatment (CSAT), is offering an online program on Motivational Interviewing. A highly effective treatment approach, Motivational Interviewing techniques can help you assist individuals in recognizing present and potential problems, while creating an openness to the concept of change.

This program will be taught by Richard L. Brown, MD, MPH. Dr. Brown is a tenured Associate Professor in the Department of Family Medicine at the University of Wisconsin Medical School. His research, teaching, and publications reflect his long-standing interest in alcohol and drug abuse. In addition, Dr. Brown serves as a consultant to several managed care organizations providing assistance in the design of alcohol screening and intervention programs for managed health care systems.

This four-week course which begins September 8, 1999, has been approved by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) for 8 educational credits. It is being provided by the Addiction Technology Transfer Center of New England, which is accredited as a NAADAC Approved Education Provider (#000151). Certificates will be mailed within two weeks to participants in the program for its duration who submit all required materials. Please contact your local certification board to verify acceptance.

For additional information regarding this course offering, as well as a link to the ATTC of New England Online Education "Motivational Interviewing" registration page, please go to the following WWW site and read the Official Course Announcement.

http://CAAS.caas.biomed.brown.edu/CED/Courses/033/announcement-033.html

At the bottom of the course announcement you will find a link to the registration page. If you find that you have additional questions or concerns after reading the course announcement, please feel free to contact me.

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Addiction Exchange

Our Addiction Technology Transfer Center has developed a new product this year called "Addiction Exchange" that will be a method of communication among addiction clinicians and researchers. Part of the ATTC mission is to facilitate the exchange of empirically-supported techniques to the field and key field questions to the researchers. The Addiction Exchange will be a one page biweekly document that can be faxed, emailed, and website-posted. If you would like to be included as a "subscriber" (free of course), please email me directly and let me know, and you will be included. Specify what method of receipt is preferable to you- via email attachment, fax, etc. Also, if you would like to contribute as a clinician or researcher to future issues, please let me know. Feel free to copy and distribute to colleagues or students who may find it useful. Thanks in advance!

Karen Ingersoll
Virginia Addiction Technology Transfer Center.
email: kingerso@hsc.vcu.edu.
Phone: 804-828-7456.
FAX: 804-828-9906.

Announcement and Call for Papers

Dear MINTies –
Please forward to interested friends. The call for papers is open to anyone - see details below. Feel free to edit and make announcements in your newsletters and list serves. Thanks a bunch.
Rick

Association of Behavioral Science and Medical Education Conference
Savannah, Georgia Oct 2-5th 1999

PROMOTING HEALTHY BEHAVIORS: CHANGING INSTITUTIONS, TEACHERS AND LEARNERS

Good health is a result of many factors. However, healthy behaviors are the major determinants of health. The behaviors of individuals, healthcare organizations, and the wider society all interact to either promote health or produce disease. An organizational, interdisciplinary and population-based approach is needed to reduce the prevalence of risk behaviors and to address the behavioral aspects of disease management programs. To address these issues effectively, we first need to learn about changing:

- our institutions, teachers, and learners
- our health care organizations and practitioners before helping our patients change.

This conference will explore innovative ideas and approaches that address these key themes and training issues. Other key points: We are inviting educators working in other disciplines (nursing, public health, etc) so that we can learn from one another. We would be delighted if representations from the American Academy of Medical Colleges, The Health of the Public Group, Society of Behavior Medicine, and the American Nursing Association. When health care educators and practitioners learn to work across disciplines and organizational levels, we can begin to have a population-based impact in reducing the incidence and prevalence of risk behaviors.

The Health Behavior Change Institute (Co-directors: Rick Botelho and Professor Harvey Skinner, Chair of the Department of Public Health Sciences, University of Toronto.) will organize a full day pre-conference workshop "Unhealthy Behaviors: Motivating Resistant Patients to Change" on October 1st. Limited enrollment. Cost $95 (includes the cost of videotapes and advanced reading materials)

E-mail: Pam_Democker@URMC.Rochester.Edu for conference brochure. Note there is a _ after Pam in this address.

CALL FOR PAPERS

We are now planning a special, collaborative issue of our two journals, to be published in the Fall of 2000. The theme of this special issue will be: "Enhancing Patients' Health Behaviors." We are interested in manuscripts that present project and research reports as well as provocative "Think Pieces." The focus of submissions for this special issue should be on achieving those changes needed in teachers, learners, and/or institutions for producing future health professionals who will be effective at helping their patients adopt and sustain healthy behaviors. The technical requirements and submission instructions for contributions for this special issue will be the same as those summarized in the Instructions for Authors, which are available on the Education for Health web site at: www.uchsc.edu/CIS/EfHinfo.html

(Please copy the URL exactly, as parts of it are case sensitive.)

Submission deadline October 31st 1999

Papers for this special issue of our respective journals will come from three potential sources: presentations made at the Fall, 1999 Annual Meeting of ABSAME in Savannah; presentations made at the Fall, 1999. Annual Meeting of the Network in Linkoping; and manuscripts submitted directly, without having been presented at either conference.

If you have specific questions, please contact me via email.

Richard J. Botelho, M.D.
Guest Editor, Annals of Behavioral Science and Medical Education
Rick_Botelho@URMC.rochester.edu

Upcoming Training Events

Dear colleagues,

The European Addiction Training Institute (EATI) will organise a 3-day 'Introduction to the principles and practice of Motivational Interviewing', 11 - 13 November 1999 in Sta. Margherita, Italy. A maximum of 20 participants form different European countries will be admitted. Teaching medium will be English.

For more information (a brochure with application details), please contact Iris Geitel, project Assistant EATI at IGeitel@eati.org.

Best regards,

Rik Bes
Senior Trainer/Advisor
Jellinek Consultancy
Stadhouderskade 125
1074 AV Amsterdam
The Netherlands

A Listserve Conversation

Attached to the newsletter you wind find a Listserve “thread” about what constitutes MI. Rich Saitz was kind enough to pull this information together. Editing was kept to a minimum. It was stimulating and thought-provoking discussion.

Last Cup

David Rosengren

A SC Conference Call

At the suggestion of Mary Velasquez, the Steering Committee set a conference call for August 23. The meeting occurred just as this issue was to go to press. The goal was to begin tackling some of the SC agenda for Tarragona. I found it rather remarkable that we were able to accommodate 10 schedules across a nine-hour time zone difference and people’s busy schedules. Only two members were unable to make this time. This is a remarkable feat by any standards. A special thanks to Mary for setting the call up. She believed and made it happen.

Minutes of the MINT Steering Committee

The SC convened by international conference call. Present: Mary Velasquez, Carolina Yahne, Rik Bes, Bill Miller (recorder), Tom Barth, Steve Rollnick, Mary Ellen McCann, Richard Saitz, and Vaughn Keller, David Rosengren (Chair).

PRELIMINARY ITEMS
A time for the SC meeting in Tarragona was set for 4:00 p.m. on Tuesday, September 14. Meet in the lobby of the Imperial Tarraco Hotel.

The MINT meeting will be on Wednesday, September 15. Carolina Yahne requested 30 minutes to discuss a MI workbook for counselors that she is preparing with Terri Moyers and Kathy Jackson. It is on the MINT program after lunch on Wednesday.

The training of new MI trainers will be September 16-18. Carolina Yahne invited SC members to come into the Spanish-language group. Participation of MINTies in the two TNTs will be

discussed at the beginning of the morning on Wednesday.

MINT MEETINGS.
There was a consensus MINT should be "organized but not *too* organized." The format of an annual meeting, corresponding with TNT, is working well. It seems a good idea to designate, at the annual meeting, one or two people to organize the following year's MINT meeting. Program planning has involved a balance of structure with open discussion time; the issue of program structure will be discussed further at Tarragona.

NEWSLETTER
Responses to the question, "Should the newsletter continue," have strongly favored continuation of the newsletter. Copies of the newsletter are also posted on the web site. Some MINT colleagues who do not have email or web access will still need hard copies, and the membership will continue to have the option of receiving a hard copy. The Listserve and website seem to serve different and useful functions. Denise Ernst was confirmed as the new Senior Editor for the newsletter. Tom Barth offered to mail the MINT newsletter to European MINTies who still desire a hard copy, covering mailing costs from an internal budget. There will be discussion in Tarragona about a Spanish-language version of the newsletter. The SC again expressed thanks to Dave Rosengren for his long service as the newsletter editor.

MEMBERSHIP FEE
It was agreed to maintain a single annual fee for all members, regardless of newsletter status (hard copy vs. electronic).

STEERING COMMITTEE COMPOSITION
To date, MINT Steering Committee members have been chosen from among those who participated in the annual meeting. It was agreed that the opportunity to participate should also be extended to MINTies who did not attend the annual meeting. Additional discussion is needed in Tarragona regarding how and how often the SC should meet. The possibility of a 3-year term of service on the SC was discussed, and will be considered further in Tarragona. A SC coordinator is needed, as a separate function from the newsletter editor, and will be chosen in Tarragona.

The Joy of Last Minute Revisions

I was about to print the final version of the newsletter today and realized since the SC Meeting notes were already in place – that Bill is remarkable – they should be included. How wonderful, except I realized that most of what I had written was no longer appropriate. Actually, it wasn't very interesting to start with so it was no great loss.

Of Partial Success and Paying Attention

Since I had to cut out that other drivel, I'll tell a training story. I recently had the rare opportunity of having a "re-do". That is, an opportunity to do exactly the same session – with a different group – only two days later. The first session went reasonably well, but the energy flagged badly during the fourth and final hour a skills training. I was trying to do a generalization exercise I had done before that had worked previously. Nobody complained, but the energy shifted and it was tough to build momentum for the end of the workshop.

So, I of course, ignored everything that went well and focused all of my energies on why I was a lousy trainer and if Steve and Bill only knew they'd take away my MI training license. Fortunately, Stephanie Ballasiotes – one of my favorite MI trainers who also happens to be my wife – suggested an entirely different direction. Brilliantly, she suggested going back to what created energy in the first place: people talking about themselves and applying MI to their life. Her analogy was, you can either give a review of a movie or they can go see it themselves. So, after some random thoughts, I formulated a plan and did it. And it worked!

The moral of the story, which you knew well before I did, pay attention to your clients and your trainees. If you get resistance, do something different.

Oh what did I do? In dyads, I had them talk about a client they were struggling with on the job. I had the listener use MI skills. After each had a turn, I asked them to play their client and talk about the struggles with their helper. Finally, I had them reflect on what they discovered about themselves, their client and identify one thing they might do differently the next time they met. They loved it!

Time!

Okay, that's it. I'm done. Denise's turn.

Hmm… It's not going to be quite that easy, is it? Okay, I'll give you all a break. For those who don't care for this sort of leave-taking nonsense, you can skip to the pieces at the end of the newsletter. Fair enough?

For those who are still with me, I'm sitting here with an admixture of gratitude, satisfaction and sadness about leaving the newsletter. The gratitude is for being given the opportunity to be part of such a stimulating enterprise. This MI stuff is fascinating and you folks are pretty interesting as well. I learned a lot from all of you and will miss the regular interactions that came with this role.

Of course, the satisfaction part is self-indulgent. I am pleased the newsletter has served a need and that people enjoy receiving it. It's interesting to look backwards and see how things evolved. Obviously, this is an accomplishment of many and, without sounding too syrupy, I'd like to say a few thanks.

Steve and Bill –
The ideas you've produced, nurtured and spread are fabulous. Good seeds grow! Your willingness to share them has been a great model. Thanks also for your regular contributions to the newsletter. I know it's been one more item on plates that were already heaping, but without your pieces this newsletter and this organization would not have happened.

Tom, Tore and Peter –
You brought fresh perspectives, thoughtful pieces, great humor and hard work to the newsletter. I have been so caught up in the mundane that I have not, until this moment, realized how much your addition caused the newsletter to blossom. Thanks.

Chris –
If the Euro-Editors made the Newsletter blossom, it's the List Serve that has breathed life into the MINT organization. It's provided us a ready resource and a method for developing as a group. I think it is a fabulous addition to the training process and the Website will only enhance that. Thank you for all your hard work behind the scenes.

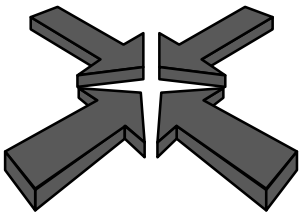
Finally, to the MINTies –
You bring vitality and creativity to the training process and are so willing to share your knowledge. I feel pretty humble when I hear about what you do and how you do it. A frequent reaction for me is: "Wow! That is a great idea. I never would have thought of that." So, thanks to all of you.

I want to welcome Denise Ernst to the helm of the MINUET. She's a good egg! I have no doubt that she will take one look at my quaint little methods, throw her hands in the air, and say, "My God! What have I agreed to do?" She will do a great job as the Editor and I look forward to the new directions the MINUET will go.

Funny, I don't feel quite so sad now. There were headaches, too. I won't go into those now because Denise could still back out. But, to tell you the truth, I'm often just grateful I can get the newsletter out the door on time. It will be nice not worrying about that anymore.

While I am at it, I have a little confession to make. If it seemed the last edition came out a little early, it's because it did. I, uh, er, um, accidentally published a month early. I can't help but laugh. I guess it balances out those times when I was a little late. Won't you be glad to have a new editor?

Happy trails to you!



Inquiries and submissions for this newsletter should be forwarded to:
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This newsletter is a free publication made available to members of the International Association of Motivational Interviewing Trainers.

Brief BYTES on Studying Brief MI: A 5-month, ongoing conversation in cyberspace

Richard Saitz, Guest Editor

Richard Saitz wrote:
Hello all, I am writing to ask for your help. Can you give me leads to identify a manual that could be taken off the shelf (published or not) or modified for use in a research study where the intervention is efficacious and brief (i.e. 30 minutes or less [remember, I'm an internist!!], one time only) and is motivational, based on FRAMES/DARES, and could be used in medical (non-specialty) settings for alcohol problems?

I am very familiar with the brief intervention literature, where interventions are often described but manuals tend not to be cited. I'd rather not reinvent the wheel. Any leads (i.e. contacts or publications) would be greatly appreciated. Thanks!

Steve Rollnick wrote:
Dear Rich,
I don' t know of a FRAMES manual, and can only refer you to the "brief motivational interviewing strategies" we developed for use in health promotion consultations with heavy drinkers on general medical wards. There was no manual. But the strategies used were written out as a collection of single-page outlines. We have since used this approach to method development in other controlled trials, and added to the basket or toolbox after doing studies among smokers and Type II diabetic sufferers. I assume you have all the references. Can I make a few observations? Your request got me trying to imagine what will happen next!

MI is a skillful counseling style. If a manual for using frames did exist, should it be called MI? I see that you delicately bypassed this possibility by requesting an intervention which was "motivational" i.e. it increases to motivation to change as a result of its use, but we might not call it MI as such! Sneaky logic! Of course, I totally trust your use of terms when writing up your work, but I struggle with this issue every week. I tend to avoid using the term MI when teaching general health practitioners. I have noticed some rewarding signs: A call from a leading research hospital in London last week: can we have training not just in brief intervention, but in the skillful MI method. The distinction has filtered though to them. I was really pleased.

Can FRAMES be manualised? How far would it approach MI? I can't resolve this one. The ADVICE component could be counter to the spirit of MI. In the manual and in the training of practitioners, it would have to be carefully tackled. Handing over RESPONSIBILITY can get tricky in everyday practice. It's a huge skillful leap for many practitioners who find it so hard to let go.

You don't want to reinvent the wheel, yet if you take a manual off a shelf, and teach it to practitioners almost as if it is a finished product, a training intervention, then you are taking risks. While you might be able to write up your study with precision, the method might not suit the context, and you could meet with resistance from practitioners. Pilot

work would be essential to allow some "bottom-up" information from the context to influence the method itself. Then the method changes... and the manual needs to change... So I am skeptical about the idea of manual development in attempts to motivated health behavior change in generic settings - if the idea is to approach to spirit and practice of MI. It gives rise to "magic bullet" fantasies in others (not you) which will only meet with disappointment.

I would be happy to discuss this further with you Rich. It's such an enormously stimulating area. We might consider doing this 1 to 1, since I am not sure how many others on our list will be interested.

Richard Saitz wrote:
The NIAAA didn't have manuals for brief MI but they have curricula for training MDs in brief interventions.

To have a manual or not to have a manual, that is the question. My goal is to develop a study that tests an intervention. My impression is that the trend in efficacy studies is to carefully document and manualize therapies (as one would for pharmacotherapy--dose, frequency, content). The down side may be the rigidity but the upside is that then you can document what worked. One way to document is to manualize. But I suppose I could also propose a study where the intervention is given boundaries but not trivialized/manualized. For example, I could have the counselor trained in a method (i.e. MI) and then suggest that that approach be followed but not with a strict roadmap for every counseling session (to preserve flexibility). Then I could document in some way (i.e. tape review, etc) features of counseling. Perhaps that would suffice, or even be better. I'd like to hear what other researchers think.

Regarding the other issues you raised, Steve, Does a manual using FRAMES=MI? No, I don't think so. Is there motivational counseling that is not MI? Yes, I think so. Can FRAMES be manualized? I think it can, if only like a college chemistry experiment where one documents what was done. I think it will be important to write up a study with as much precision as possible as a starting point; how it is translated into practice may be another story.

As you and I have had the opportunity to discuss, I believe that very brief interactions with patients in medical settings can be informed by MI techniques. Basing interventions and interview style on MI I think will be effective in practice even though it is not the Cadillac version of MI. I think that the alternative, saving MI only for when patients can encounter the complete version would leave many patients out. It seems 'in the spirit' to meet clients where they are at with this and where they are at, may not allow a big time MI intervention.

By the way--do you (all) think Project MATCH's MET (in a manual) Motivational Interviewing? How do we know when something is MI? How do you all feel about "motivational techniques" or "motivational counseling" to describe "incomplete" "MI"?

Karen Ingersoll wrote:
Rich, count me in on the discussion. Your ideas about how a manual could trivialize the spirit of MI are familiar concerns to me, and I can suggest one solution that I am involved in, along with another MINTie, Mary Velasquez. We are working with the CDC on a

multisite project designed to reduce the risk of alcohol affected pregnancies by intervening with women at high risk for risk drinking AND poor contraception, using the spirit of MI but a manualized, semi structured curriculum of 4 sessions. It would be fair to say that many reviewers (and certainly CDC staffers) are hesitant to award funds for less structured interventions that do not include a manual that specifies activities, proposed active ingredients, and outcome indicators, even though "manualizing" MI probably can't be done perfectly. The compromise we've reached, through painstaking (and sometimes painful) education of all involved, is to train our counselors well in MI, then to "add on" training on the particulars of the manualized curriculum, such as exercises to complete in the various sessions, etc., and to pilot test how well these can be integrated. I'll keep folks posted on how this seems to work once we've completed both the MI training and the protocol training, by this March, if there is interest.

Carolina Yahne wrote:
Terri Moyers, Kathy Jackson and I are working on a workbook for practitioners to use with clients. It is related to what you are discussing. It will include some photocopiable pages for practitioners to give to clients.

Charles Bombardier wrote:
I agree with Karen. You will need a manual, documented training and also process measures to capture the "spirit" issues, ensure fidelity to your manual and to protect against drift over time. I don't think grant reviewers are going to be that concerned about some of the finer distinctions we are drawing. We had success with CDC, albeit several years ago, referring to an accepted training manual (MET Manual from NIAAA) and then spelling out in some detail how we were going to tailor it to our specific setting and patient population. Of course you also probably need to show, through pilot work, that you actually can implement the tailored protocol you devise and give preliminary indications that it is working.

David Rosengren wrote:
Just a thought about whether the MET manual = MI, and the problems inherent in "manualizing" treatment. Since this manual and various derivations of the Drinker's Check-up have been the primary methods for testing the efficacy of MI in research, Steve's research notwithstanding, and this information forms the basis of our assertion that MI works, I hope we think it reflects MI. If not, don't we have a problem?

Bo Miller wrote:
I've been following this discussion (as well as enjoying the other postings to the list) and would like to be included in future exchanges on this topic. I've been doing a fair number of sessions introducing health care providers to brief motivational strategies they can use with their patients. I struggle with what to call it, but always put it in the context of Bill and Steve's work and differentiate it from full-blown MI.

Just a few thoughts on manuals and MET. As a MET therapist on Project Match, I actually liked having the structure of a manual. I never felt too restricted -- discretion was built in (e.g., you could move at the client's pace, you had adequate freedom to respond to special needs or crisis situations, etc.). I also did not feel the manual squelched the MI spirit. It was more likely to REMIND me of the spirit as I prepped for a session. I realize there are individual differences on how people respond to being

"manualized," but it's good to remind therapists of the potential benefits for them of a structured approach (e.g., I can be more consistent with every client; I'm less likely to be side-tracked by marginal issues; Reviewing the manual or a session format before a session can help me focus on what I want to accomplish with that client and get me in the right frame of mind.)

I would certainly say that MET is Motivational Interviewing, even though the sequence differs slightly from the Drinker's Check-up. I am faced with adapting the MET manual for American Indian practitioners who will be trained for a MI intervention with women in their communities who are at risk for FAS births. I am anxious to begin getting input from these practitioners so we can work together on the manual, the training, and other materials. Any thoughts for this cross-cultural process would be welcomed.

Steve Rollnick wrote:
Rich, I understand your need for documentation, and the rationale for thorough development work, which I think, is essential. Two suggestions.

First, let choice about very specific things be at the heart of the manual! A menu. This is what we did with that first "brief motivational interviewing" study. Very clear and concrete guidelines - in the form of single page strategies - for the nurses involved, but a selection of them. In fact, to begin with, we all walked up to the bedside of hospitalized heavy drinkers with a little card in the palm of our hand - our list of strategies. Back at base, we had our single-page guidelines for reference purposes. We didn't, but could have put these strategies in a manual. What I have done since those balmy days in Sydney in 1990, is add to the menu. I decided to put a manual together, then a publisher persuaded me to put them in a book. Without wishing to seem immodest, this book, HEALTH BEHAVIOR CHANGE: A GUIDE FOR PRACTITIONERS is coming out soon. You might find it useful when developing your manual.

Second, if you do get involved in pilot work, let the voice of the patient speak out in this process. Involve them in either developing the actual method or at the very least use it with them and get their feedback. We (Dr Chris Butler & I) did this in our smoking study in primary care. The smokers gave us our biggest present - a new method, based on the assessment of importance and confidence.

I don't like manuals if they are perceived as a containing a fixed dose of expert intervention, when it is skillful consulting which in truth determines successful outcome (or so I believe!). The above suggestions allow one to have a manual, and avoid the expert trap.

Steve Rollnick wrote:
Dear Rich, Vaughn & so many other MINTies interested in brief methods,

Rich, I worry about this discussion having too many facets. I wonder whether you feel like asking the group specific questions, so we can look at them in an orderly way? If not, next time I write I will track down your original note, and respond.

For the time being, how about this, just as a thought in the meanwhile: practitioners will adapt their consulting styles if they feel it is worthwhile (importance) and if they feel they

can do it (confidence). Training and manuals have tended to focus on the latter at the expense of the former.

A second thought. A pragmatic trial, like so many I have been involved with, tends to focus on patient behavior change, with the training of practitioners being viewed as a slightly messy byproduct of what seems like a more worthy endeavour - getting the dam patients to change! If one thinks about the implications of what Vaughn is saying, one ends up taking practitioner behavior change as seriously as patient behavior change. In fact, we should really do the work on practitioners before that on patients. To do this, one needs quality training time with the practitioners.

Just as an aside, I rang a funding body yesterday, to assess their level of interest in a controlled trial of training Bill & I want to do on both sides of the Atlantic. The response - yes, but... make sure your proposal makes the case that this work will lead to good patient outcomes!

Richard Saitz wrote:
Thanks for refocusing the discussion. And I'd like to remind the group that there is no smaller group discussing this--WE-ARE-IT (like IAMIT).

My original question was about how to test the effectiveness of brief MI in various populations (medical in my case). To do this one has to implement brief MI and convince others that brief MI was implemented. Brief interventions using components of MI have been found to be efficacious.

As a researcher, I can divide intervention research into (A) studying what elements "work" (efficacy) and (B) studying elements proven to work in one setting in a new setting (effectiveness).

At the moment I generated my question for the Listserve 2 months ago, I was interested in "B": I'd like to take something efficacious and try it somewhere new. Others might be interested in reshaping and modifying and inventing new techniques, which would be another line of research.

To do effectiveness research with MI I wish to have a way to employ MI; if one must re-invent MI every time it is used, then MI would not be very generalizable. Thus I think there is a way to transport and study it. Several of you pointed out that if the Project MATCH MET (manual) is not MI then what was MET? And you also pointed out: isn't MET research used to support the evidence of MI efficacy?

Now, just because there must be a way to codify and transport MI does not mean that it must be done by cookie cutter approach. Manuals or guidelines can likely direct one in how to employ MI leaving enough leeway to adapt MI to one's specific situation.

When I began this discussion, I was (and am) in search of that balance--how to take something efficacious and apply it, modifying it just as needed for the setting but still having it be MI.

I'd rather not outline/restrict the discussion further than that--Take it where you will, MINTies...

Allan Zuckoff wrote:
Rich,
I've really been enjoying the dialogue your questions have generated, and I thought I might add my own two cents (or so).

Your thought to train counselors in the 'method' of MI and then ask them to follow it 'without a strict roadmap' puts me in mind of the psychodynamic treatment research literature, where flexibility is highly prized and thus this approach is frequently encountered. Strupp and the Vanderbilt group, as I recall, trained experienced therapists in their time-limited dynamic psychotherapy, then told them to just go on and do therapy with their study patients, in order to see whether and how much the training influenced practice. Also, in the recently completed 'Treatments for Cocaine Addiction Collaborative Study', Luborsky and Mark did write a cocaine-specific manual as a supplement to Luborsky's earlier general manual for supportive-expressive psychotherapy. However, though guidelines for the 'opening' and 'end game' were given, a specific method with its associated techniques were elaborated, and a number of relevant themes were presented, in neither of these manuals were session templates provided. (I was a therapist for this latter study, and I'd be glad to share my view of the experience of working with such manuals if you're interested.)

As most of the discussions on this Listserve have been eminently practical I'm a bit hesitant to introduce my other thought, so I'll just do so briefly. I'm often taken aback by the comparisons of psychotherapy research with pharmacological treatment research. It seems to me that defining psychotherapy for research purposes in terms of "dose, frequency, content" takes literally what ought to be regarded as a rather evocative metaphor.

Pharmacotherapy obviously involves the introduction of a material substance with objective, specifiable chemical properties into a passive subject, conceived of as a biochemical entity whose state can be manipulated in this fashion. Psychotherapy or counseling involves bringing two persons into relationship with each other via dialogue, where each has a specific though usually only partially explicit idea about how that relationship should be structured and how the dialogue should go; though one is designated the 'therapist/counselor' and the other the 'patient/client', and the former takes on the responsibility of in some way influencing the latter for the better (defined differently by each theoretical orientation), each is inevitably an active participant in the creation of an ever-shifting interpersonal field. Quantitative research obviously requires objective measures in order to go forward, but in what sense can what is "given" by each unique counselor in this field be precisely controlled or 'doled out'? And isn't what escapes precise quantification precisely what we (and clients) value most in our work? It seems to me that the "physics envy" which has for so long influenced contemporary psychology and psychiatry can lead us into doing our own contributions an injustice. Is it really so far-fetched to hope that human phenomena could be investigated according to a methodology proper to those phenomena?

Sorry - not so brief after all.

Vaughn Keller wrote:
Rich,

Another thought about the "manual" question, MI, and research. The basic question is whether MI is actually done --manual or no manual. I know of no way to track that except through audio or videotapes. Even having therapists demonstrate that they can do it with standardized patients doesn't assure that they are transferring that to the actual encounter. I would opt for a three stages: training, demonstration with standardized patients, and then actual recordings with on-going coaching until you are assured that the transfer has occurred -- then start collecting the intervention data.

I have been stunned by the difference between the cognition and behavior of therapists over and over again -- even when they have years of experience. It is the differentiation that Chris Argyris makes between espoused theory and theory-in-use.

Given how time consuming it is to write a good manual, I wonder if the energy isn't best devoted to following the behavioral track. I know it is a lot more expensive and might require smaller numbers to keep the budget in line, but I think it is ultimately a much surer way of testing efficacy.

Steve Rollnick wrote:
Dear Richard, Vaughn and others,

Sorry I have not taken up this topic which so many of us are interested in. Here is a response to the notes from Richard and Vaughn below. Who knows if this is worth discussing further. Let Richard decide.

Because misconceptions can arise about some quite basic points, at the risk of stating the obvious, what about a few simple observations to start with:

WHAT IS MI?
It's a counseling style, and a range of derivatives like MET has been developed.

WHAT IS BRIEF MI?
It is not a "technique". In the language of medical settings, in which Rich wants to work, brief MI is like a set of communication skills for dealing with the challenges of decision-making and behavior change. Like the breaking of bad news to patients, one does not use this or that technique, but particular kinds of communication skills.

IS MI EFFECTIVE?
The counseling style? There's some evidence for this. The derivatives? Yes and no. The field is still in it infancy. My suspicion is that carefully conducted studies will produce better results.

USE OF EVIDENCE
Why are we not much more skeptical about the evidence? Lack of skepticism can lead to wooly, wishful thinking: overstating the effectiveness of MI; using any positive evidence of a derivative as evidence that the counseling style is effective, and vice versa; failure to realise that in most fields, research moves away from the BIG QUESTION (Does it work?) towards asking, what form of treatment, under what

conditions, with what subjects... is effective? Of all people who might assess the evidence, we should be the most skeptical! We are not salespeople for MI.

EFFICACY & EFFECTIVENESS

I worry about how this distinction is used. Your use of it conforms to the action-oriented approach I so often come across among medics interested in MI. Chris Butler, my dear friend with whom I have done a study of brief MI among smokers in primary care, used the same logic when we first started our work: Steve, he said, you say that this MI thing works in other settings, let's do an effectiveness study in primary care. He wanted to skip over the efficacy stage. Just give me the method on one page, he said. What we ended up doing was developmental work on the derivative of MI (two days with smokers themselves, then 5-10 hours of discussion and writing up the single page), followed by the training of practitioners. A few hours. No audio or video. Then we set the practitioners free, and found a small but significant effect (paper in press). Looking back, we were lucky to find an effect.

To return to the efficacy/effectiveness distinction, my perception is that this entire controlled trial was an efficacy study (limited by poor training & lack of audio evidence). We were looking at how a brief derivative of MI might work in primary care, and what its key elements were. We used volunteer practitioners. We interviewed practitioners and patients about their experiences. Now, having found an effect, and having developed a method of which I am truly proud, we could go on to an effectiveness study, i.e. seeing how the method works in a much wider setting with non-volunteers in everyday practice. So that's a different use of the efficacy/effectiveness distinction.

THE WAY AHEAD

Vaughn has suggested that you focus on demonstrating skill acquisition among practitioners, using audio/video, before you examine behavior change among patients. He wants you to take the training of practitioners seriously. If you do, then you can have confidence that you are evaluating a derivative of MI (a set of communication skills). This is the point I think you should specifically answer. I agree with Vaughn completely. I suspect that you will feel impatient about this, because it implies looking at efficacy in some form before effectiveness. Are you jumping too far ahead, trying to get the big question answered prematurely? You will probably not want to use audio/video evidence, because you will presumably have limited training time? Will you run the risk of not knowing whether the communication skills for talking about decision-making and change were ever used?

TO RE-INVENT MI EVERY TIME WOULD NOT MAKE IT VERY GENERALIZEABLE

This comment of yours hit me between the eyes, because I realise that this is to some extent what I am suggesting, i.e. that you ensure that your method is sensitive to context by doing developmental work before you train practitioners. But surely, Rich, if you were going to evaluate breaking bad news in an HIV clinic, for example, what would you do? Wouldn't you listen carefully to what the practitioners/patients say about the context; look at the literature on breaking bad news; construct a "method", perhaps a single-page guide for practitioners which takes into account the particular demands of the context? What's the difference when it comes to derivatives of MI?

Rich, don't feel you need to respond. I am off to Cape Town and a trip into the singing African bush. I'll be back in mid-April.

Richard Saitz wrote:
Steve, I'm glad you are back and hope you enjoyed Cape Town.

Reviewing the discussion, there had been an active exchange of 12 messages about brief MI, in which Steve, others and I raised questions and discussed the issue. The last message was from Steve and said he would be away until mid April (I actually saved it in my "inbox" anticipating the discussion would resume upon his return. So, the discussion ended there (temporarily).

I thought it was a very useful exchange about brief MI by many Listserve participants. I'm not sure when it is "OK" to have a 'last' email about a subject. It seems that some feel the discussion was unfinished and I'm happy to continue it further.

If you are all game, I'll take a stab at continuing the discussion:

Steve's last post from 3/19 appears at the end of this message so as to remind participants of the context of the discussion.

The discussion started when I asked MINTies about research on MI and its effectiveness, especially brief MI, and whether there was a "manual."

To use Steve's observation categories in quotes as a jumping off point...

"What is MI?" It IS a counseling style. I think we know it when we do it or see it. But when designing research on MI, I next consider how we can demonstrate to others that MI was done? I think Bill and others have been working to measure this. The MET manual is one way of setting stricter bounds on exactly how the counseling is done in one setting. I think this is important (just as important as specifying drug and dose in a study of a pharmaceutical). Whether one can take a manual off the shelf and apply it in one's (new, different) situation is another question...

"What is brief MI?" A "technique" or a "set of communication skills" seems a reasonable way to describe it. I may be missing the essence of the objection to the word "technique" but I don't object to the objection. I think brief MI is using the strategies of MI in a shorter time period. In studying it, since a manual or book did not exist I wondered how best to go about this. It may be that it needs to be developed with patients and practitioners in the situation of interest, before studying it.

"Is MI effective?" As Chris or David mentioned, the way we know whether it is or isn't, seems to be from studies that outlined exactly what they did (i.e. using MET) or included some key component of MI (empathy for example). To do carefully conducted studies on this will require that researchers be able to specify exactly what they did and then we can all decide whether it was MI or had enough MI-ness in it to qualify as a test of MI. Actually, as a somewhat random thought, I wonder if patients and interventionists should have a role in reporting whether MI was done (in addition to monitoring "fidelity" by "experts" reviewing videotapes)? [probably they should...]

"Use of evidence." I wholeheartedly agree that we should be skeptical and we should be in the forefront of testing MI.

"Efficacy and effectiveness." Efficacy is "does it work?" and effectiveness is "does what worked there work here?' "We" (MINTies) are already proposing the uses of MI in many diverse settings. But the evidence isn't in yet. Steve, I agree with you 100% that taking a brief version of MI into a medical setting really is doing an efficacy and not an effectiveness study (unless the test of the method has been done for that diagnosis, in that setting). An example of an effectiveness study would be taking MET from Project MATCH and testing it for relapse prevention after initial treatment in diverse populations that would have been excluded from that project, perhaps with counselors who are trained and employed in real world settings.

I may have confused the discussion because I am interested in the effectiveness of brief methods for health behavior change in medical settings, which might include MI and/or some of its components as well as other skills and content. Brief interventions have proven efficacy for some diagnoses in some settings and we know what some of the efficacious components are. Calling it brief MI may be going too far.

"The way ahead." Vaughn suggested focusing on training practitioners first, then testing efficacy, and then effectiveness. I think this is an important step. But there may be two levels here. One is can physicians be taught to do motivational interviewing? Another is can MI taught to physicians result in improved patient outcomes? A single study might answer both or just one of these questions.

"Reinventing MI every time would not make it very generalizable." As I review the discussion on the Listserve, I think perhaps I've learned that MI may not be ready to be generalized to all health care settings just yet (or at least the evidence of efficacy in medical settings is not quite there yet). And maybe it should be re-invented for each new application and setting. Of course, the teaching and application of MI that I have seen at MINT meetings and on this Listserve, seems to be going way beyond the current evidence. Perhaps that is OK (that's a challenge to all of us!). The counseling style feels right, and certainly better than confrontational alternatives. And there is evidence for efficacy of its components as pieces of brief interventions for alcohol problems, for example. And I wonder how much more developmental work need be done on designing brief MI for alcohol problems? Certainly pilot work in new settings should be done before effectiveness studies but I'm not so sure how interesting it would be to find/report that brief counseling using MI principles in medical settings is efficacious for decreasing alcohol use, since there are many studies suggesting this is the case. So perhaps in some settings it will be OK to go ahead with study of effectiveness [i.e. brief MI for alcohol problems in primary care], (where there is already evidence of efficacy of brief intervention). But maybe it best not be called brief MI. Maybe it should be "brief intervention" using the MI counseling style as a component or style of an intervention.

As we teach MI to many learners, they are going back to the real world outside of research settings and doing it, for many health behaviors, in real practice (including medical settings). I wonder if what they are doing is effective? (I have some fears about this as there are many classic examples in medicine of interventions that appear to have efficacy, later proven to actually be harmful, or just not effective in real life practice--I hope and don't think that to be the case for MI, but the challenge is to prove both efficacy and effectiveness).

I'll leave it there for now and see if this is the end of the discussion, or if I've reflected and summarized enough to stimulate further discussion. That's it for now.

Zambia 2

Angelica Thevos

7 July 1999

Early this morning I arrived at the Tropical Diseases Research Center and met the behavioral scientist (Dr. Kaona) and the social worker (Mrs. Mary Siajunza) that I will be working with most closely. I was obviously happy to discover that one of the key people on the project is a social worker, schooled in the capital, Lusaka. They are both delightful in their own ways. Dr. K has a keen sense of humor. Mary is caring and quiet, with stylized hair and an obvious commitment to the people of her country. The TDRC is located within the Ndola Central Hospital, a place with broken windows, inoperable elevators ("lifts") and wall-paintings (advertisements like billboards) on the outside wall for…. Funeral services! There was an article in the newspaper today about a primary school teacher who died of cerebral malaria because she could not afford the Kw 4,000 ($1.60) to buy a health card to get treatment. The story was critical of the economy and made a plea to do away with the necessity of health cards for treatment eligibility.

I spent over 45 minutes today with the TDRC vehicle driver looking for a gas station that had fuel. There is a severe gas shortage here, particularly for diesel. We gave up and returned to the TDRC just in time before we had to walk. Later in the afternoon, on the way to the compound to pretest the baseline survey, we finally found one station with fuel to sell, and paid 210,000 kwacha (over $80) to fill both tanks of the Land Cruiser. This should get us through the weekend and partial completion of the baseline survey.

Oh, boy. The compounds. We went to pretest the questionnaire at a compound similar to the ones where I will be conducting the studies. They seem to be much poorer than those I worked in last year, although I did not think that was even possible before today. There are no individual shallow wells to obtain water. People walk long distances to bring water back to their huts from central community tap locations with hand pumps. For effective use of chlorine, the water containers must have lids. But I did not see a lid in sight. People are using open buckets, pails, or containers without lids. Children as young as 3 are seen carrying pails of water on their heads. The children obviously have worms (swollen bellies) and respiratory infections (coughs and excretions). In the compounds last year, almost all had individual shallow wells and latrines for their households. Here, as many as ten huts share a latrine and, as I said, they use a communal tap for water. One of the women we interviewed gave the following information: she had 6 surviving children, one 3 year old had died. She had only 1 bed and 2 chairs as furniture (one she offered to me, the other to the interviewer) while she sat on some discarded plastic. There were 2 bedrooms. She did not feel that her water was unsafe and believed that cholera and diarrhea could be prevented by clean air and bedding. This is what I am up against. Motivational Interviewing has some test in these circumstances!

The pretest was very helpful. I will spend the rest of tonight reviewing it and making adjustments based on the experience of today. It needs to be reordered and reworded in many instances.

So, here I go.

9 July

The work here has intensified, as expected. After a no-show yesterday, the woman assigned to the "Clorin" social marketing effort, Mercy Chilangwa, finally got here. Her problem yesterday was that she could not get any fuel. We need her because she has information on the sales rates of Clorin over the last two months. The product was rushed here due to a cholera outbreak in March. I need to have those data so I can compare sale rates pre and post intervention for those particular areas.

Mercy also brought maps of the compounds where the studies will be done. These are essential to randomizing the households within the designated study zones. Two of the maps seemed OK at first sight: the ones for Chipulukusu (the control community where we will be studying the effect of social marketing alone) and Kawama (the Neighborhood Health Committee member study community which will try to replicate the positive findings of last year). The one for Nkwazi (the Opinion Leaders study community) was dark, smudged, and completely unreadable. On closer inspection, I noticed that Kawama's map was dated January 1974 (!) but there was general agreement that it seemed to be relatively accurate and useable just the same, and that perhaps the cartographer neglected to change the date. That was hard for me to believe, even for this country. The demographics in the compounds are constantly changing, so even maps done one year ago are probably no longer correct. However, Mercy explained that these were the ones recently used by City Council to track the cholera outbreaks so I gained some confidence in them. There was a lengthy, very Zambian, deliberative process on whether to use these maps or send a team out to start over again. It was finally decided that we could start with what we had and rely on the survey workers (there are four of them) to amend them while in the field. This seemed to be the best solution both in terms of preserving the per diem resources of the field workers for the actual survey work, but also to avoid even more delays on my already uncomfortably short timetable. We must complete 300 baseline surveys (100 in each compound) before starting the intervention. MI training of the social scientists and NHCs may have to overlap with the last days of completing the survey. But I want to accompany the survey workers in the field for at least 2 days to assure that the data is being collected properly.

My Tropical Diseases Research Centre (TDRC) colleagues left this afternoon for Lusaka to present the results of a 4 year study just completed on HIV and sex workers in Ndola (the city where we are). As they were putting the finishing touches on their talks I was briefed on their shocking and tragic findings. The HIV rate among these women is a staggering 67%! While we were in the field yesterday, a few women shouted out greetings to Mary (the social worker I am working with). She told me today that those women were the only survivors left of the study participants in the compound. There were four of them. Out of an original 15. Another jolt came when she told me that the women are paid as little as 500 kwacha for one encounter. That is less than 20 cents. The average payment is 5,000 - 10,000 kwacha, or $2-4. These women sacrifice their lives for that. Mary proceeded to explain that legitimate jobs, like waitressing or market selling (if they have any vegetables or product to sell), yielded the study participants less than $10 a month. They have little education and no skills so they must turn to sex work in order to feed their children. Many are widows. Others are very young and resort to sex work because their parents can not afford to pay what is needed to send them to school. Sometimes they live with single mothers who are themselves sex workers.

Their numbers are increasing rather than decreasing because the economy is abysmal. There are no jobs. Times are even more hard here than last year. When I asked about programs to teach trades (anybody reminded of Jane Addams and her settlement houses?) or the availability of low interest loans for microenterprise or cooperative work group development, Mary said that this is difficult to establish because there is no market to sell whatever goods are produced. The cycle of poverty is daunting.

One of the good things about the research (here as well as in the US) is that funds were included in the study budget to provide free treatment of STDs when they were identified in the interviews. This was very valuable to the women, many of whom were continuing to work with ongoing pain from chronic disease. There was no way they could receive treatment without participating in the study. Towards the end of the project, it ran out of money in part because of the treatment costs incurred. Mary, who certainly is poor herself, gave up her pay associated with the study work so that they could continue to provide treatment at the Clinic for the women. A touching example of what Zambians do for each other, in the face of having nothing themselves.

Despite the map negotiations, we had a productive day together. I demonstrated the chlorine sampling technique. They were all dismayed that there is NO chlorine in Central Hospital's water supply; jokes ensued about the Council going on strike as the reason, how patients IN the hospital would be sicker than those out, etc. The field workers, on their own initiative, took a few sampling kits to practice before the start of the study.

I also led a review of the survey, question by question, with explanations and discussion of the intent of each. I had to spend time doing this since one, and maybe two, of the workers were weak (based on my review of the survey responses produced from the pretest yesterday). The other two are very good. I was careful to ask for their suggestions first, and some of them were excellent. So, happily, the final product will be a group effort.

The last section of the questionnaire is reserved for the interviewer to fill in observational items that require going into the house (to check for the presence of soap, how food is stored, the general cleanliness of the place, etc.). Dr. Kaona was uncomfortable with this yesterday. During the meeting where I was going over the instrument, I offered him the opportunity to discuss his concerns about these questions and that was a great thing to do. It was interesting how it played out with a couple of the field workers advocating for keeping it and others not. I like that Dr. Kaona is very concerned about respecting the respondents. He emphasized this often and in a good way. I was back in my element since facilitating the discussion was such a parallel process to doing psychotherapy groups and was a exquisite chance to model MI. Everyone had their say and I reflected and summarized. In the end all agreed that personal judgement would determine how each individual interaction would be handled. If the survey worker senses uneasiness in the respondent, he or she should be sensitive to this and the "home visit" will be waived. I think everyone realized that this will be a rare occurrence but it was important to those with reservations to voice them, be heard, and acknowledged. Not a lot of brainpower for that one -- but the process was infinitely more important than the content. As is so often the case.

I am coming to appreciate this group and we are getting comfortable with each other. The Zambian humor, wit, language phrasing, and interpersonal style are really

enchanting, although admittedly much still gets by me. There is a feeling of mutuality and cooperation, which is very nice. I will feel even better once I get the randomization tasks near to being finalized. And I still have the budget and payment issues to work out.

While my TDRC colleagues are gone, I am going to rework my study questionnaire myself in order to help get back on track, timewise. I will meet them and the field workers on Saturday at 3:00. They are going to come directly to the hospital as soon as they arrive back in town. Sometime during this morning, I realized that two secretaries appeared to be working on the time consuming task of translating the survey into Bemba, so I asked Dr. Kaona why they were bothering and he stopped and wondered why too. The pretest was all done with an English version of the instrument and went just fine. The brakes were put on further work to the Bemba edition.

11 July

We have been blessed again? This time by missing an armed robbery in the Pamodzi hotel where we usually stay when in Lusaka. It is the nicest hotel in the capital. And we were there only last week. In the paper today, it was reported that yesterday afternoon "bandits" armed with AK47s ambushed the cashier at the front door as he was returning from the bank. They stole 70,000,000 Zambian kwacha which is about $29,000. The money was to be used to pay the workers at the hotel and I can't help thinking that they will never get paid what they are owed. In the story it was reported that the hotel security guard desired to remain anonymous….

We went back to Kitwe today to visit old friends from the study last year. What a bittersweet experience! The roads have not been repaired and the effect of the heavy rains in the rainy season as well as the wear and tear after almost a year and a half, are obvious. We never thought the roads could deteriorate any more than they were but they certainly have. Even if travelling at only a crawl, the car and its occupants toss and jolt along the way. Socioeconomically it is a mess too (but that is not exclusive to distressed Kitwe). Riots occurred the day before because of housing disputes and evictions involving workers at the mines. There was no water in the main part of the city for a few days a week or so ago because of a strike at the water plant.

Many of those we wanted to see in Kitwe were not there. Since no one has a phone, it is impossible to plan for visits. One just takes their chances. Our first stop was Luangwa where I did the second, very positive, study last year. Violet, the nurse responsible for supervising the project after I left, was not there and that was a real disappointment to me. While there, I picked up the Motivational Interviewing videotapes I had left so I could try to use them for the studies coming up now. Catherine, the nurse-in-charge, was there and she did the "ooo's and ahhh's" when she saw me again. She said that chlorine sales were still good and consequently diarrhea was under control more or less; malaria was still rampant. Saw my first Clorin wall painting outside the Luangwa Clinic. Beautiful!

We then went on to Ipusukilo (where we did the first study last year) and we immediately found Joyce, a nurse whom I worked very closely with. When we met, we hugged for a long time and we both shed some tears at reuniting. Joyce is in deep grief due to having lost her 9-year-old daughter in a minibus accident only 6 months ago. Her emotional anguish was palpable. Another nurse I very much wanted to see was Royce, but Joyce said she was on leave. Between Joyce and the driver, we put together where she was

now living and we found it. She was so happy and surprised, exclaiming that it was like we "dropped out of heaven". But I was concerned at how she looked and when I asked how she was, she related being sick for over the past month. She took a 2-week leave because she is very short of breath and weak. She attributes her symptoms to "heart problems" and thought that she would do well with a lot of rest. Thoughts of echocardiograms and stress tests popped into my mind and I began to ask about tests, medicine, etc (a true Westerner, I am). She said she was taking herbs from a Chinese traditional healer because she could not be seen at the hospital. How can it be that Royce, a clinic nurse for goodness sakes, can not get prompt doctor appointments? She thought the herbs were helping her however, which is great. Her husband has been gone since last August, studying for his Ph.D. in China. She will not see him again for another year at least. As I left, I encouraged her to continue the herbs AND to stay on the wait list to be seen at the hospital. She can not even walk the length of her side street so walking to work is impossible. She is such a dear person; I am very worried about her now. One other nurse was also on leave: at her brother's funeral, the second that had died in the last month. So, the visit to Kitwe was disturbing in many ways and touching in others. Just like Zambia.

I have diligently been working on the survey. Kaona et al. met me as soon as they returned from Lusaka this afternoon and we went through it again, with good suggestions. I managed to get the instrument down to 8 pages and we are going to try to have the field workers fill it out 2 sided so I only have to take 1200 completed ones as carryon baggage when I return (!). Since we can not get copies made on a Sunday, I am using my printer to get enough done so we can work tomorrow. This requires lots of manual intervention: printing 4 odd numbered pages, waiting, turning the paper over, and printing the even pages, one form at a time. This is necessary because tomorrow morning we head out to Kawama to start administering the real thing. I am glad I thought to buy a ream of paper on Friday. Again, I honor how hard some of these Zambians work. They will not have off at all this weekend, and Mary says weekends off are rare.

I have been inquiring a lot about the 3 compounds where we are to work. They seem to be qualitatively different, but that is hard to measure or describe. It sounds like the compound where we are doing the Opinion Leaders study (Nkwazi) may be worse off than the other two. Not great for study comparisons to say the least. The workers at the GuestHouse and the drivers at TDRC live in Nkwazi; they all think their water is fine since it comes "from underground". When I asked Mary about the general level of concern for water, she said the only thing the residents are concerned about is the distance they must walk to get it, not the quality. Lots of "precontemplators" here, which may mean a slow response, if any. And more need for skillful MI change agents.

Looks like training will not begin until Tuesday, but we are still roughly on schedule….

13 July

There is now a critical shortage of medicines in stock at the Ndola Central Hospital. INPATIENTS are handed prescriptions and family members have to go to the local "chemist" (pharmacy) and hope to fill it, if they have the money and if the chemist by some good fortune happens to have it. In some cases, inpatients are getting up out of their hospital beds in order to go and try to purchase their needed medications. Sadly, I am informed that this is not unusual for developing countries. The TDRC does not have

the reagents needed to perform necessary tests on patients coming in need. TDRC is out of basic office supplies too, like paper, pens, and staples. I think it must be so much worse to know what you could do but do not have the resources, than to not even know that resources exist.

We are a little off the study schedule. The baseline survey in the first community is only half completed. I will start Motivational Interviewing training tomorrow, Wednesday, and go through Friday. Depending on the progress of the group, I may do an additional day on Monday. If it is not enough that I am challenging myself by doing any of this in the first place, now I am faced with a harder task. My research proposal specifies TEN Neighborhood Health Committee Members (the local health workers who I am trying to train in the rudiments of MI). However, this number was somehow overlooked and instead, TDRC has included TWENTY. I told them that one trainer for 23 people is a formidable task and not recommended. But they are emphatic that "un-inviting" them is impossible. So, a sole trainer with 23 expectant faces will be immersed in MI training tomorrow --- in English AND Bemba. Mary keeps telling me, "Don't worry, we weel manage". Oh, boy.

I have met some of the NHCs, and slowly, they are warming up to me. I hope I can make the training enjoyable as well as instructive. Some of the toys I brought for mid-training breaks (to double as gifts for the participants' children) will not be enough now, since I was counting on half the number and ordered one dozen of things. As is the norm here, I am regrouping again. I decided that I will give the stuff that only comes in quantities of 12 to the survey workers, a chosen few of the NHCs who have taken us around the compound neighborhoods, and the Guest House staff. Hopefully the remainder of the toys, which I brought for training breaks (balls, propeller toys, matchbox cars, etc.), will stretch far enough.

We are still killing mosquitoes by the scores...but to date have only suffered from colds. No diarrhea and no other weird symptoms. So far, so good.

15 July

MI training has begun. Yesterday was the first day and it was typical for most African first-things. After many delays, we ended up in Kawama and, instead of having a room at the Health Clinic as I had expected, the NHCs had spent the previous afternoon preparing Mrs. Esther Sakama's YARD for the training! It was all swept, 2 chairs with embroidered coverings were in place for Mary and me beside a long hedge, and places (mostly stones, a couple of stools, and a few cinder blocks) were set for the 20 women all around (in the zone in which we are working, all the Neighborhood Health Committee Members are women). It was all nice and neat and it was obvious that they had spent time and care in preparing it.

As I was sizing up this unexpected situation, Kaona stepped in. He looked at me and said "This is not an appropriate training place!" then quickly shifted into Bemba and proceeded to somehow tell the women just that, without them getting too hurt or angry. A tribute to his charm and guile.

I gathered from his discussion with them that there were no other suitable places around either (churches, etc), especially since no prior arrangements had been made with any

of them. "Plan B": Kaona decides to take everyone back to the TDRC. We all pile in the Land Cruiser but it would take two trips to fit everyone so off I go with the first batch. We arrive and walk 7 floors up to the BoardRoom, a big room with a huge table with chairs all around it. Not ideal but better than Mrs. Sakala's yard. There was an easel so I could use the flip chart pad that I bought. We did the name exchange thing, signed everybody in and started. As I review the list, I notice that we have picked up another person. There are suddenly 21 now. I ask about that and it is determined that another person decided to slip into the Land Cruiser the second trip. But she was only an NHC trainee so they ejected her from the room! She was whisked away by Shepherd to be driven back to Kawama. OK, so I try to start again. Then Mary interrupts and says "We have a problem". What is that? That baby over there is sick. It takes another couple of minutes for me to suggest that the Mom and sick child accompany the poor rejected trainee back home. And then it is too late! Luckily, Shepherd forgot something so when he returned to the room we arranged for him to take the ailing baby and disappointed mother with him too.

A rather untraditional beginning to MI training.

Very early in the morning, I checked Email, my blessed connection to remote home. Waiting for me was a helpful message, along with two attachments, from a Seattle colleague and friend, Dave Rosengren. He made quite a few useful suggestions to ease my fears about doing a large training under these circumstances. So, even though I had anxiety about it (what else is new?), I decided to change strategies and start the training using one of his recommendations.

Briefly, I asked people to talk about a problem they really struggled with but were ultimately able to solve. As David suggested, it allows people to talk about their successes while also learning and sharing about what has worked for them. The cultural gulf between our worlds was once again revealed to me. These are some of their examples: a widow shared that she has two bright daughters but since her husband died, she could no longer afford tuition for them to attend school (18,000 kwacha per year or $7.50). She worried about this until she decided to ask the Headmaster for help, who offered to write a letter to the Zambian Widows Association on behalf of the two girls. They gave her a grant for this year, for which she is grateful. She will worry about next year when it comes. The next example to be offered was from another woman who has 3 children. Her sister, who was also a widow, died recently. She took her sister's children in her home, for a total of 6 children. Now her husband has also died leaving her a widow with 6 children (AIDS has ravaged Africa). She had no money but thought of a good friend whom she had helped in the past and went to her for help. The friend lent her money to start a small business (selling small amounts of essentials from a stand in front of her home, a common occupation). That Zambian Widows Association must be a gigantic organization. Another example was a little more familiar, about a husband who drank too much, was counseled in a supportive way by the church board, and after this and realizing how worried his wife was, has cut down. I was amazed at how self-disclosing this was for the very beginning of the training. Then I considered two different thoughts: that people living in compound communities probably have few secrets from each other and/or that perhaps alcohol abuse is not as great a stigma here.

At the end of the day I was exhausted and not able to judge how much the women grasped. The sheer number of participants was unwieldy. And the room was far from intimate. It was harder than I thought it would be to connect with them in the way I am

used to. I had alternative strategies in mind if Day 2 did not go better (split the group and run two consecutive trainings, change the room if possible, lengthen the number of training days, etc. There must always be a "Plan B" in Africa).

A wild thing happened as we walked down the steps of the Ndola Central Hospital (where TDRC is located). Suddenly Elizabeth starts to screech, shake with body tremors, and collapse -- all of her belongings spilling down the stairs. I was behind her and thought she was having a seizure. Yet the woman attending her were not as upset as I thought they should be if that was the case. Elizabeth could not be consoled. She tried to stand and continue but could not. A doctor came and brought a drink of water in a dirty cup (awful looking) and vigorously rubbed her back. It took about 10 minutes before she could continue, visibly upset and shaken. The cause, as I was finally told, was that Elizabeth had seen a corpse wheeled by on a gurney. The death demons had gotten hold of her. It runs in her family. Her people can not be anywhere near dead people without going into fits. Wow. I wondered if she had ever even been in a hospital.

Today was the second day of training. I was to be "picked" at 8:00 this morning. They did not come until after 9:30. We proceeded directly to Kawama community and it was apparent that Kaona did some fancy footwork all yesterday afternoon and secured a spot at the Health Clinic for the training. It is an open-air area at the front of a building which is currently under construction (the noise level at times is problematic and we must shout to be heard, but it is short lived and widely spaced). When completed, this building will be used as a birthing center.

Training was better today; I was not nearly as tired when I got back tonight. That enormous table was gone. And it is indispensable to be located within the NHCs own community. We lost one other NHC (attending a funeral) so that brings us down to 18. We did more practice and they have a ways to go but some are coming along. Towards the end of the day, when it came time to integrate the concepts presented, we made some progress. Tomorrow, if all goes well, should bring things together more, hopefully. This still leaves open the eternal question of if they will really apply MI in vivo. I still think I may use Monday to give them all one more boost before releasing them into the community. I'll see how it goes on Day 3.

Interestingly, today I got more resistance from Mary than from the others. It reminded me that the more education you have, the more entrenched you become. I had to patiently explain (trying to avoid defending) reflective listening as she insisted that, in Bemba, one simply must ask questions. It took awhile and she finally grasped what I was trying to do. Shepherd actually helped in this regard. I offered that using reflective listening is not easy and there is strong temptation to ask questions instead. I am struck at how this is even more pronounced with seasoned counselors and clinicians. So there I was, getting resistance from my ally, Mary the social worker! I stuck with her and modeled reflective listening and affirmed how hard this is and we forged ahead with examples, which luckily perfectly illustrated what I was trying to get across: that you get more information that is client-centered when you use reflective listening statements. They role-plays made my point for me. The "cultural Bemba problem" was lifted and she came around. Although it is true that the subtleties in the Bemba language are even greater, and everything could sound like a question since it is so melodious. However, it was also understood that a statement is a statement and a question is a question no matter what the language.

When it came time to role-play a typical encounter with a neighborhood resident, I could see that those playing the resident were falling into the typical trap and habit of being impossible (it is called playing "the client from hell"). So I intervened and suggested that they be easy on the ones playing the NHC, as this will be the most likely scenario. Mary objected saying that this will be good for them, because if they can master this kind of person, they can master someone easier. It was almost the end of the day, and they were having a good time, laughing and whooping it up. So I let it go and made a joke that Mary was a tough teacher. In the car afterwards, I tried again, suggesting to her that tomorrow it may be helpful to try the same exercise with someone "easy" so that the NHCs can experience some success and build self efficacy (a concept covered in training). Yes! She got it and understood. Gentle and patient, using MI, I am making my way with her.

As I may have mentioned, I bring toys as gifts to the participants (their children ultimately) to liven up breaks. Yesterday it was spinning tops. Today, plastic propellers. These are always a huge hit. I can not convey to you that there is not ONE toy in sight in these compounds. Children just sit and sit for hours on their mother's or sister's or brother's laps. As they get older they may run around but still no toy (except for an occasional ball made of string-wrapped plastic bags). I gave the survey workers and the NHC members who helped in the community special multi-ink colored pens. Tomorrow is "ball" day and maybe Polaroids if it is the last day of training.

One more note: after training I got a chance to go to Nkwazi community, where the opinion leaders study will be conducted. Most of the houses do not seem to be numbered and, if they are, they are not consecutive. It took us a long time to locate the survey team. They came to the Land Cruiser looking more spent than usual, having to map everything anew (we have no maps for Nkawsi and I can certainly see why). Plus the zone is very large. The households are clustered closely together, very densely. The roads twist and turn. And there are several taverns. Poor Mary and Shepherd. They are to do the intervention here and have their work cut out for them. This one is truly a shanty compound. It is clearly worse off than Kawama, again making comparisons between the communities more difficult. But this is real world research (the developing world no less) so you do the best you can with what you've got. I hear that Chipulukusu (the social marketing control community) has a blend of Nkwasi type areas and Kawama-type ones. I hope to visit there soon.

19 July

Well, MI training is now completed. What will be, will be. The women gave a valiant effort. Many tried very hard, offering to role play in front of the whole group (which seemed to work better than breaking into smaller groups since we could all participate in learning together and I could follow just one "group" at a time). I was impressed with their stamina and persistence. But, as would be expected in a group this large (the final number of NHCs remained at 18 ? a huge group to train with one trainer in need of translation!), a few were better than most. Mary and I selected the 6 better ones and gave them 1or 2 houses more each than the remainder. We will track and evaluate their effectiveness with their households separately

On Friday, which was supposed to be the last training day, it was obvious that a lot more work was needed. Extensive information was required simply on the factual foundation

of what causes cholera and diarrhea. So I enlisted a nurse from the Health Clinic to review the causes, signs, symptoms and treatment of waterborne diseases and emphasize the role of contaminated water. She did a great job. Thank goodness I thought to bring one sample of the educational "brochure" that Tony had drawn last year for our study in Kitwe. The nurse covered it in her talk and I gave a copy to each NHC. Now they, in turn, can use them to educate their neighbors on how water contamination occurs and how it contributes to the cause of cholera and diarrhea.

After this, we proceeded to more role-play. But we got stuck on what I have called "A General Method of Beginning with Someone". They were lost on the very basics. Their role play and exercise performance was acceptable on the more abstract concepts (open ended questions, affirmations, and the beginnings reflective listening) but when it came to putting it all together and doing a fundamental introduction, they got all confused. This unsettled me for a bit. After a while, I decided to just "start where the client is" and went back to practicing the way to begin with someone. We went over it step by step and wrote the instructions on the flip chart in Bemba. At that point there was no question that a full day on Monday would be needed.

In the meantime, I asked Shepherd to translate more of the essentials into Bemba. That night, I typed those, as well as all of the notes from the nurse and the disease rates from the Kawama community, onto a handout.

So, Friday it was back to basics in training. And I spent the subsequent days of the weekend preparing the handouts I thought were needed (for example anything I had in Bemba which included the introduction and the stages of change, the notes from the nurse on cholera and diarrhea, and the specific disease rates from Kawama community to use in feedback) and planning the training for Monday. I also needed to randomize the houses to each NHC over the weekend, and John-Anthony helped me do that on Sunday night by picking the house numbers out of a bowl. He enjoyed the task as well as playing a helpful role.

So all was prepared for today’s training. We continued with role-plays and, once again, all participants were stalwart in their willingness to keep trying. A true attribute of Zambians. Today’s end-of-training "gifts" included a certificate of completion on special paper with each NHC’s name prominently printed on it, 2 matchbox cars each, a Medical University Institute of Psychiatry pen, and… an instant Polaroid picture for every participant. Predictably, they LOVED all my offerings but the certificates and the Polaroids were fabulously popular. Screeches of excitement and appreciation were everywhere. How reinforcing for me!

In the end, I did not succeed in covering as much of the imaginative techniques that have been evolving in MI lately, as I would have liked. I had big plans to cover quite a few of these. In the end, all I managed were the rudiments of FRAMES, OARS, and stage-based interventions (my apologies for using acronyms to those on the recipient list for my Emails who are not familiar with MI theory or practice). It is yet to be seen how much they have integrated and will use them, however.

Mary, Shepherd, and I have arranged to go in the field with every single NHC for 2 hours each over the next three days that I have remaining here. As always, the time allotted is simply not enough! I could use at least another week (or two, or three, or….). I am leaving the study in capable hands, though, which is a comfort to me.

Now on to the real test of the training: whether we can succeed in enhancing health behavior change. Ken will get me at 8:00 tomorrow to start field supervision with the NHC's (by the way, he WALKS two and a half hours ONE WAY to work each day! He has to leave his hut at 5 to start duty as a driver at 7:30. Do I hear anyone complaining about American work schedules?