Motivational Interviewing Newsletter: Updates, Education and Training

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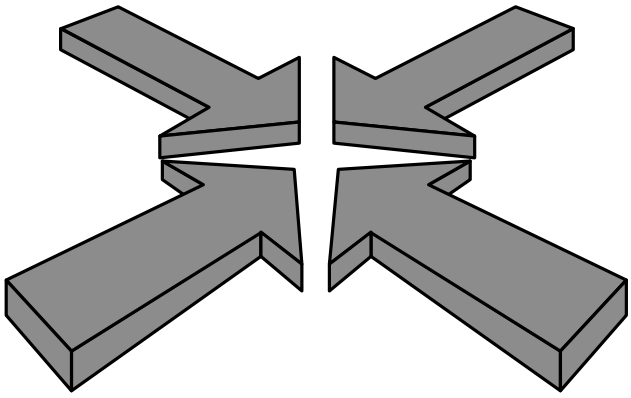
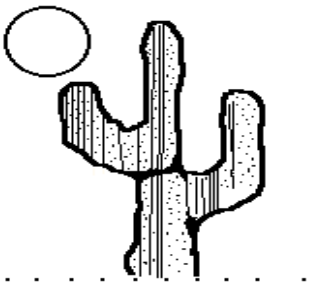


New Perspectives



Notes From the Desert

Bill Miller

First, I want to join the chorus of voices thanking Dave Rosengren for his faithful service as editor of our newsletter, and to welcome and thank Denise Ernst who assumes the editorship with this issue. This continues to be an important link among MINT trainers, who as of the Tarragona meeting number over 300.

Upcoming Meetings. The next MINT meeting will be held July 5-8, 2000, in Quebec City. We will announce the details on the website (remember the new address: *www.motivationalinterview.org*.) as soon as they are finalized. Meanwhile, the ninth International Conference on Treatment of Addictive Behaviors (ICTAB-9) is set for Cape Town, South Africa, September 21-25, 2000. We will have the conference brochure available in January, including a call for papers by May 1. Evaluating Training. At CASAA we will soon be launching a NIDA-funded study of the effectiveness of training in motivational interviewing. This will allow us to provide free training to health professionals (one per site) who treat substance use disorders, if they are willing to travel to Albuquerque for training and participate in pre- and post-training evaluations. My Co-Investigators on this project are Drs. Carolina Yahne and Terri Moyers. We will post details on the website as soon as we are ready to accept applicants. You will be welcome to refer individuals for free Level 1 training in motivational interviewing.

MISC Coding. We continue to refine the three-level Motivational Interviewing Skill Code, which we will soon make available through the website. We now have target proficiency levels for training on several of the summary codes, as well as expert coding of segments from the training tapes that can be useful in training coders. It will be fun to continue to add to our library of expert-coded interviews. We are clearly discriminating pre-training from post-training tapes (coded blind), as well as demonstration interviews for different styles of therapy. If there are sites, studies, or trainers for whom it is not cost-effective to train up and maintain coders, CASAA is prepared to provide expert coding of audio or videotapes on a fee-for-service basis.

Holistic Herding. It's not just for horses anymore. According to a front-page story in the October 22 (1999) *Wall Street Journal*, the latest in cattle care

is "holistic herding," a respectful approach which coaxes rather than coerces cattle, and makes them WANT to mosey along. The article claims that cows treated in this way are less stressed, gain roughly a pound a day more than those treated rudely, and are not as hard on the environment. (Didn't Delia Smith find that one LOSES weight with motivational interviewing?) Of course, some "real" cowboys don't buy this kinder and gentler approach, and move on to rougher pastures. A 20-year-old cowboy, however, was determined to learn the new approach: " 'I'm gonna figure it out,' he vows from astride his horse, shooting a stream of tobacco juice at the ground. 'I can't see spending the rest of my days punching cows and getting ticked off.' " Now, of course, we're getting into a whole new ethical territory, when you think about where those cattle are being led. And knowing MINTies, I fear that this is just going to stirrup an unbridled stampede of new jokes.

Meanwhile Back at the Ranch. The clinical and research adaptations of MI are growing so fast that I can't begin to keep track of them. Two colleagues from initial review groups of different NIH Institutes independently told me, "I'm getting sick of reviewing applications to apply motivational interviewing in the treatment of _____ (fill in the blank)." MI seems to be the flavor of the month, which worries me a bit. Quality control is just bound to break down as studies (not to mention clinical applications) proliferate. The pathological optimist in me, however, looks forward to the day when we can't find an effect of adding MI to treatment, because treatment in general is too similar in style. We've already reached the point where we can't do any more randomized trials of MI here at CASAA, simply because too many of the regular staff have learned and apply it.

European Blend

From the Euro-editors
Tom Barth
Peter Prescott
Tore Boertveit
Bergen, Norway

Hi everybody and greetings from "the high north" The sun and the beaches of Tarragona feel very distant just now. We have had our first winter storm, and the world is dark and windy. Sunrise at 9:30 am and sunset at 3:30 pm, so it's dark when we leave home in the morning and dark when we return. In northern parts of Scandinavia the sun doesn't rise at all this time of the year, but there aren't any MINTies there (yet) – so we don't have to think about it....

Practical matters
We (the Bergen MINTies) have offered to co-ordinate the distribution of the newsletter, and the collecting of dues for European MINTies. Hopefully detailed instructions on how to pay dues will be posted with this newsletter. The steering committee has set the dues to $25 for year 2000. That is more or less equivalent to 25 Euro.

If you have questions, don't hesitate to call us at "The Bergen Clinics" (+47) 55 90 86 00 or fax (+47) 90 86 10. Actually the best thing to do is to call our secretary, Guro Andersen (direct number (+47) 55 90 86 60), who is going to help with the practical work. She is more easily available on the phone and has agreed to be a kind of "contact point" for the Euro-MINTies – keeping our membership and address lists updated, and so on.

Euro-MINT
As we grow in numbers, we need to organise ourselves in smaller units. The steering committee now consists of representatives from different regions/continents – from Europe, Mary Ellen McCann (Ireland), Rik Bes (Netherlands), Steve Rollnick (UK), Gian Paolo Guelfi (Italy),

Mercedes Balcells-Olivero (Spain), and Tom Barth (Norway).

There have been different thoughts about how to organise this in the future, and we are moving purposefully slowly on that issue. One thing that may come off is a European TNT workshop (Training New Trainers) in 2001. At last Gian Paolo, Steve, and Tom have started talking about it.

Section for philosophical thoughts I: Models for counsellor-client relationship

Peter, Tore, and Tom are in the process of writing a MI textbook in Norwegian. We have found a very interested publisher who has given us deadlines and encouragement and feedback and all the kind of things you need to get something like this done. We actually have delivered a first version of 10 chapters. A great relief to be finished, and at the same time concern when one realises that this was only the beginning.... Anyway, in the middle of this process I went to a lecture by one of the leading doctors within drug/alcohol prevention in Norway (Olaf Aasland). He referred to an article by Emanuel & Emanuel (*JAMA*, 1992 no 16) "Four Models of the Physician-Patient Relationship" – and suggested that these models could be applied to treatment or counselling in general. (I'm sure Steve Rollnick will agree that there is interesting material to be found in the medical literature about consultation and the working relationship with patients.)

The four models suggested are:

The paternalistic model

- which assumes that patient and physician agree upon ultimate values and goals, and that the physician is responsible for selecting goals, and pointing out how to get there. *"Your smoking is bad for you in many different ways, and it would be best if you quit as soon as possible. There's a self-help manual that seems to be effective and you can……"*

The informative model

- underlining patient's autonomy, and the patient's right to choose. The physician is a purveyor of technical expertise, providing the patient with the means to exercise control. The patient is viewed more like a consumer. *"Smoking is bad for you, and you can choose to stop or not. If you decide to stop then there are different ways to do this: Nicotine substitution, medication, self-help books, groups, The Smokers' Telephone, or you can do it on your own. Do you need more detailed information?"*

The interpretative model

- where the aim of the interaction is to elucidate the patient's values and goals and help the patient select interventions that realise these values. *"Could we talk about smoking? How do you feel about it? What good and bad things are there? How do feel about being a smoker? If you were to quit, which method would……."*

The deliberative model

- building on the interpretative model, but at the same time recognising that the physician's own values must be openly engaged in a discussion with the patient. Some likeness to the relationship between friends. *"Could we talk about smoking? How do you feel about it? What good and bad things are there? How would you like your smoking to be? My thoughts are that the long term risk is far greater than the short term pleasure, but what do you think?"*

Although the article (and the lecturer) points out that the models are helpful for different purposes (acute medical interventions call for the paternalistic approach – especially with an unconscious patient) – it is obvious that some models are more "modern" and supported by contemporary thinking in the philosophy of social science.

The lecturer then went on by saying that Motivational Interviewing could be classified as "modern paternalism", where the physician (or counsellor) *leads* the client to choosing the "right" goals, instead of trying to tell him/her flatly. My first reaction, of course, was to protest. Believing in MI, I think we should be best in <u>any</u> classification system. Later on, I have read the article (recommended! – and only 7 pages) and

started thinking. This leads directly into discussions of the differences between MI and classical Rogerian counselling, to the issue of manipulation, and the definition of MI as client-centred *and* directive.

I believe we could have more discussions on the question of values. Are we right to assume that that we know what is important for our clients? For example, how do they feel about the relative value of short term pleasure, compared to long term health? I suddenly remembered a Finnish colleague trying to explain why controlled drinking was a difficult treatment goal in her country. She said that in Finland, 'controlled drinking' would give you the same feeling as 'controlled loving' – and who would want that! It gives you something to think about, doesn't it?

These issues almost always come up in my workshops. (Perhaps because I wonder about them myself, and my workshops are usually very sensitive to "projective identification".....) We are trying to integrate this discussion in our book, as well, which is why I'm mentioning it here….

Section for philosophical thoughts II: Solution focused therapy

Also a recent experience:
A workshop by Scott D. Miller on "Solution Focused Brief Therapy" (this has been a rather big thing in Scandinavia the last decade) has led to different thoughts.

One thing was his teaching method:
I have often found that the systemic, and family therapy people run great shows. Lots of anecdotes and metaphors and videos of fascinating patients. Also interesting with the use of one-way mirrors and reflecting teams. Sometimes, however, the show and entertainment seems to get in the way of more serious learning and contemplation. (Important to remember for those of you who have charismatic abilities. I remember Allison Bell commenting on the disappointment of meeting people who have attended workshops a year earlier, saying it was a great workshop, and it turns out that what they remember is the entertaining exercises, and not the content. *"I really loved your chocolate exercise !"*)

In this case, of course, the main problem may be a cultural difference, in the interaction with a slow-thinking Norwegian audience.....

The solution focused approach is not unlike MI - especially the group around Scott Miller – who are growing less and less dogmatic. On the other hand, I was thinking of some important differences:
- Solution focused therapists ask a lot of questions! Watching their videos with "MI-eyes", one can see that their "Reflection-to-Question-Ratio" is disastrous.
On the other hand one can see that the way they question is respectful and empathic, and they manage to avoid many of the drawbacks of question/answer interactions. But still I wonder, why haven't they paid more attention to the difference between reflecting and questioning (like we do in MI)? After all they are very interested in relationship factors.
- They accept ambivalence, but don't explore it very much. That, I guess, is a major difference in strategy. Then they use much more time exploring possible solutions, of course. Can we imagine that clients are different in what they need? That pessimistic, stubborn, neurotic "thinkers" need to use time on *all* the pros and cons, while more optimistic, easy-going, inconsistent "feelers" are better helped with the constructing of solutions? (Perhaps this is the reason for "solution focused popularity" in Norway – we feel an overwhelming unconscious desire to be more like the clients who are helped with therapy for the optimistic.)
- They are very good on positive reframing - asking about small changes and exceptions from the problem. (When is the problem not present ? What do you do then?) In MI words this is more or less the same as "eliciting self-motivational statements", for example, in the classic opening question about pre-treatment change. ("Since you contacted me for this appointment, have you noticed anything different regarding.....?)
- One interesting point on working with discrepancy: Scott Miller was demonstrating how one can focus on the difference between the client's "preferred view" of himself and "the dominant view" (discrepancy) – explaining that there is a gap between the two views. Then he places things like resistance in "the gap", saying

that if you confront the resistance you're trying to force the client to accept "the dominate view" – (where there are not very many self-motivational statements to find.) What you need to do is to give feedback on "the preferred view" (empathy, affirmation), explore times when the client is/was viewed as he would like (s-m-s), and talk about what the client can do to make others see "the preferred view". Putting resistance in "the gap" also makes it clear that this is an interactional phenomenon and not a personality trait.

Much of this makes a lot of sense to me, so I guess what I'm trying to say is that if you have a chance, go to a good "solution focused therapy" workshop. Those people are close cousins in the family of treatment, and there is much to learn from them, on practical treatment as well as training.

And this concludes the philosophical rave
Greetings to everybody in the new year. We hope there will be places to meet – on the net and in real life.

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Upside Down Training

Steve Rollnick

No handout, no role-play, no method, manual, or references. Raw experiences, a willing heart, simulated patients, and a lot of laughs.

I described in a previous newsletter our use of on site-simulated patients in training GPs to change their behaviour (prescribe fewer antibiotics) and that of their patients (improve self-care skills; demand fewer antibiotics). We are writing up accounts of the training method and of the findings of this intensive single case study of four colleagues working together on this difficult consulting problem. We had 3 x 45 mins of actual training in a group, and each session was preceded and followed by consulting with a simulated patient whose presenting problem (eg, the demanding patient) was congruent with the topic of the training session. The method seems replicable.

I have never been into a training experience with so little immediate input of my own to present. It's been one of the most successful I have been involved in. Is this a coincidence? For example, I didn't want to write the manual on how to deal with the antibiotic consultation beforehand, to the frustration of my co-trainers, because I wanted to work with the GPs' skills, from the inside, and avoid presenting clever ideas in a top down fashion to them. So we started with their experiences and their skills, and worked forward, introducing ideas and strategies from MI and the patient-centred method as we went along. One GP had a terrible time with the demanding simulated patient from Hell. His script reads like a William Miller nightmare, full of challenge and counter challenge. We discussed this in the training session the next day. Introduced *rolling with resistance*. His consultation the next day with the same patient was a transformation. The tape machine broke, so unfortunately we lost the evidence, but actress came out and said something like, "He was so nice this time. It was no problem not getting what I wanted, because he cared, and he explained carefully….."

At the outset, the lead practitioner said to me in a friendly and challenging way: "I am not involved in this because I want to change my consulting skills but only because I want to see our prescribing rates go down". After the second session he said, "Steve, I am using it in other consultations." When asked what the "it" was, he replied: "That rolling with resistance notion, and I find that it is definitely a good plan to elicit patient expectations before I examine them. It's much easier for me in the last stage of the consultation…" He got engaged with the process of looking at his own consulting. He was very

skilled to begin with, and now I think we have evidence on tape of the extension of his skill repertoire. I now feel able to write the manual, because I understand this consulting problem from the inside. We will use their material to pepper the manual with realistic and useful ideas. They are busy now with collecting tapes of their real life consultations, so we will see whether their improvement in competence extends to actual performance.

The lessons for me from this experience have been profound. At the end of our third and last brief training session, in the "feel good" atmosphere we all know, my co-trainer, Dr Paul Kinnersley asked the GPs if they would respond to an invitation to attend a full day's workshop on communication skills. "I'd bin it", a GP said (throw the invitation away). Why?, we asked. "Because you helped us with real problems here in our real world. I don't want to go to one of those role-play sessions. I hate role play where people nod wisely when I ask an open question to a colleague doing a bad acting impression of one of my patients…." My training world fell apart at that moment. Paul and I are picking up the pieces, scurrying around the remnants of our memories of workshop training, rescuing genuinely good experiences, and asking ourselves why we have designed communication skills workshops for 600 medical undergraduates, based on role-play in a workshop format. Despite lots of good experiences, the answers have a hollow ring to them. That Norwegian MINTie Tore Bortveit should take us to that town called Hell for a bit of rest and recreation.

Important MINT Dates

Submission	Publication
4/1/00	5/1/00
8/1/00	9/1/00
12/1/00	1/1/01

Notes from Tarragona

Training in Tarragona

All the threads of my lifetime of personal and professional experience wove themselves together into a tapestry in Tarragona. The legacy I received from my language teacher father, Charles Yahne, allowed me to give the training in Spanish. The loving presence of my husband, Bill Zimmer, who has consistently believed in my abilities, lifted me up. Another collaboration with my colleague and longtime friend, Bill Miller, reminded me of the numerous times he has challenged me and supported me. Antoni Gual i Sole has been my training partner three times now in Spain, and faithfully provided a solid foundation there. Merce Balcells i Olivero, Meritxell Torres, and Neus Freixa treated me like their North American sister with affection and teasing. The jack-o-lantern stickers I brought from the USA to place on the name badges of participants who successfully functioned as trainers in the seminar drew a lot of laughter. After the merriment subsided, I learned that pumpkins ("calabacitas") are the symbol for performing poorly on an exam in Spain! The participants enthusiastically jumped in to try the role of trainer anyway, and Spain now has 40 new MINTies who clearly grasp the spirit and techniques of Motivational Interviewing. When our son, Paul Zimmer, also flew from Chicago to stay with us there after the meeting, it felt that the final shining thread was woven into the thick and satisfying fabric of my life. I wrap the Tarragona tapestry around myself and bask in its warmth.

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Reflections from Tarragona (No pun intended)

If I had to sum up my experience at the MINT meeting in Tarragona in just one word, I would have to say it was "refreshing." The breathtaking

Mediterranean coast serves as the perfect backdrop for the interactions and collegial relationships that developed over the week. The genuine desire to share our work and receive feedback from the group created an energy that continued to grow. While each of us came with our own personal agenda, I sensed an openness to learn in ways that were unanticipated. Tom Barth, Tore Bortveit, and Peter Prescott did a fine job facilitating each day's events, which included a fluid blend of show, tell, and experience. Being able to practice new exercises to demonstrate motivational concepts helped me to expand my repertoire for future training workshops.

Having MINTies come from the Scandinavian countries, Holland, England, Ireland, Wales, and the US (did I forget anyone?) added to the richness of our workshop. What struck me most was, despite the wide geographic differences, we seemed to identify many similarities across our experiences. I left this meeting feeling invigorated by the work we are all doing and eager to try out some new training strategies. But most importantly, I value the connections and collegial bonds that were created and fostered over the three days. I am excited about helping to shape and facilitate our upcoming meeting in Quebec, and I invite all of you to offer your ideas and recommendations so that we can continue the theme of mutual sharing, self-reflection, and renewed enthusiasm for the compassionate work we do.

While many ideas have stuck with me, the one that has been most integrated into my current activities is Gian Paolo's Pizza Hut song. I taught this to my 7-year-old twins and 4-year-old son, and they all took to it immediately. They repeatedly sing this song while incorporating the hand gestures, and even taught it to some friends! I guess the take-home message here is that the widespread appeal of MI and its associated teachings is broader than I ever imagined!

Good health to all, Jacki Hecht

Minutes from Tarragona

Steering Committee Minutes – 9/14/99

Present: Rik Bes, Carolina Yahne, Mary Velasquez, Jacki Hecht, Mary Ellen McCann, Tom Barth, & David Rosengren (recorder).

Old Business:

Minutes of conference call reviewed and approved.

New Business:

Tarragona MINT business.

- Tom discussed the meeting schedule for the Tarragona MINT Meeting.
- Carolina solicited MINTie involvement in the Spanish-speaking TNT and requested time in the Tarragona MINT to solicit information for a workbook.
- The Steering Committee (SC) thanked Tom (and in absentia, Tore & Peter) for their work in preparation for Tarragona.

The SC and Decision-making

- The meeting began with a general consensus that the MINT appeared to be functioning reasonably well. Therefore, the bias of the group was to avoid adding unnecessary structure.
- SC membership would be open to all MINTies after their first year of MINT membership.
- SC membership would try to limit its size to no more than 15 to ensure the ability to meet and make decisions.
- SC considered the group's composition and decided to encourage more European representation.
- SC discussed time limits on membership, but decided these were unnecessary for the present. Once the SC reaches 15 members, new members will be added as old members step down.
- SC agreed to meet in conjunction with the MINT meetings. The SC regarded as successful the conference call prior to the

Tarragona SC meeting and encouraged that this be used again.
- SC discussed issues about decision-making within the MINT structure. It was agreed that the SC would act as the general decision-making body of the MINT. The administrative head of the MINT could make day-to-day decision about operations, but SC would handle issues of policy and MINT direction. Major decisions before the SC would be presented to the ListServe prior to the annual MINT meeting to solicit input. MINTies attending the MINT meeting would also be used as a resource for additional information. Decisions by the SC would be communicated back to the membership at MINT meetings and through the MINUET.

Recognition of Training Programs

- This issue remains a challenge to the SC and the MINT (i.e., recognition vs. accreditation).
- After much discussion, no changes in policy were made. We will continue to offer recognition to programs that train trainers of MI.
- The SC felt it should post a statement on the MI Website about the MINT's position on MI training and should include this with any mailings. David R. was to draft a statement for SC review and distribute it to the SC members.
- The committee supported the idea of writing a professional paper about elements that ought to be included in MI training.

Structure of MINT Leadership

- The group decided that it would use a four-section approach to handling the tasks of the MINT. Leaders of the four sections would participate on the SC.
- The four sections are MINUET, Electronic and Emerging Media, MINT Meeting, and Administration.
- Leaders in the four sections are:
  1. MINUET – Denise Ernst
  2. Electronic – Chris Wagner
  3. MINT Meeting – Tom Barth, Tore Bortveit, & Peter Prescott
  4. Administration – David Rosengren
- The MINT meeting leader would rotate yearly. A new leader for this section would be solicited from the attendees at the annual MINT meeting.
- The administrative head would be responsible for conducting the business of the MINT, placing items before the SC and communicating decisions back to the MINT membership. He or she would also be responsible for collecting dues, overseeing MINT funds, and maintaining MINT rosters.

Miscellaneous Business

- Tom Barth agreed to oversee collection of European dues. He also offered to distribute the MINUET to European MINTies.
- The MINUET will be offered to people in an electronic form. However, no discount on dues will be offered for the present. MINTies will be encouraged to use electronic distribution to reduce mailing costs. MINTies will be asked to indicate their preferred method for receiving the MINUET on their dues statement.
- The SC again noted the MINUET has not been self-sustaining on dues alone. The SC discussed the need for funds to handle administrative functions, as well as cover mailing costs.

Respectfully submitted,

David Rosengren

Post Script

- It appears the next TNT and MINT will happen in Quebec City.
- Two new European members were added to the SC after Tarragona: Gian Paolo Guelfi and Mercedes Balcells-Olivero.
- David Rosengren decided against filling the administrative position. Gary Rose

volunteered and the SC approved his appointment.

- Gary Rose agreed to lead the Quebec City MINT meeting. However, he stepped down from this position upon taking the administrative head position. Jacki Hecht took over the MINT meeting leadership.

Comments on YIPsters

Hi everybody. Just an update from rainy Seattle. Our YIP project (Youth Injury Prevention) study goes along well. We have trained three social workers to do brief MI with adolescents (ages 12-20) in the ER, targeting six risky behaviors: binge drinking, driving after drinking, riding with driver who has been drinking, not wearing seat belts, not wearing bike helmets, and carrying a weapon.

Our YIPsters (interventionists) had to get used to the gruesomeness of the ER and the poignancy of high-risk youth, who seem to be able to tweak one's countertransferrence even more than adults. Some of the interventions involve prevention of behaviors not yet practiced, and some involve reducing or stopping things already going on.

Some teenage "Cognitions-from-Hell" that tweak our Yipsters:

- "My friend survived an accident once and the cops told him that if he had been wearing his seat belt, he would have died."
- "I am certain that I am safer when I carry a gun."
- "nobody drinks less than three beers on any one occasion. That's just how people are…."

The length of MI sessions is driven by the youth's attention span and the "interruptions" of medical care. The youths are often very distracted by their injuries or medical treatment and sometimes participate in the study not to help themselves, but to help out the Yipsters.

Some training/supervision issues I struggle with: Wanting to be more directive with Yipsters by insisting that they audiotape more aggressively (they find it difficult to ask permission to tape sessions which can add to the awkwardness and confusion of doing MI in non-private settings) and discuss the content of their MI sessions more openly during supervision. Early on in the study, they needed more palliative support from me, rather than feedback on whether or not they were adhering to principles of MI. So as supervisor, I had to struggle with the listening-directive internal conflict, just as I struggle with this same conflict when doing MI with trauma patients around alcohol consumption. I decided to err on the side of listening and being supportive, despite my insecurities about how well I had helped them prepare to do MI.

Our Yipsters have decided that it is important to let the youth pull the plug on the conversation, as well as agree to begin the conversation itself. They also tell me that one of their most commonly encountered challenges is mustering the nerve to bring up the possibility of change. Their fear is that by doing so they may damage rapport. Yet they say that when they do bring it up, even if they encounter resistance, they generally find that they have put enough money in the rapport bank that little harm is done as long as they roll with resistance when it occurs. They are finding that they feel better about the sessions when they are sure that they have "taken up as much slack as possible" by at least asking about taking action, even if they think the youth is in precontemplation. In other words, we are finding that just because somebody is in precontemplation doesn't mean you can't talk about taking action, at least in a hypothetical way.

Our tentative clinical impressions about doing MI with adolescents:

1. Youth have less cognitive ability to abstractly think about cause and effect, and so the less directly related the intervention is to something concrete like suffering, the harder it is to make the intervention hit home. For example, it's harder to engage a kid in a discussion about the danger of carrying a gun if he does not habitually carry a weapon than if he is currently suffering from a gunshot wound.

2. Within an age range of 12-20, autonomy and authority developmental issues vary wildly. We're finding that more directive with 12- to 14-year-olds causes less resistance than it does with 19- to 20-year-olds.

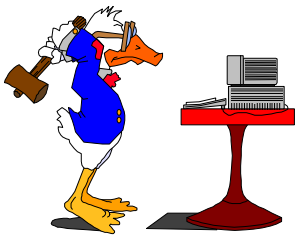
Warm thoughts and Merry Christmas to you all.
Chris Dunn

Regional MINT Meetings

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

MINUET Contributions

As a reminder, MINTies, subscribers (and others interested in MI) are invited to submit pieces for the MINUET. 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

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 resource 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*

Comments

Miller's Motivational Model of Addiction: A Commentary
Allan Zuckoff, M.A.

In last September's MINT newsletter, Bill presented a "rough draft" understanding of the nature of addiction, conceptualized as a matter of motivation (Miller, 1998). At the end of the essay, he invites readers to add "pieces to the puzzle" that he has begun to construct. It is the spirit of that invitation that I offer the following review and commentary.

Miller argues that what we refer to as "addiction" is comprised of two core components. The first has to do with volitional control over the behavior in question, and rests on what seems to me the inarguable point that such control should be understood not as an either/or ("in control" vs. "out of control") but as existing on a continuum of *relative* control or capacity for self-regulation. This continuum, Miller goes on to say, exists for any given behavior across all persons, for behaviors within a person, and across time for a given behavior within a particular person. For example, different behaviors are subject across persons to varying severity of limitation – think of breathing vs. locomotion – but at the same time, within each behavior across persons there is a range of such limitation (e.g., yogic breath control). The extent of self-regulation for a given behavior will also vary for a given person over time; though he does not illustrate this point, one thinks of developmental changes (volitional control tends to increase from childhood through adulthood and then decrease again with advancing age), new learning (volitional control may be increasingly exerted over a previously uncontrollable behavior with incorporation of a new skill), or the effects of illness, injury, etc. (which may rob one of previously held volitional control over certain behaviors). Persons with addictions, it is suggested, have a "diminished but retrievable" capacity for volitional control over behavior associated with the object of their addiction – retrievable under specific, and presumably limited, conditions which for most

addicted persons do not obtain most of the time. (Treatment, from this perspective, presumably involves at least in part the provision of such conditions – as when we remove persons from their usual environment and provide one in which self-control becomes possible.)

The second core component of addiction is described as "diminished deterrence" – that the person persists in a behavior despite negative consequences ("risk or harm") which one might otherwise expect to lead to the curtailment of that behavior. It seems that the person is "willing to pay too high a price in order to continue" – as though alternative "rewards" to those received through participation in the addictive behavior have diminished or are no longer perceived as sufficiently rewarding to make nonparticipation worthwhile.

Therefore: since control *can* be exerted with sufficient perception of alternate rewards, "the problem of addiction is one of competing motivations" – with "motivation" understood as a complex of determinants including biological drives, conditioning, cognition, emotional processes, and social influence. Rational decision-making is only one of many influences on motivation, and judging motivation by its rules will inevitably leave motivations to appear irrational.

What follows is that escape from addiction "involves finding alternatives that are more motivating," or "shift[ing] the balance" so that the rewards of the behavior are outweighed by its consequences *from the perspective of the addicted person* (rather than that of an observer, who will not be privy to all the aspects/competing motivational factors). Such shifts can occur in "external, obvious" ways, wherein continued engagement in the behavior would result in clear negative consequences and/or loss of positive contingencies – but at other times may involve instead a "sudden shift in meaning" or in how costs/benefits are perceived, which seems to require the person to "see himself or herself from another perspective," from "outside the self."

And this may account for the power of MI. Miller offers two rather distinct formulations. One might argue that the client "leaves with a new set of contingencies" or "perceived relationships between behavior and consequences," a shift in the "stimulus equivalence set to which the behavior belongs." Or, one might say that in MI we lend clients, via "empathic merger," an outside perspective on themselves – a perspective, as I read Miller, which is neither mine nor the client's individually but a third term (what the hermeneutician Gadamer refers to as the "fusion of horizons") which is fundamentally shared – and which is infused with hope and a sense of *possibility* that the client may lack. From this perspective, the client sees "that the cost of the behavior is indeed too high, and that he or she does have the means to change it." And this lending via empathic merger may also be described as "loving."

Miller defines addiction as involving the "willingness" on the part of the addicted person to suffer consequences for the behavior which seem by cultural norms excessively high, and a diminished level of control over the behavior as judged by others as well. But isn't "willing" just what the addicted person is thought to not experience, or at minimum to be deficient in? To the extent that the addict's capacity to act according to what s/he wills is limited, the first component of the definition collapses into the second. If it is truly the case that self-control is retrievable when the positive consequences of self-control, or the negative consequences of failure to exert control, are both strong and salient enough, then this would seem to reduce addiction to the absence of "salience" of consequences, or of perception of sufficient benefit to stopping the behavior to outweigh the perceived benefits of continuing (or in other words, to make the person "willing" to stop).

It seems to me that this problem arises in part from one of the proposed continua of "diminished volitional control." For certain behaviors there are limits on self-regulation that cannot be transgressed: no matter how hard s/he tries no person can keep from jerking his/her knee when the patella is hit. A bit further down that proposed

continuum, in order to stay awake indefinitely any person must work very hard and tolerate very high levels of physical and psychological discomfort, and even then all will eventually reach an absolute limit. And then there is the use of alcohol or other drugs: for most people volitional control is easily exerted, and yet for others to do so appears to approach the difficulty of never sleeping.

It may be that the conflation of relatively simple or reflexive behaviors with those which are more complex, placing them on a single continuum, is misleading. Isn't what distinguishes the two the very fact that we *can* exert volitional control over the latter and not the former? And isn't the question of addiction, really, What is the source of the difficulty some people have in controlling certain complex behaviors that others control with ease?

Miller notes, in an aside, that we have no good animal models of recovery, while asserting as obvious that we do have good animal models of addiction. I would argue that it is this assertion which is most misleading. The rat in the Skinner box, bar-pressing for cocaine, hardly seems an adequate model for the complexity of human addictive behavior; in what sense could we meaningfully speak of an individual rat's "drug of choice, " or of rat "self-medication?" More broadly, it is precisely because the human choice to abstain from highly rewarding substances whose use has been thoroughly conditioned has no animal corollary that animal models of addiction tell us so little about human behavior; losing and regaining the capacity for choiceful action can only be understood as complementary phenomena.

"Diminished volitional control," then, should refer to complex behaviors which "normally" persons are capable of controlling, but which certain persons come to experience themselves as having to "fight against" if they are not to engage in them. Perhaps we may clarify this issue by returning to Miller's own example of "eating," described as a behavior over which we have limited control yet which we would not describe as "addictive." Not only overeating, as he suggests, but also *abstaining* from eating (e.g., anorexia) could be characterized as "addictive;" in order to not eat, persons must tolerate very high levels of discomfort, negative secondary effects (dizziness, confusion), etc., yet in time a person may come to experience him/herself as having limited control over eating and may go on "not eating" despite the consequences.

What is definitive of such behavior is that the individual *experiences* it as "compulsive" – that s/he does not feel as though or believe that s/he has adequate control over the behavior to keep from engaging in it whenever such engaging is not consciously *willed*. The behavior, they say, "takes on a life of its own"; it is no longer me willfully/willingly engaging in it, but it is "behaving" me. This *experience* of compulsivity seems to me the hallmark of the "addictive" experience, as opposed to the "actual" or "objective" level of control another person (whether involved other or "objective" researcher) might attribute to the addicted individual.

In fact, I'm not sure that the proposed definition applies exclusively to behaviors we traditionally refer to as "addictive." I alluded to the way in which anorexia fits the pattern; one might also regard obsessive-compulsive symptoms as "addictive" in this sense – the sufferer experiences him/herself as having limited control over engaging in his/her rituals, though such control can be (under certain circumstances) retrieved, and s/he will persist in these behaviors despite considerable or even extreme negative consequences which from an external standpoint ought to be more than enough to suppress them. In fact, I'm not sure that Miller's proposed definition of addiction isn't actually a descriptive definition of "neurosis" in general – e.g., persistence in self-defeating behavior despite obvious negative consequences for doing so.

The distance between the perceptions of the experiencing and the observing person begs the question: what must be fought against to refrain from the behavior? Given that there is no externally observable restriction on the addicted individual's self-control – and assuming that there need not be a physical "dependency" to qualify for addiction – the answer must lie in the realm of the psychological.

One way of answering might be in terms of "conditioning": operantly conditioned behaviors can be resisted (by persons, who may reflectively choose to do so), but at the price of subjective tension – thus "diminished control." Yet it seems to me that, as practitioners of an "insight-oriented" intervention – providing clients no skills, no counter-conditioning, but only (!) information and acceptance – we must begin from the premise that behavior is psychologically *meaningful* (that it serves a *purpose* or achieves a *goal* of some kind) and not merely a product of exposure to previous environmental contingencies.

It seems to me that the way to make sense of the reality of limited control over volitional behavior is to acknowledge that certain of our purposes, goals, wishes, and fears are outside of our direct awareness, and that this limits our volitional control – and that because the addicted person does not know exactly what makes it so important to go on behaving in that way, despite the obvious consequences of doing so, s/he is under normal circumstances "unable" to change. This is why addicted persons are subjected to moral censure – because there is no non-psychological restriction on the person's freedom. Moral culpability requires the possibility of doing other than what is morally wrong, so that society does not hold persons liable for shaking when afflicted with Parkinson's disease, jerking one's leg when the patella is hit, or doing something illegal at gunpoint, even if the action leads to a harmful outcome (e.g., the doctor gets his/her leg kicked). Our problem – the addicted person's problem – is that our society does not accord psychological limitations the same "reality" as it does physical or external ones, and as a result we expect others (and often ourselves) to act with a level of "free will" which none of us fully achieves, limited as we are by experience and the wishes and fears it produces.

Referring to the salutary effect of the disease model in providing the addicted person relief from damaging guilt and moral condemnation, Miller notes that "there are, however, other routes to compassionate understanding." This begs the question: what are these other routes, and how can we offer them to the person who has been acting addictively? One approach would be to say: though this person could control his behavior, it would take an unusual, even extreme effort to do so, as s/he is driven by motivations of which s/he is at best vaguely aware and doesn't fully know what s/he's fighting against. But this form of forgiveness (if not absolution) only gains its force from the realization that we are *all* capable of being self-deceived in important ways, and the recognition that the addicted person suffers from the condition we all share: that we are in important ways opaque to ourselves, and that at times we become caught in a sequence of behavior which, as it serves its shadowy purposes, takes on a life of its own, eliminating alternative ways of accomplishing the same goals while alienating us from those others who might help us to rediscover them, increasingly circumscribing our options until we no longer see a way out.

And this, I think, is the important meaning of the idea of addiction being perpetuated by "diminished rewards": what changes isn't the quantity but the *quality* of potential rewards available. What becomes increasingly focal and "salient" for the addicted person are the simplest forms of reward – immediate gratification/pleasure, reduction of tension, the experience of a shallow kind of excitement. More subtle, complex, rich rewards – intimacy, the satisfactions of accomplishment of a goal over time, the sense of personal integrity, the nurturing of something fragile into full bloom (a garden, a child, an idea, an enterprise) – are neglected, and the capacity to experience them atrophies. One might even say that, far from *explaining* addiction (as early psychoanalysis thought it did), the running rampant of primitive ("oral"/acquisitive) urges is precisely the *product* of addiction, which reduces the person to a kind of Freudian caricature of drive-dominated behavior and economics of tension reduction.

From such a perspective, MI would be seen as restoring, by proxy, the component of *values* – in the sense of Erickson's core values of trust, autonomy, initiative, competence, identity, intimacy, generativity, integrity – which the addicted individual has increasingly lost touch

with. As *all* truly meaningful therapy does, it offers clients an alternate view, "lending" them (as Miller so evocatively puts it) a wider scope and outlook than they've become limited to and recreating the belief in their capacity to act freely which has been diminished or, in extreme cases, lost.

And perhaps this really is, as Miller says, a form of "loving." Michael Kahn (1991) suggests that Rogers' "necessary and sufficient conditions" were essentially an iteration of loving in the sense of "agape." Yet I must note that I find it especially hard to fathom how Miller can use the reductive, mechanistic, dehumanizing language of radical behaviorism in the service of so humane an enterprise as MI; even more so to make sense of the shift from such language to talk of "loving" without acknowledgment or apparent recognition of the radical disconnection between these levels of explanation.

Behavioral theory begins from the positivist or "realist" assumption of an absolute split between perceiving subject and perceived object, between the organism and the environment which impinges upon it "from outside." In what way can it be coherent to speak of "empathic merger" from such a perspective? Such a concept requires recognition of aspects of human being which behaviorism, in its efforts to achieve the status of a natural science, must exclude or reduce to quantitative phenomena. (Can "love" be quantified and still be love? Is it coherent to speak of a "quantity" of freedom?) It seems to me that Miller's account is descriptively acute (and quite beautiful) but in this sense theoretically incoherent – that one cannot have it both ways: either one can speak of "merger," "sharing a view" and therapy as "loving," or one can speak of external contingencies and stimulus equivalence sets, but not both.

The French psychologist Maurice Merleau-Ponty (1964) argued that human beings are born into a state of pre-personal communion with others which precedes and underlies the self-other distinction we take for granted. He also gives an account (1962) of what he refers to as "conditioned freedom" – freedom within limits, conditioned by the givens of a person's existence (developmental history, genetic structures) and the sedimentation of experience, possessed by an embodied (and thus finite) being gifted with self-consciousness. This is the kind of conceptual space which is required to do justice to the phenomena which Miller describes. It allows for the reality that we are all responsible for our behavior – but that, given the real limits and obstacles we must face in order to choose freely and wisely, we are all deserving of each others' compassion and understanding when we fail to do so and (thankfully) capable of the empathic stance which allows us to offer it.

Kahn, M (1991). *Between Therapist and Client: The New Relationship.* New York: W.H. Freeman and Company

Merleau-Ponty, M. (1962). *Phenomenology of Perception*. (Trans. Colin Smith). London: Routledge and Kegan Paul. Original work published in 1945.

Merleau-Ponty, M. (1964). The child's relations with others. (Trans. William Cobb). In J.M. Edie (ed.), *The Primacy of Perception.* Evanston, Ill: Northwestern University Press. Original work published in 1960.

Miller, W.R. (1998). Toward a motivational definition and understanding of addiction. *MINT 5*, 3, 2-6.

MI Exercises to Keep You Fit and Toned

The long awaited sharing of MI exercises has begun! Attached, as appendices, are some MI exercises that our colleagues have tested and found to be successful with trainees. Jacki Hecht and Mary Velasquez have been requesting and receiving submissions over the past year, and have made every effort to include your exercises as part of this evolving training manual. Some of the exercises could not easily fit into the standard format that Bill proposed, and we will therefore try to disseminate them separately in the near future, perhaps with the next newsletter. If you submitted an exercise and do not see it included here, please contact Jacki or Mary, and we will try to include it in the next round of distribution. If

you try out any of these exercises and would like to add your comments and reactions, please email Jacki, and she will include these as updates to the exercises.

We hope that you find the distribution and sharing of these exercises to be a helpful way to keep your training skills sharp and toned… as this might be the only exercise you can get these days. (Hope that's not true!) We hope ultimately to post new exercises to the website and limit mailing hard copies to those who don't have web access. Any comments or feedback about how to make this process smoother and more efficient are most welcome!

A Fresh Cup

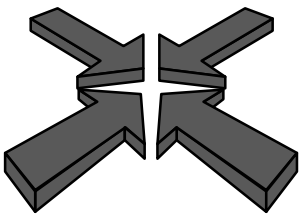
Denise Ernst

I am excited to be here even if following in David's footsteps is not easy. David – you have been most helpful in this transition. Thank you. And thanks to all of you who so graciously contributed and met the timelines. It has made this so much easier.

This has been a pretty chaotic fall for me. My husband and I sold our house, moved into a very small apartment that doesn't hold our college-age sons very well, and are preparing to embark on a couple of years in a fifth-wheel traveling around the country. This takes a lot of preparation. Mostly, I have been preparing my office for the road. Technology is great! It will allow me (I hope) to continue to work in an almost seamless way. That, of course, is when it is working. I know enough about this stuff to get me into trouble but not out of it. My new email address is *d.b.ernst@worldnet.att.net*. I promise to stay current with my email.

When I agreed to take on the work of editing this newsletter, I saw it as a way to stay connected to this wonderful and stimulating group as I wander around. In addition, it will help me stay in touch with what is happening in the MI world. As it turns out, I will also be actively involved in several research projects that are using MI and will continue to provide training, consultation, and supervision to those projects. I must admit, I feel pretty blessed to have this opportunity. And I hope it also gives me a chance to meet with some of you as I travel. Nothing replaces the face-to-face sharing and discussion.

We will be in the southwest for the first few months of the year. Feel free to send me an email if you are in that area and would like to get together. The work of this group provides consistently stimulating, thoughtful, and provocative dialogue. I hope to contribute to that and to bring more people into the discussion by offering a different way to participate.



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