Motivational Interviewing Newsletter: Updates, Education and Training

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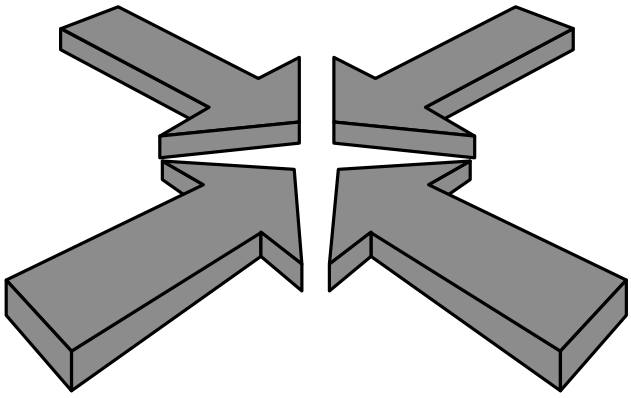
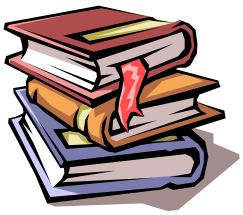


New Perspectives



Notes From Fumeri

Bill Miller and Steve Rollnick

Fumeri is the location of Gian Paolo Guelfi's summer home near Genova, which he so kindly offered us to use for two weeks of working together on the second edition of *Motivational Interviewing*. We are most grateful to Gian Paolo for his generous hospitality, giving us a peaceful and productive April sabbatical.

A Second Edition

We left Fumeri with a draft manuscript completed for the first fourteen chapters. There will again be contributed chapters in the second part of the book (see below for an invitation to MINTies), but first let us describe a few important changes that we have made. The revisions are substantial, and this will be quite a different book.

The working title is *Motivational Interviewing: Preparing People for Change*, reflecting our departure from the addiction focus of the first edition. We have written to a broad audience and drawn clinical examples from many different problem areas. The addiction-specific material is gone, for the most part, and thus people who are particularly interested in the application of MI to addictions will probably want to refer to the first edition. We plan for the second edition to be published by Guilford in the autumn of 2001. The working outline is as follows:

I. Context

1. Why Do People Change?
2. Ambivalence
3. Facilitating Change

II. Clinical Method

4. What Is Motivational Interviewing?
5. Change and Resistance: Opposite Sides of the Coin
6. Phase 1: Eliciting Intrinsic Motivation
7. Responding to Change Talk
8. Responding to Resistance
9. Enhancing Confidence
10. Phase 2: Strengthening Commitment to Change
11. A Practical Case Example
12. Ethical Considerations

III. Learning Motivational Interviewing

13. Reflections on Learning

14. Facilitating Learning

IV. Research, Applications, and Reflections

[Contributed Chapters]

Part I is almost entirely rewritten. We have removed most of the former material contrasting MI with other counseling approaches. The prior heavy counterpoint with confrontation is gone. We have focused instead on a clear statement of what MI is, rather than what it is not. For the same reason, we have removed from the first 14 chapters nearly all of the material on approaches with which MI is sometimes confused: FRAMES, MET and assessment feedback, stages of change, brief negotiation, and other "in-the-spirit-of-MI" adaptations. This material will now appear in Part IV, making the distinction from MI clearer.

We have taken a further step away from the traditional conception of resistance as motivated client defensiveness. We now present (in Chapter 6) change talk (formerly self-motivational statements) and resistance behavior as opposite sides of the same coin, simply reflecting the poles of ambivalence. After some deliberation, we did decide to keep the term "resistance" because of its familiarity, but to rehabilitate it. (We just couldn't make *countermotivational statements* or *counter-change talk* work, or sound any less pejorative.) Change talk and resistance are now presented as complementary behaviors, and we have a chapter on how to respond to each: *Responding to Change Talk* (Chapter 7) is completely new, and Chapter 8 is a reworking of our prior chapter on handling resistance. We have jettisoned the problematic concept of therapeutic paradox in favor of *coming alongside*.

Other chapters contain new material as well. We remembered this time to include a definition of MI (Chapter 4). There is a new chapter on *Values, Ethics, and Priorities*, reflecting developments in these areas since the first edition. Chapter 9 is entirely new, addressing an issue on which we have been largely silent before: What do you do when importance is high but confidence is low? We have introduced a distinctly MI approach to enhancing confidence that, while incorporating some familiar strategies, places them in the collaborative change-talk context of MI. It is accompanied by a case example, and new clinical dialogue appears throughout the book, although Chapter 11 is retained with relatively little change.

Part III is also almost entirely new. We have abandoned the "how to teach MI" approach, deleting all of the prior exercises that are by now thoroughly familiar to MINTies. Instead we focus on how people *learn* MI. We reflect on processes of learning (including our own) in Chapter 13, and broad ways of facilitating learning in Chapter 14. Detailed discussions of and exercises for training are now the province of MINT.

All in all, we're reasonably pleased with the first draft. Clearly there is much that is new, and this will not be just a rehash and updating of the first edition. We also have a sense of the material fitting together much more tightly and clearly. With ten more years of experience in what seems to help or confuse people as they learn MI, we have sharpened up many of the presentations and left out previously distracting material.

A Call to Pens

That brings us to Part IV. Guilford did a market survey among people who have used the first edition and concluded that we clearly should retain the contributed chapters section on applications. We hereby invite MINTies to let us know if you are interested in the possibility of contributing a chapter for Part IV. The current timetable:

May 2000 Call for contributed chapter proposals

June 1 Deadline to propose chapters (to Steve)

October 1 Deadline for receipt of first drafts of chapters

November 1 Editorial feedback on chapter drafts

January 1 Deadline for receipt of final drafts

February 1 Manuscript sent to Guilford

August 2001 Book published by Guilford

As a general guideline, we will not entertain chapters on the application of MI to particular *problem* areas (addictions, diabetes, fitness, schizophrenia, etc.). There may be reason for an edited volume down the line consisting of such application chapters, but for Part IV of the second edition we will stay away from problem-specific applications. Here is our list of possible chapter topics, and we certainly invite proposals on other topics we have not listed here. These aren't titles, but topics. If you are interested in working on one of the chapters below, or have another chapter idea in mind, please contact Steve pronto, and no later than June 1.

A Brief History of Motivational Interviewing (sycophantic-free, please)

The Effectiveness of Motivational Interviewing: A Critical Review of Outcome Research (methodologically rigorous; including recommendations for future research)

The Effectiveness of Interventions Derived from MI (rigorous outcome review)

Motivational Interviewing and Stages of Change (transtheoretical model)

Brief Negotiation and Health Behavior Change (Steve will write this one)

Giving Feedback: Motivational Enhancement Therapy (Bill will write this one)

Motivational Interviewing in Groups

Incorporating Values in Motivational Interviewing

Motivational Interviewing with Couples / Significant Others / Relationships

Assessing Motivation (instruments, clinical and research uses, psychometrics)

MI with Coerced and Correctional Populations

MI with Adolescents (and Children?)

If you propose authoring a chapter, we will get back to you as soon after June 1 as feasible. We plan to adhere strictly to writing deadlines. Not all of the above topics will necessarily become chapters, and we may or may not use additional ideas that are proposed. Also, we can't make a decision about inclusion until we see a chapter draft, and in any event the final editorial decision lies with Guilford.

If you want to propose taking responsibility for a chapter, please contact Steve directly, simply stating your interest. We will ask for outlines later.

Rollnick's Musings

Steve Rollnick

Love the newsletter

I do. It's helping me realise the limitations of the Internet. I got it in my hands, and sat down somewhere peaceful. Thanks to Denise, our new overall editor. And to our Euroeditors in Bergen, Norway.

Love resistance

I keep hearing criticisms about the value of the concept of *resistance*. Tom Barth from Norway mutters about putting it on a little ship and letting the wind take it away, and Bill Miller talks about a new notion, *counter-motivational statements*. Can someone please come up with a term which describes not just what the client is or isn't doing (which is what the counter-motivational concept refers to), but which captures a disturbance in the relationship? I have borrowed the phrase *damaged rapport* from a colleague in Calgary. My problem with chucking out *resistance* is that it works brilliantly in training, whatever worries we might have about it. I describe it not as the patient's problem, but as a feeling in the practitioner's stomach which makes them sigh at the realisation that the rapport is damaged. Rolling with resistance is such a useful phrase, so

easy to remember. Bill, are we now going to say *rolling with counter-motivational statements?*

Love Italian herbs

2001, Italy. Dr Gian Paolo Guelfi has provisionally agreed to host a MINT meeting, or to find a host, having done this some years ago in Santa Maragarita, near Genova. It was a superb venue and atmosphere. There will be good opportunity for MINTies to help with the parallel meeting and the new trainers meeting as well.

Love more contemplation

Full steam ahead, as they say in some English countries, which means moving forward with optimism and no hesitation, like a steam train. That's what seems to be happening with evaluations of motivational interviewing. All action. I hate to think how many emails Bill Miller gets from researchers in the US. I get quite a lot. I get the shivers at the lack of contemplation involved.

The most alarming inquiry, and not at all infrequent, is from a senior researcher who has already won a grant for a randomized controlled trial, and now wants help with training practitioners. The method to be evaluated? Why, motivational interviewing, of course (the researcher does not really understand even the spirit of the method). The context? Oh, some setting in which social deprivation flows like lava into the consulting room (not that the researcher has much experience of this). The training? "Oh," says the researcher over the telephone, "can you give us the PROTOCOL for MI, and come over and teach for …… let's see ….." (looking at research proposal for the number of training hours put into the grant application……..). And so on. I can see the looks on the faces of the practitioners in training. If they are not too burnt-out, they will react to the delivery of top-down intervention by presenting the trainer with the patient from Hell.

Are we going to take the results of this kind of study seriously? And if it fails, will MI get a bad name? Did this person's grant application look good on paper? I look forward to the day when no controlled trial is carried out on MI until the researcher provides evidence of knowledge of: What communication difficulties do people actually experience in a given setting? How might MI help? How might one best enhance skill acquisition among practitioners in that setting? How does one ensure that the intervention method was delivered to a high standard?

Brief training interventions

I hate to suggest this, but have you heard about BTI, brief training intervention? Probably not a good idea to let researchers like that described above know too much about this….. but you can effect change in trainees in a very short amount of time! You don't need role-play, fishbowls, post-lunch workshop fatigue resistance, or days sweating over hot cases, just a brief motivational nudge…..

You can be brief if you hit the right buttons, in the right context, and set things up very carefully……. Here are some comments from participants four weeks after attending *two one-hour seminars*, using the SPICE training method I described in previous newsletters. They were nine managers apparently wanting help with abrasive interviews with colleagues. I called the training Communication Training: Dealing with Difficult Interviews. I tape recorded this follow-up meeting.

Practitioner A: ….for me it was more sort of learning techniques, it's like, you know, rolling with resistance, not challenging someone but getting them on board for you. To me it was more about that, and I found the workshops really useful in terms of picking up different techniques that I could use.

Practitioner B: ….for me, whilst it was called "Communication Training," I don't think it is about training where you learn a skill, because I don't believe I've learnt a skill. I believe I've learnt something, and I believe I've learnt to do things differently, to be differently… to be different. So I don't actually think that I've been trained. And I don't… I can't put my finger on what it is that it's given me, but it's given me something. And maybe that's a different perspective, maybe that's a different feeling, maybe that's a different level of awareness. It's a very intangible thing that it's given me, but it's given me something.

Practitioner C: For me, it had quite a profound effect on me, probably more so than everybody else. And it just made me think in a way that I've never felt before about how I actually come across to people. And I think the benefit of that was that I now consider more than I've ever done how other people might feel also. You maybe don't use these techniques in all situations, but one thing I do do now that I didn't do before is think about how I make other people feel.

It was *closeness to everyday context* that made the training a success. The participants decided on the problems to be addressed, and did this (interviewing the actor) as they were going about their everyday lives. If that closeness to context is useful in training, what about counselling? Surely it means that we should not assume that the best place for counselling is in the office of the counsellor, away from the context in which the person is struggling? Why is it that counsellors decide where clients should be seen, at what time, for how long, and so on? Should we infer from this that the counsellor's context is more important than that of the client? Or have we strayed too far into idealistic twaddle? By the way, can I please beg you not to use the term BTI? It was just a joke.

Love those uncomfortable exceptions

I've been looking at transcripts of simulated consultations between a smoker and a group of nurses and doctors. One of the nurses pushes this precontemplator to agree to a day of abstinence, using every persuasive trick in the book, while the majority of his colleagues use variations of a softly-softly, MI-like approach. Afterwards, the actor, naïve about my training intentions, told me that it was a fine line between being pushed too far and not being pushed enough. Interesting how some people expect pushing. I would dearly love to see evidence about the relationship between practitioner behavior and patient outcome in this kind of brief health care consultation.

Contact Information for the Euro-Editors

E-mail addresses:

Peter Prescott	*petereva@online.no*
Tom Barth	*tfwb@online.no*
Tore Børtveit	*bente.ubostad@psych.uib.no*

Mail address:

Bergensklinikkene
P.O. Box 297
N-5001 Bergen
Norway

Fax : +47 55908610
Phone: +47 55908600

A Taste of MI

Bon Appétit – Jacki Hecht

I have received several requests over the past few months to consult on research studies that are testing a motivational intervention for behavior change as one of the "treatment" arms. Two questions that have made me pause are:

1. How can we add motivational interviewing, when what we really want is for people to comply with our treatment recommendations?
2. Is there some MI training I can attend so that I can supervise the intervention staff?

These questions are evidence of a perception that MI is like a seasoning, i.e., a sprinkle here and there is all you need. This perception, however, is quite different from most of our experiences. I find myself responding to question #1 in ways that describe MI more as the process of assembling the recipe ingredients, rather than as some flavoring that gets sprinkled on at the end. For example, if the aim of the study intervention is to facilitate participants' use of an effective behavioral (or pharmacologic) treatment, MI can be used to assess participants' reasons and commitment for wanting to follow treatment guidelines, and to help overcome the barriers that may limit adopting and maintaining successful behavior change. More specifically, MI can help the participant see the value in following through with the various steps of treatment that has been shown to lead to ultimate behavior change. This process of facilitation should not interfere with treatment compliance, but rather enhance follow-through by

selectively addressing the issues that appear to be holding the participant back.

My response to question 2 includes a definition of training, which does not end after the one- or two-day workshop. Like many of you, I typically arrange additional small group or one-on-one meetings with intervention staff to review what they learned from the workshop and to practice different role play scenarios in order to highlight core MI skills. Ideally, these ongoing meetings are frequent (at least monthly) in the beginning, and move to less frequent intervals as intervention "counselors" become more comfortable with the strategies and overall spirit. Conducting these "supervision" sessions with the project manager helps the project manager set up a structure for providing ongoing practice and feedback in a constructive way that models MI strategies. Defining training in this way often helps project managers who are less familiar with MI better understand that learning MI requires much hands-on practice and cannot be quickly learned in order to teach and supervise others.

Although it seems tempting, at times, to offer a generic MI training for project managers and study staff to do with it what they will, I believe we all have an ethical responsibility to consider the science that is relying on the integrity of quality motivational interventions. Therefore, it seems critical that we communicate how important it is to allocate adequate time and resources to provide initial and ongoing training with skilled supervision.

As many of us struggle to preserve the spirit and integrity of MI, it is helpful to educate clinical and research staff that MI is a method of assembling fine ingredients to enhance the flavor, acceptance and adoption of proven treatments.

New Dual Diagnosis Program Directory

A directory for dual diagnosis of co-occurring mental illness and substance disorder treatment programs is now available on the Internet. The directory includes both national and international entries. You can access the Program directory at: <http://cgibin.erols.com/ksciacca/cgi-bin/db.cgi>

If you provide dual diagnosis services please add your program to the data base. Numerous consumers and their family members inquire about treatment services on a daily basis. Their requests frequently include frustration. Any assistance you may provide by passing the information along to other service providers who may add their programs will be appreciated. The data base can be searched by families, consumers, and providers who are seeking services.

Monty Roberts Tapes

In response to requests from MINTies, Bill has obtained permission for IAMIT members to use Monty Roberts (The Man Who Listens to Horses) tapes as part of MI training workshops. Here is the text of their generous permission:

Monty Roberts hereby grants permission for the videotapes, Join-Up and Shy-Boy, to which we hold copyright, to be used in training workshops by members of the International Association of Motivational Interviewing Trainers. Once a member has purchased a copy of the tapes, he or she has permission to show all or part of it during training workshops on motivational interviewing, without payment of any additional fee for such public use. This permission is limited to current members of the International Association of Motivational Interviewing Trainers. The tapes may not be copied, however; any tape used in training must be an original that was purchased for such use.

MI Professional Training Videotapes

In 1998, a set of seven videotapes on motivational interviewing was produced at the University of New Mexico, Albuquerque, USA, by William R. Miller Ph.D., Stephen Rollnick Ph.D., and Theresa B. Moyers Ph.D., with the assistance of professional videographers from Horizon West Productions, Albuquerque. The tapes provide an introduction to motivational interviewing. They are intended as a professional training resource. The tapes *were not designed to be used as a stand-alone form of training,* but for only one part of a thorough presentation of the approach and skills involved in motivational interviewing. Because it is often helpful to see a method demonstrated in

various contexts, the tapes show a variety of therapists and counsellors practicing the component skills of motivational interviewing.

Features:

- The tapes provide an introduction to the subject and are designed as a professional training resource, not as a stand-alone form of training.
- The tapes are produced at low cost, below broadcast standard, but of good quality for training purposes.
- The contain illustrations of interviews with a wide range of clients in a variety of settings.
- For ethical reasons real clients were not used. Instead, professional actors were given general guidelines for their roles. Interviews were filmed without rehearsal. Both actors and interviewers knew very little beforehand about how the interview would proceed.

There are seven tapes in the series:

A. **Introduction to Motivational Interviewing**

The introductory tape is a conversational interview with *Bill Miller* and *Stephen Rollnick*, conducted in the summer of 1997 by *Theresa Moyers*. They review the background and current directions of motivational interviewing, explore its essential theoretical and conceptual under-pinnings, and discuss its five basic principles. This is by no means a comprehensive introduction to motivational interviewing. Rather, it sets the context for the demonstration tapes that follow.

B. **Phase I: Opening Strategies**, first tape

C. Phase I: Opening Strategies, second tape

This is the most complex of the tapes, and spans two cassettes, 2a and 2b. It is designed to illustrate the skills involved in the opening phase of motivational interviewing. Phase I focuses on identifying and strengthening the person's intrinsic motivation for change. It begins with the first contact and continues until transition into Phase II, illustrated on tape 6.

D. **Handling Resistance**

The information presented in this videotape is particularly useful during Phase I, although the methods are applicable throughout counseling. The phenomenon of "resistance" is discussed, and various strategies are explained and demonstrated.

E. **Feedback and Information Exchange**

One context in which motivational interviewing has been widely practiced is the "check-up" or feedback assessment information. This specialized application involves much more talking on the part of the therapist, in that more information is being imparted to the client. How does one take this more active, information-giving role and still be consistent with the spirit of motivational interviewing? That is the focus of this tape.

F. **Motivational Interviewing in Health care Settings**

A rapidly growing application of motivational interviewing is in general health care settings. Here it is often necessary to compress the process of counseling into a shorter period of time. This tape explores how the spirit of motivational interviewing can be applied in busy health care settings. It is emphasized that this is a very new field and that there is no single method for use in these settings. It depends upon the setting, the constraints of consultation length and training time, and, critically, on the skill of the practitioner.

G. Phase II: Moving Toward Action

How do you know when to move from Phase I (building motivation for change) into Phase II (consolidating commitment to a change plan)? What counseling methods are used in Phase II, and how do they differ from the opening strategies of motivational interviewing? This is the focus of the final tape in this series.

These tapes will be distributed in Europe by the Bergen Clinics Foundation, in VHS-PAL format. For more information just call, fax or E-mail. To order the videos please fill in the enclosed order form. A brochure describing each tape will be included.

Interview from across the Ocean: Mercedes

Mercedes was central to the preparation for the TNT workshop in Tarragona last year, and she has joined the steering group for the MINT network.

Comment from the editor: With Tom's permission, I did make some minor changes in the

text for translation purposes. I have tried to maintain the meaning but may have missed the boat in some instances.

Tom: First, tell a little bit about yourself – background, profession, experience, etc.

Mercedes: I have been working in the substance abuse field since 1992. I worked as a medical doctor, first in an ambulatory setting in the public health system, with patients mainly abusing illegal drugs (trench warfare or first line command, whatever you call it!). Later on I worked as a research fellow for three years in the Department of Pharmacological and Physiological Sciences at the University of Chicago (Il, USA) with Dr. Lewis S. Seiden. In basic research, my strongest field of interest was drug craving, and neuronal sensitization related to drug abuse and dependence. I worked mainly with laboratory rats and to be honest I didn't need to be very motivational then. I always had the last word and I seemed to be the one to know the best (do not try to ask the rats!). My background and my formation have been very biological until now. MI has been for me like opening a window to let in fresh air and also like opening Pandora's box. At the present time I am doing mainly clinical work in the Alcohol Dependent Unit in the Hospital Clínic de Barcelona (Spain) on Dr. Gual's team. My relationship with MI has been short but intense. It began in 1998 when I attended my first workshop of MI with Carolina Yahne and Antoni Gual at Benicassim, and already it is seems to be permanent.

Tom: In Tarragona last year 40 persons attended the Spanish-language TNT workshop, and some more of you were in the English workshop. So suddenly there were 50 MI trainers in Spain. What do you think will happen with MI in Spain?

Mercedes: Tough question. Fifty MI-trainers in Spain are really only like a drop of water. I think though that this drop could mean that finally it is going to start to rain.

Tom: There has been some discussion and some research about the effect of teaching MI to practitioners. What do you think of trying to produce MI trainers in a three-day workshop?

Mercedes: I am very concerned about that. Above all because of my own experience when learning MI. When I attended my first workshop I felt that it was enough to introduce the theoretical background and principles of motivational therapy but not enough to successfully integrate MI in my daily practice. That was one of the reasons that we started the GETEM group in 1998 (Spanish Group of Motivational Interviewing Techniques). We planned to have weekly MI sessions with supervision (which unfortunately but maybe more realistically have become monthly!) and also theoretical sessions with MI discussions. The training part that enables you to pass from theory to practice was missing in the basic workshop, and I think it may also be missing on the MI trainers' three-day workshop. After the meeting in Tarragona they asked all new MI trainers from 0 to 10: "How useful it will be for you to teach MI?" I answered 10. "How ready do you think you are to teach MI?" I answered 5. Just in the middle of ambivalence!

Tom: Steve Rollnick has been suggesting that our basic strategy for teaching MI may be wrong, and that we have to start thinking of training through a bottom-up perspective.
a) What do you think he means?
b) What are your thoughts?

Mercedes: Steve is a great "agitator." "Bottom-up perspective" sounds to me very appealing and motivational. I will be the first to sign on for this new workshop. (Please Steve, let me know about it with some time in advance!) I guess it all stands for using MI strategies not only as practitioners but to extend it and adapt it to other parts of our lives and activities like teaching. Why not?

(Comment from Tom: I think it is a point that one does not "sign on" for a bottom-up workshop. More the other way around: you invite the workshop to come to your own place.)

Tom: What are the good things about MI in Spain ?

Mercedes: Well, I think we could say that Spain is a rather dry country that needs and welcomes the rain…..

Tom: – And what are the things that you are not quite happy about…..

Mercedes: The good things and the not so good things! That sounds familiar and rather appropriate for this interview. I guess beginnings are always tough and then there is also the growing pains phase. There is a lot of interest for MI in Spain now but it is rather a new thing and we do not know what will happen. Is it going to be only a short fashion? Are we building a solid groundwork? There is also the language barrier; much of the MI bibliography is available only in English and it is going to take a while to translate everything or make our own. (I know what I am talking about. It took me a whole summer to translate the MI manual for the Tarragona meeting!)

Tom: I guess what I'm really asking, is about cultural differences in the response to MI. One can think that clients/patients respond differently, and also that practitioners from different cultures may have basic values that are more, or less, congruent with the basic values of MI. What do you think?

Mercedes: You really raise an interesting point here. It is always said in tourists' ads that "Spain is different." That may be true for doctor-patient relationship as well. Having a National Public Health System there is very little room for "clients," and subjects are called "patients" or users." Historically they have always expected the doctor to tell them what to do (at least that is what we have been told and felt!). We work under the impression that patients are going to argue that it is our job to know best. "How should I know? You are the expert." I think we have been for a long time inside the expert trap. Also, as a fellow MINTie, Neus Freixa, told me, there is the question of repression. Forty years of national and political repression is not easily overcome, and a good proportion of the Spanish population do not find it easy to express themselves freely. Furthermore, it is not usual to be reinforced for doing good things, and people get suspicious if you do so. (You can ask Carolina Yahne about her experience with this in the Tarragona Spanish workshop!) Still, I have to say that being Mediterranean and Latin as we are, we work a lot from the heart and the feelings. Proximity (even physical proximity) and caring for the patient is prioritized in front of other type of qualities.

Overall, I think it is important and very reinforcing to see attitudes or aptitudes that we have been integrating through long years of practice well structured and organized as MI strategies!

Comments from Tom:
I'm intrigued by the last comment. We have known that the non-verbal communication is always there, and that it is a major part of the counselling relationship. I think Mercedes is suggesting that also the non-verbal communication can, or should, be structured into MI-interventions? That non-verbal communication is more that just waving your arms and wrinkling your forehead in a friendly way ? (A colleague told me once that one should make vertical wrinkles for the neurotics, horizontal wrinkles for the psychotic, and a criss-cross pattern for borderline patients.) It makes sense to say that our non-verbal communication can match or mismatch – or even enhance – our verbal interventions.

I have heard Jeff Allison say that watching Bill Miller doing MI on the "MI tapes" is like watching a duck swimming in a quiet pond. Over the water it seems that the duck is elegantly and effortless moving over the still surface, but under the water you would see the feet paddling like mad to move the duck in a good position. Perhaps with some patients, or in some cultures, the counselor should be waving his arms, raising his voice, moving around in his chair, and acting more like a windmill than a duck?

I often get into discussions about cultural differences in my workshop. In Norway they ask "How much is this a North American method?" And sometimes: "Is this a gender-neutral method?" Since my feminist colleagues have taught me that *nothing* is gender-neutral, I say "Of course not!" – but I'm not sure *why* that is. (Perhaps a question for somebody in a later MINTerview)

To the first question I must say that the basic MI values of humanism, free will, individual choice, etc., are not "outside" a cultural or political context. In many ways one can see that they are

not really congruent with the basic values of the Scandinavian social-democratic ideology (like solidarity, society's responsibility for the well-being of the individual, social problems as symptoms of a malfunctioning community, etc.). On the other hand, Scandinavia is developing to be more and more like the US, so the point is less important…. But still, which of the basic MI values are more universal – and apply to all cultures – and which are more specific for male, North American, Protestant, white, middle-class values?

I'd love to chair a discussion once, about these questions – and the participants should be:

- an Englishman/woman with a radical working-class background,
- a black African Muslim, and
- and an East-Asian Buddhist……

Nashville MI-Line: A Report from the Society of Behavioral Medicine Catfish Club

John Martin Reporting

Well, we've all returned from our trip to Nashville and the City of Opryland (actually, the Hotel was big and clumsy enough to have its own zip code and dysfunctional post office, and was far enough away from everything else to be its own small city), where about 10 of us MINTies attended the Society of Behavioral Medicine annual meeting. Interestingly, there was quite a lot of talk about brief counseling methods for health behavior intervention (and a fine talk by fellow MINTie, Ken Resnicow–showing MI with high health risk African Americans resulted% in considerably better health outcomes compared to the other treatments–look for his abstract on the MI Web site). Rick Botehlo also did a very nice seminar on MI and brief negotiation in medical settings (I went and really enjoyed it). Rick did an interesting thing too: He had the workshop attendees come up with their own cases and had the audience vote on which one to use in the role plays. My "Mr. Jones" very overweight gourmet cook lawyer highly resistant case 'won' and I ended up sitting for several role plays as my 'made-up' case example. I think I was quite tough on Rick, but he rolled with all my punches and resistance quite well. To add insult to injury, so to speak, Rick did a most intriguing thing after we all left–he emailed the lot of us and asked for more ideas on what could be done with this Mr. Jones, even prompting me for further details. Fascinating. A good idea that can keep workshop participants thinking and connected with the presenters. Nice going, Rick. Great idea.

Now for the catfish story: My days in Mississippi, as a PMI (pre-MI), brought back memories of wonderful catfish and southern fried everything meals at a place called (no kidding) "Cock of the Walk." Come to find out they had one of these just down the road from the Opreyland Hotel. Not only was the catfish fillet deep fat fried, but so were the hush puppies (translation for non-Southerners and our European colleagues: fried cornbread balls with interesting flavorful things mixed up in there), the french fries (of course), and the pickles! (Yes, they breaded and deep fat fried the pickles. Quite tasty if you and your heart are hearty enough, no pun intended.) So, Rick B., Denise Ernst, Jas (unspellable last name), and about 5 others and I all made it over for our heart-healthy evening of Southern fried cooking, completed with bacon-fat-smothered and totally (but traditionally) overcooked collard greens (translation: never mind). Great conversation (to follow) on MI and everything else, wonderfully tasty catfish and other unmentionables, and a run-in of sorts between a southern "gent" (we found out who they named the place for), our "pretty ladies" and ultimately Jas. (I think Jas' turban attracted him.) Fortunately he didn't sit down to join the ladies (they didn't exactly invite him to stay), and he was finally chased off by Jas' eloquent resistance-roll reframe (something along the lines of, with a smile, "get lost, Bubba").

MI-Talk: We addressed two topics, as follows. First, possible to conduct motivational intervention in a group setting, especially a larger one, without losing fidelity or effectiveness? I discussed some of our research and that conducted at UNM, on college drinkers, suggesting that while it appears that even written drinking feedback presented in a motivational context appears effective in cutting higher-risk drinking up

to 50% when mailed to participants, the jury is still out on whether this effect can be achieved, or enhanced, by combining this written feedback with a motivational interview discussion group. Our two previous studies with college freshmen and sophomores resulted in a split-decision, of sorts. In the first study, the group discussion was no better than the no-feedback control. In fact, the group intervention was associated with an overall increase in drinking, when compared to the control and especially the mailed feedback conditions. I recall conducting one of those small groups (8-12 participants) with a doctoral student co-facilitator, and when we finished it, we just looked at each other and said: "I think they're all going drinking now." Seems our values card sort and "new roads" exercises resulted in almost uniformly positive comments about the pleasures and benefits of drinking in this apparently uniformly pre-contemplating group. This may have had something to do with the fact that they were recruited out of Psychology 101 classes for research credit (we selected students who reported drinking 40 drinks or more in the previous month). Unfortunately our second study had insufficient numbers to compare (N< 8 vs. N=15 for Study 1) fairly, but in this study the group intervention, but not the mailed feedback, was associated with a significant reduction (again, roughly halving) in drinking.

Our most recent study seeks to test this same question on larger groups already in fellowship. We spent about a year working on recruiting, somehow, fraternities and sororities to participate in this study replication and extension. The real trick finally was to recruit a couple of sorority and fraternity presidents from my psychology classes who were interested in independent research hours and graduate school recommendation letters. Thanks to their insider efforts we recruited three sororities and three fraternities interested in participating. Some of their national organizations were quite pleased with their proactive stance on alcohol problems (although one national organization vetoed the participation of one willing house), and one even made it a requirement for its local chapter. We randomized one sorority and one fraternity to either no-feedback control, mailed feedback, or written feedback and group motivational discussion. To date we have conducted the initial assessments, as well as the group discussion sessions. In my rounds to the houses for assessments and group intervention, I was regularly recognized by students and became known as "hey, Beer Man!" I wear the moniker with pride. During one assessment at a fraternity, one of the guys was drinking a beer at the time and asked: "Should I include this beer on this form?" Running the groups was a lesson in rolling with resistance big time! Whew. Initial reactions to the written alcohol use patterns were often strongly argumentative (the feedback was individualized for everyone based on their assessments–we used a student off-shoot of the Drinkers Check-up by Miller, refined by Scott Walters of UNM, and called the "CHUG," or "check-up to go"). It was a real test of my abilities to roll with this resistance through reflective listening and affirmations. We got some quite interesting comments to what they liked most about drinking, some unprintable. (I decided in the future I'll mix the men and women in the same discussion group to hopefully modulate some of those rather uncomfortable needed reflections). We should have our results analyzed by mid June, and I will be presenting some of them (i.e., group vs. individual written MI interventions in college drinkers) at the Research Society on Alcohol in Denver in late June.

The second topic was much more briefly addressed, and concerned how to do research on health behavior using MI approaches to delivering a package treatment program. The question is how we might offer treatment component (menu) choice to participants when all the components are believed necessary for the treatment to be efficacious. Are we violating a core MI principal by restricting free choice of treatment components when testing a whole treatment package that is adapted to motivational interviewing? There was an interesting discussion around this point while the restaurant noise allowed.

We left the Cock of the Walk, stuffed to the gills (pun intended) and now in recovery. We hope to repeat our get-together at the next SBM meeting next spring in Seattle. Perhaps Ken R. and I will resubmit our workshop/seminar that was rejected (!) by SBM this year, and maybe connect with

Rick B. There definitely seems to be much more interest in MI in the organization, and we hope that there will be more formal presentations and papers addressing brief motivational counseling in this organization of health care physicians, psychologists, nurses, etc. Maybe we'll see you there?

Interview with Victoria Maizes, MD

Denise: Victoria, thanks for meeting with me today. Tell us about the work you do and what you are up to.

Victoria: As you know I'm a family doctor by training and I'm currently doing a fellowship in integrative medicine (IM) at the University of Arizona program in integrative medicine.

Denise: **What do you mean by IM?**

Victoria: Well, that is an excellent question. Because there is no universally accepted definition of IM and different people mean different things when they say IM. What I mean is healing-oriented medicine, that focuses on the relationship between the doctor and the patient, and integrates alternative and complementary therapies when appropriate.

Denise: I know you have been trained as an MI trainer and we've done some work together in your previous life at Kaiser. I'm wondering how you see or if you see MI or that style fitting into the model of IM you are describing.

Victoria: I think it fits incredibly well. In October I had the opportunity to do an introductory MI lecture at Duke. Duke and the University of Arizona cosponsored a conference on IM. It was one of the workshops offered and, by the way, had the highest attendance of any workshop offered. It was a lot of fun. That it was part of the conference is testimony to the fact that MI is considered part of IM. MI is also a part of the training that fellows in the University of Arizona integrative medicine program receive. A huge part of IM is dealing with lifestyle issues and prevention. Having the tools from MI is extremely helpful as you help people in the area of lifestyle change. So it is a very natural fit. But I think there is also a deeper fit. When I read Bill Miller's thoughts on the philosophical underpinnings, the theory of MI, in the September 99 Minuet, it easily could have been titled IM. I was really touched by what he wrote. These underpinnings seem very similar to the way that we approach our patients, how we view them, and how we hold them. We try to understand what it is that our patients value, what gives them their sense of purpose, and to hold the space for them to live that. We attempt to give them a sense of hope, of possibility, of the range of options that may be available to them to move towards healing. So the Brief Negotiation techniques that I taught at Kaiser are relevant in terms of what do you do with someone who smokes or who can't figure out a way to incorporate exercise into their life. Of course these techniques are important, but I think the more interesting synergy is the way one values a human being. That is core to both.

Denise: So it's really the deeper level that you see. The strategies are important but it's the deeper level that is more interesting.

Victoria: Right. Both levels are valuable. Techniques are certainly useful. Sometimes in IM we use the analogy of a tool box. IM physicians in this program have all had conventional medical training. So we have those tools, the conventional medical tools in the tool bag. But then in addition to that I've learned guided imagery, homeopathy, a little about osteopathic manipulation. So those tools are added to my tool bag. I don't do Chinese medicine but I've learned more about who will benefit from a Chinese medicine approach. Well, that becomes another tool that I add to my tool bag. Similarly, the MI techniques can go into the tool bag. But beyond the tools there's the whole way of being in the room with another person and that's the deeper level that both MI and IM seek to reach.

Denise: Many of the trainers in the organization have done training with physicians. I'm really interested in what your thought are about training physicians. What kinds of training is happening in your program or just how you see that working?

Victoria: The training in our program is done by Robert Rhodes who went to one of the early MINT trainings. It is six-hour training that goes

over the theory and teaches some strategies. We also have training in doctor-patient communication training and in the art of medicine. There is overlap between these curricular areas and MI. In general, MI strategies are very teachable. Doctors are pragmatic; if something works for them they are going to incorporate it and use it. I think the strategies that are taught fit into that category. And I think that the broader, deeper, philosophical underpinnings of acceptance, belief in our patient's potential, are the art of medicine and can be taught from a variety of perspectives.

Denise: For clarification, could you briefly mention what the strategies are that you think are useful?

Victoria: Well, perhaps the most useful strategies for physicians are assessing readiness, understanding how to work with ambivalence, shifting how they give advice, and rolling with resistance. One of the differences in my practice here is that I see many more motivated patients. There is something you didn't ask that I have been thinking about and wanted to share with you. The way we see patients in the IM clinic is in two visits divided in time by two weeks. In the first visit, we meet with our patients for approximately an hour. We try to understand our patients in the broader context of their lives. We may ask about pivotal events in their life, about their relationships, about what it is that they enjoy. We also ask about any intuitions they may have about the cause of their disease. And we ask what they believe they need to do to heal. So we ask a broader set of questions. Then we research the options, have a patient conference, and write up a treatment plan. The second interview is quite different because we present the plan. In the first interview the patient probably does 80-90% of the talking. In the second one, the physician does a lot of the talking because we have the treatment plan to present. I usually go over the plan paragraph by paragraph. And answer questions. I realized fairly early on in the process of developing these treatment plans that they focus on all the things patients need to change. Now I start my treatment plan with what I call successes. What is going well with the person, in what ways have they achieved success. That relates back to what I would call that deeper level of MI and IM. It supports self efficacy. At the end of my treatment plan I discuss the challenge of creating change. As I finish the plan I suggest, it is a menu of options. Because it is expensive to come in to the IM clinic, we offer more options than we are expecting someone to do. We may suggest a whole range of possibilities and ask the patient to consider where their energies might be, where they see themselves proceeding, where their readiness is. We remind them that they have choices. We accept where the person is, and recognize what they have already been able to accomplish, often in very difficult circumstances.

Denise: You talked about training physicians to the strategies. Could you speak a little bit about that? Some people have gone as far as to be discouraged and not very hopeful that physicians, as a whole, will be able to do what you are talking about, the deeper level. What thoughts do you have about that?

Victoria: Well, I have confidence that this can be taught to physicians, and this is some of the most satisfying work that we do as physicians. It is the inner work. It may not be for everybody, but I do think that for many doctors it is the soul of their work so I wouldn't give up too easily. And how you train them depends on where people are coming from. What experiences they have had, what touches them, where they see their growing edge. The deeper, more self-reflective process is about how one engages another human being. I think it can be modeled. And it can also be articulated in writing. There are certainly lots of pieces that doctors have written that about different levels of doctor-patient communication. About encountering the soul of the patient. So, I think there are ways to train doctors but many of them are non-linear.

Denise: Non-linear. Talk about that.

Victoria: Well it certainly is not part of the 16-hour Brief Negotiation training that we did although it may show up there. It is self-reflection process, it could be a mentoring process, it could be a process that right now doesn't exist much in conventional medicine training.

Denise: So you see that it could happen in the medical training but it would be different from the way that it is now.

Victoria: One experience that I had that is similar is Balint training. I went through Balint training as a resident and again as a practicing physician. It is a different model of training. Are you familiar with Balint training?

Denise: No.

Victoria: Michael Balint was an English psychoanalyst. His father was a general practitioner. He developed a process for physicians in which they talk about their difficult patients. Not difficult in the medical sense but difficult in the emotional sense. And that is a self-reflective process in which you begin to understand who it is that pushes your buttons and why that might be. As your self-reflection deepens you become more aware of the process that is going on as opposed to the content. Now when process training becomes a part of medical training we will see a shift. Again that is the heart of MI and IM–the deeper part. It is a way of holding another human being that is deeply respectful and accepting and yet still leaves room for offering suggestions or giving advice without being paternalistic or overly directive.

Denise: Sounds wonderful.

Victoria: Yes! This is a really wonderful way to practice medicine. And it takes time. One of the challenges we find in medicine today is that developing relationships takes time and we don't have the luxury of the old time GP who knew their patients from cradle to grave.

Well certainly, I know I hear frequently from the physicians I have trained, that this is all well and good but I don't have time to do that.

Well there is always time to hold people with love and respect. That is the way you hold yourself as you enter the room. Steve Berg-Smith teaches physicians a 30-60 seconds advice piece. That is a strategy. There is always time for 30-60 seconds, and doctors give advice all the time.

Denise: You have a lot of hope that physicians really can learn this and when they are interested they will be able to find the time, that there are many ways it could happen through education, mentoring programs, or other things. If you were to give us some suggestions about how this group of trainers could influence that or be a part of that, what would you say?

Victoria: Well, one thing that influences doctors is evidence. I think more scientific journals does help to some extent. I remember a doctor I trained at the end said "Well you know, even if when I tell someone to quit smoking it only works 5% of the time, at least I know it works 5% of the time." How do I know that this works? So there always a level at which having more journal articles helps physicians. I think that some of the training videos are very powerful because they show in relatively short period of time how someone who is highly resistant might shift when worked with in a different style. Of course the easiest way is to just find physicians who are ready.

Denise: Well, if you look in the IM program you might find a whole bunch of them.

Victoria: Yes, I think you would. And there may other places to find them. I think it is more fun working with people who are asking for it and ready to incorporate it. One of the things that doesn't currently exist are free-standing MI conferences or trainings. I think there is a need to offer trainings that are not linked to Kaiser or some other group but instead are free-standing or linked to another conference.

Denise: How long a training might that be? Two days? Three days?

Victoria: I don't know. I think the training works better when offered over an extended period of time. Logistically this is more difficult so it is often done back to back. At Kaiser we sometimes did one day and then the second day a week or two later. In terms of the way people learn it would probably be much better if it were three hours every month for a year. Where people really got time to practice and come back and discuss it and then practice again. We tend to offer trainings with no follow-up, no reinforcement.

Denise: It is an important issue. It does get linked to a lot of conferences but sometimes

that continuity or follow-thru is really difficult. I think this is an issue that this group really needs to grapple with.

Victoria: Logistical things may help as well. One of the things I tried to do at Kaiser was to create a stamp for the chart to record readiness, etc., so that the next person who saw the chart would know.

Denise: Would support their change. I know that is a lot of what we have done in research. Try to figure out how to actually change practice and implement new things. A lot of logistical support. Do you have anything else you would like to add or to tell us?

Victoria: Well, I think this is really important work. I'm glad that you are doing it. I think teasing out more of the philosophical and theoretical bases is good to do. And understanding more about assessment. How do you know when someone is doing MI? How do you know when it is going well? In a simple way. One of my research questions is how do you measure the doctor-patient relationship in IM? I would like to see a simple marker. If this marker was present then IM probably was happening. Right now with doctor-patient communication, we have such difficult, time-consuming ways of assessing. So here is my question for the group, for this smart group of people who are thinking about doctor-patient communication. I believe that there probably are some simple questions or markers that would let you know that IM was happening or let you know that MI was happening. Our job is to tease out what those markers are rather than coding every word or phrase, rather than measuring talk time or counting reflections vs. questions. There probably are some very simple markers. And if we're smart enough to figure those out our jobs would be much easier and the training would be much easier.

Denise: Sounds good. Thank you, Victoria, for taking the time with me today.

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*

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.

Important MINT Dates

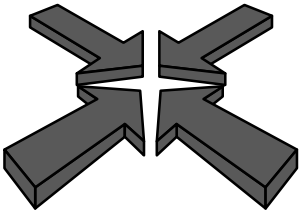
Submission	Publication
8/1/00	9/1/00
12/1/00	1/1/01
4/1/00	5/1/00

From the Road (Florida this time)

Denise Ernst

It is good that there really are some things that get easier with experience! The second newsletter was much easier to put together. And I have great confidence that the IAMIT steering committee will resolve the thorny issues about how to distribute it, who to distribute it to, and where to find those folks who are meant to get it. Then life as the editor will be all or mostly fun.

I have seen, in just this short time as editor, what a great group of people the MINTies are. Warm, friendly, generous, creative, and enthusiastic. And very "organic" in shape. The need for organization (or sometimes sanity) often calls for more structure, firmer boundaries, and clearer definitions of who we are and what we do. This produces a dynamic tension that the group must somehow manage. It will require all our creativity **and** organizational skills to keep the association one that nourishes its members and supports excellence in our training endeavors. Any ideas on how we can manage the tension and stay the competent, committed, and creative bunch that we are?



Inquiries and submissions for this newsletter should be forwarded to:
Denise B. Ernst, M.A.
Motivational Interviewing Network of Trainers
Center for Health Research, 3800 N. Interstate Ave., Portland, Oregon 97227
Email: *d.b.ernst@worldnet.att.net*