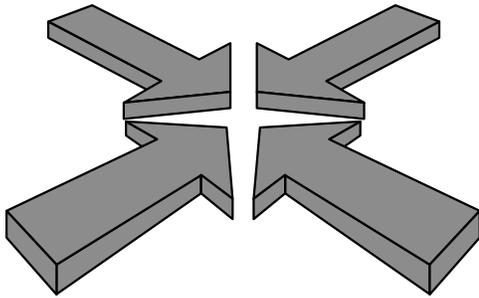


Motivational Interviewing Newsletter: Updates, Education and Training

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New Perspectives



FROM THE DESERT

A Streetcar Named Desire

It is about an hour's ride from the Minneapolis/St. Paul airport out to the 500 acre Center City campus of Hazelden, flagship program of the Minnesota model. The jovial driver who met me at the arrival gate also escorted a new patient directly from his flight, past the airport bars, out into the rain and the Hazelden transport van. He offered an upbeat and extraverted patter as we traversed freeways and two-lane roads and waited while a hundred-car freight train crawled through a crossing. "It's a great program with wonderful staff," he assured us. "All you have to bring is the desire to change. They do the rest."

It reminded me of a remark quoted by Ernie Kurtz from an interview with the stalwart former president of Hazelden, Dan Anderson. Asked what it takes to make such a successful treatment program, Anderson quipped, "Be the place where people go once they have finally decided to quit drinking."

Like the best of humor, Anderson's wry wit points to a deeper truth of which we are aware, and that makes us a bit uncomfortable. An analogy that occurs to me: "Are you single and want to be married? You just bring the groom (or bride), and we'll do the rest."

So what is this elusive and crucial vehicle called "desire"? There is a danger of circularity, of course: If treatment works, you had enough desire; if it fails, then you didn't. Assume, however, that there is something more here than our self-protective rationalization; that there really *is* a conveyance called desire that gets people from one station to the next. Enhancing that intrinsic desire for change is the historical goal of motivational interviewing, yet we know surprisingly little about it. My initial naive assumption was that we could measure motivation with a simple questionnaire (such as SOCRATES or URICA), and that pre/post changes on such a scale would be enhanced by MI and would mediate behavior change. It never worked out. SOCRATES, at least, does not seem to reflect an immediate motivational impact; yet behavior changes after MI, and subsequently so do SOCRATES scores. The most extensive test of this motivational mediation hypothesis was with the 1 726 clients in Project MATCH (1997), where initial findings were, if anything, contradictory to predictions. SOCRATES at baseline is a reasonably good predictor of outcomes (as is URICA), but I don't recommend using SOCRATES as an outcome measure.

The most exciting things I've learned during the past few years about desire for change have come through collaboration with my psycholinguist colleague, Dr. Paul Amrhein. As of this writing, Paul is just revising the first report of his MI findings in response to very favorable reviewer comments (Amrhein et al., 2002), but I

can provide a useful summary without scooping the scientific reports.

Our most important work to date has been in psycholinguistic analyses of tapes from MI sessions in a NIDA-funded clinical trial known as MIDAS (Motivational Interviewing in Drug Abuse Services). To our surprise (I don't know why I'm still surprised - I seldom find what I expected!), we found in the main trial absolutely no hint of an effect of MI when clients entering treatment for drug use disorders (primarily cocaine, amphetamines and heroin) were randomly assigned to receive or not receive one initial session of MI (Miller, Yahne & Tonigan, in press). Clients in both groups fared rather well. We considered a range of reasons why we might have failed to replicate our own and others' findings of beneficial effects of MI in drug abuse treatment, but suffice it to say that there was nothing there to persuade even the most ardent believer.

Enter Paul Amrhein and his graduate students, who coded all the MI sessions for the presence, strength, and pattern of client commitment language. Voila! Client speech and outcomes behaved just as would be predicted by MI theory. Those who showed increasing change talk (in this case, increasing strength of commitment language) over the course of an MI session tended to abstain from illicit drugs during follow-up. In contrast, those who would continue to struggle with drug use after treatment showed a very different pattern of speech during their MI session. At key points during the session – during assessment feedback, when asked a key question to initiate Phase 2, when discussing a change plan – they showed major backpedaling in commitment language strength. This was also true, by the way, of clients whose self-reports of abstinence were contradicted by positive urine drug screens. When asked about their drug use outcomes, they were not honest, but their pattern of commitment language during the MI session foretold the truth.

It is important to note that Paul found that the *frequency* of change talk (commitment language) did not predict outcomes; only the *strength* of commitment language was prognostic. This helps us understand some prior failures to predict drinking outcomes from frequency of change talk

(Miller, Benefield & Tonigan, 1993; Pederson 1996). Paul has also been using the same MIDAS data set to study whether MISC codes (Miller & Mount, 2001) predict client outcomes, and it appears that they do not. That is, global ratings and behavior frequency counts of MI sessions do not reliably predict drug use outcomes, whereas patterning of the strength of commitment language does. This suggests that in process coding of MI, we ought to be attending to temporal patterning within sessions (rather than just mean frequency counts), and that the implicit strength of change talk (commitment) may be much more important than its frequency. Interestingly, we *did* find earlier that frequency of resistance responses predicted drinking outcomes (Miller et al, 1993), a finding that we do not seem to be replicating in MIDAS with drug use outcomes.

So what is it exactly about client speech that predicts behavior change? The clearest predictor was the strength of commitment language at the end of the session (10th decile), where a change plan was being discussed. Those who were going to abstain maintained a high level of commitment in their speech right to the end. Those who were going to flounder showed a clear backpedaling in commitment strength at the end of the session. The other place in the single MI session where good outcomes could be discriminated from poor was in the middle, during the time when MET feedback was being given. Before feedback started, the outcome groups were similar in speech pattern. It was client speech during feedback, and then again later during the change plan, that separated the abstainers from the flounders.

In essence, the flounder group backpedaled at these two points in the session, which is what differentiated them from the good prognosis group. They were progressing along with change talk until the feedback arrived, then they stepped back. After the feedback ended, their change talk began to recover, but then when the therapist started in on a change plan they crashed. This may well have been our fault for regimenting MI into a prescribed one-session procedure. Ordinarily a good motivational interviewer would see the client's drop in change talk and increase in resistance, and would pull back rather than charging ahead with feedback or a change plan.

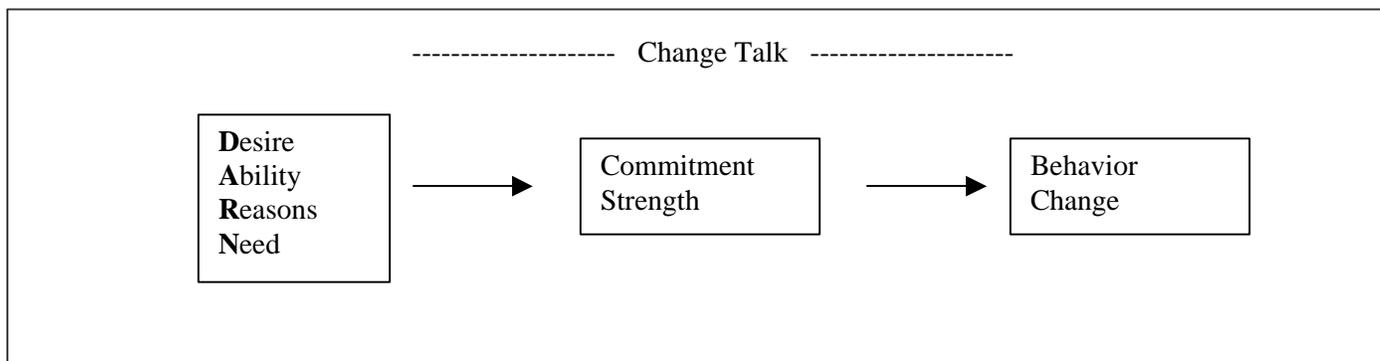
Progress in MI is driven by the client’s response: Never get ahead of your client’s level of readiness. When the order of things is prescribed and time is limited, however, therapists necessarily get ahead of some of their clients, and those are the ones who show poor outcomes. One could say, of course, that these were the less-ready clients who had poorer prognosis. It is equally plausible, however, that we caused our therapists to do poor motivational interviewing in these cases by tying their hands with regard to lockstep timing. That may be what happened in Project MATCH, too, where contrary to expectation the less-ready clients initially did more *poorly* in MET. The hazards of manual-driven therapy!

There are also subtleties of language that we haven’t been capturing in the MISC. In Paul’s coding system, client statements can reflect desire (D), ability (A), reasons (R), need (N), and commitment (C). The first four (DARN) did not predict outcomes. Only Commitment language predicted post-treatment behavior. Each of the DARN elements, however, made an independent contribution in predicting Commitment. It looks, then, like Commitment is a final common pathway to behavior change, and is increased by eliciting change talk that reflects desire for change, ability to change, reasons for change, and need for change. What you are *really* listening for, however, is strength of commitment.

This brings us back to a key point in facilitating the learning of MI. Even seasoned clinicians are unlikely to acquire MI by participating in a 2-day workshop (Miller & Mount, 2001), so perhaps the best we can do with an introductory workshop is to enhance clinician interest in this method, and show them how they can learn it from their clients.

It’s like the definition of a reinforcer: if the strength of a response increases when it is contingently followed by a stimulus, then the stimulus is a reinforcer (for that response for that client at that time). In MI, if your client is showing increasing strength of commitment language over the course of a session, then you’re doing it right. Paul’s data indicate that client speech patterns *during MI* tell us whether behavior is going to change. Thus you have instant feedback from each client about your proficiency in using MI. Once you know this, you can improve continually with practice of MI, because practice inherently includes feedback (a prerequisite for skill acquisition).

Here there is some good news, though still more preliminary. (Paul says to regard it as about half way between a finding and a rumor.) Paul is now analyzing tapes from our NIDA-funded EMMEE trial (Evaluating Methods for Motivational Enhancement Education), in which we are teaching MI to clinicians who want to learn it. That these clinicians were initially unskilled in MI is supported by Paul’s early observation that in baseline (pre-training) counseling sessions, clinicians’ clients were emitting too few change talk statements to permit reliable rating of the strength of commitment! (Here frequency matters. There must be some change talk in order to rate its strength.) After training, on average, participants’ clients are showing much higher rates of change talk and the desired pattern of increasing strength of commitment. That is precisely what we did not see after our first evaluation of a 2-day workshop alone (Miller & Mount, 2001), and it suggests that we must be doing something right in EMMEE.



So to complete the analogy – the streetcar named Desire does not get you all the way to your destination. You have to transfer over to the Commitment line, which takes you the rest of the way. You can also connect to the Commitment line from other streetcars named Ability, Reasons, and Need. The motivational interviewer is just a conductor who helps you to keep from getting lost, to climb onto a streetcar that is going in the right direction, and to make the transfer successfully from one conveyance to the next.

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The Goal Specificity Effect

The experimental literature in learning and cognitive psychology is a rich source of ideas for how to do better training. In a weekly research presentation within our department, I recently learned about the “goal specificity effect” in transfer of learning. There is some conventional wisdom that it is better to have a more specific goal, but in fact when helping people to learn relationships among observations, there are advantages to having less specific goals. In algebra, for example, one might provide knowledge of several terms and ask the student to solve for x (a very specific goal). Alternatively, with the same set of givens, one might ask the student to solve for as many of the missing terms as possible. The latter method of instruction seems to focus attention more on the relationships among terms, and this facilitates transfer of knowledge to novel situations. That is, the student is able to solve different types of problems more quickly, by virtue of a relational understanding of the subject matter. The goal that is posed is still, in some sense, specific, but it is a few steps back, a more general goal that involves active exploration of a conceptual field rather than the performance of a specific operation.

This got me thinking about how this principle might be applied in MI training. My accustomed training strategy has been to build specific microskills and then put them together. In this approach we do exercises that involve rather specific goals: practice only reflective listening; ask certain questions; follow the readiness-ruler rules. What if, instead, we showed how to recognize change talk (desire, ability, reasons, need) and then asked counselors-in-training to evoke change talk from their partner, using whatever means they can? The methods that Steve and I have described for evoking change talk then become simply ideas, possibilities on the menu, where the larger goal is to generate client change talk. This not only is consistent with the goal specificity effect, but also somehow feels closer to the spirit of MI. It's worth considering!

**Not Just Leaning to Dance –
Learning to Follow
Motivational Interviewing in Psychotherapy**

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So just what is involved in this “dance” in MI? See, I really like to dance, think of myself as a naturally good dancer, quick to learn but oh... ever so picky about my partner’s ability! I really don’t “want” to lead, am very happy to let “you” lead, but if you don’t know the step or can’t find the beat... well, I for sure want to just correct you rather than engaging in some process for us to both get on the same beat, find the steps together. And then, of course, I want you to remember that step, where the beat is... I want to go on to something else. So, if I am that way in straight forward dancing, you know I am gonna have to really restrain myself in MI dancing when it comes to really listening to learn what beat the client is hearing and following the steps that might not be the ones I expect!

My clinical work is in a health clinic for women veterans, many of whom continue to cope with the symptoms of Post Traumatic Stress Disorder from military sexual trauma, generally rape by a fellow “soldier”. Not infrequently this trauma is longstanding with the symptoms entrenched and debilitating to daily life. One would think the motivation to change would be great and the client eager to find more effective ways of coping. Medication compliance is often a fairly easy area for progress. Achieving other changes is much slower and in smaller steps. It is in this area that the use of the MI approach/the dance is vital for me in not defining the “beat and the correct steps” and in trying to gain true understanding of the complexities of the barriers for change while acutely listening for change statements. Two case examples come to mind to illustrate the necessity of letting the client define the beat, lead the dance.

“I need them, my family. I can’t risk telling them no or *showing out*” is the most poignant statement made by this mid 40’s client in our 1 ½ year long work together. This client’s clear view

of her family is their acceptance of only so much capability on her part, their lack of faith in her receiving therapy, and the true nature of their caring for her coupled with the infantilization and over protectiveness of this caring. She is convinced that she needs help with her PTSD and has fairly strong conviction that the methods outlined for work are usable. However, she is not confident she can deal with the effort it would require to take a strong stance with her family around increased independence. Over 20 years of sheltering by her family with no understanding of her problems, their lack of faith in how she is seeking help, and the fact that she is not currently able to be fully independent of their care are huge barriers that she confronts each time she has to ask someone to bring her to therapy. She sits with the strong emotions: striving to make change, the pain of having to tell her distress to a stranger rather than her family, and the risks to her family’s care when she makes a stand for herself. Together we affirm her seemingly small gain of learning to make a salad for herself. Self-efficacy is bolstered by such an accomplishment. One step learned; not a whole dance yet, but a start.

“I’m like a porcupine with my quills out. I have not been able to open up and really feel since the rape 17 years ago. I just play a part with other people. It’s too scary to feel; I don’t know if I can trust being vulnerable.” “I have an elephant sitting on my chest.” These are recurring themes for this 37 year old woman. Miserable but fearful of feelings; barriers that extend back to childhood. The practical issue at hand: Additional job responsibilities that turn out to be unrealistic for one person to handle. The solution that was offered by her boss: We’ll hire another person. So why is not there not a sense of relief felt? Forty-five minutes into a sixty minutes session during which I mostly use reflection, it finally becomes clear: the contrast between the emotional reaction and the rational self is the point. The client rationally recognizes that the expectations were unrealistic and that her boss is finding a solution; emotionally she is tied up in her self-imposed “I should have been able to do this, I can’t let anyone see how upset I am, I must be a failure” messages. If she feels like a failure, she must be a failure; the feeling defines the self. I reflect both sides of this:

on the rational side you say “great, my boss will fix this!” or the emotional side you say “if I feel like a failure, I must be a failure, no matter what other information is out there to the contrary”. She wrinkles her nose, looks surprised and asks, “so I don’t have to be what the feelings say?” I say, “well, that’s one possibility of what you can decide”. We end with her noting, “the elephant is gone, I can breathe again”. I think we have danced this step before; will this step be learned, added to a pattern... does “she” know this is a dance?

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**Reflections on Reflections:
A Response to Carl**

David Rosengren

Thoughts on Affirmation. I enjoyed reading Carl’s comments about affirmations. It brought to mind something that I have been thinking about and focusing on my training: the difference between “I” statements and “You” statements in making affirmations. I know this is heresy in some quarters and believe me when I say that at least one workshop participant has taken me to task on this point, but I think we should be using “You” statements rather than “I” statements. My reasoning, as usual, is very simple. “I” statements contain a form of judgment about the actions, thoughts, attitudes or values of the others, even if the word “I” is not included. They also are easier to dismiss and contain less power than “You” statements. Look at the examples Carl provides:

“That sounds like a good idea.”

“I think you’re right about that.”

“Thanks for coming on time today.”

“That’s a good suggestion.”

“I must say, if I were in your position, I might have a hard time dealing with that stress.”

Incorporated in all of these is an element of judgment, albeit positive and supportive in nature.

Now, listen to how these might sound if you converted them to “You” statements.

“You took the time to think this through.”

“You’ve given this some serious thought.”

“For you, being on time is a priority.”

“You’ve thought about how you might handle this.”

“You are capable of coping with quite a lot.”

These statements are devoid of my judgment of this client’s action, thoughts or feelings. In addition, the affirmation seems harder to dismiss out of hand. I can’t articulate why, except that it seems this language tends to direct the affirmation to deeper and more core characteristics and values.

So, where’s the problem? Communication skills training – indeed the work that many of us have done with couples in improving couple’s relationships – suggests that we should “own” our thoughts and feelings. I agree. This makes sense when the goal is developing mutual understanding or improving a relationship. However, I think our goal is somewhat different with a MI encounter. We are trying to develop a specific understanding of the client, the issues s/he struggles with and the resources s/he might bring to bear in resolving this situation. As part of this process, we are trying to help them recognize the strengths and resources they have to build upon. To my mind, our judgments – even positive ones – may get in the way of this process.

Carl notes differences between allusions and attributions. Obviously, my “I” vs. “You” tend to fall along the lines of this differentiation, but I’m unsure that they map completely. To Carl I would like to say, your thoughtfulness in considering this issue is evident and has caused me to realize that I need to do some more thinking.

Training Affirmations. Until recently, I found it hard to incorporate affirmation exercises and I always found this situation dissatisfying as a trainer. I have found that affirmations are one of the things that most often are left out of MI encounters, even among well trained MI therapists. And, if we don’t practice, how can we expect people to produce this skill? The answer – you can’t or at least I couldn’t. People got the

concept, but couldn't deliver the message without practicing.

So, I struggled to find something that would work. Client scenarios felt artificial. Asking people to do it in response to client statement sort of worked, but it lacked spontaneity typically and people only did one affirmation. So how could we give this thing more juice? Then it occurred to me and I felt like an idiot for not seeing it sooner. We have all kinds of juice from the real material in exercises, but we need to focus on the process, not the content. Now this was getting interesting. You could do as many affirmations as you had exercises (pairs or triads). People would get practice. It would be mutual. And we could make it fun and energetic. And so was born the List of Names and something I like to call "Give One, Get One."

So, here is what you do. Before your training you prepare a List of Names (see attached). This sheet lists all exercises conducted in pairs, threes of fours, prior to your doing your presentation on affirmations (I do not include groups because it becomes too hard to create affirmations.). Make enough copies for every person in the group.

As part of your opening remarks to the group, you distribute the "List of Names." You tell them that for every non-group exercise, you would like them to take this sheet with them. The first thing they will do when they begin an exercise is to introduce themselves, if they don't know their partners and record their names on this sheet. Then when the exercise concludes, before they give any feedback, you want them to write down something their partner did well in this exercise. Tell them not to share the specific information they wrote down at this point. As a trainer you remind them to record this information after each exercise.

Now, here comes the fun part. Later, when you have discussed what affirmations are, you have them pull out their List of Names and say something like this,

"So, now I want you to have a little practice with giving affirmation and a little fun at the same time. On your list of names, you have all the people listed that you have worked with so far. I want you to find the people listed and tell

them what you felt they did well in your work together. Remember to give them some detail. So instead of saying, "You're a good listener", tell them what they did that communicated they understood you. Also, try to remember to use "You" statements rather than "I" statements. Now, here is the really cool thing about this. Every time you give an affirmation, you'll get one back. That's why I call this "Give One, Get One". Everybody understand that? If so, than let's have everyone stand up and go find your partners."

People enjoy this exercise. They get practice doing several affirmations. They notice the difference between "I" and "You" statements. It has sort of a "cocktail party" feeling to it so there is good energy. I will often do this before a break and then do the debriefing after the break.

One issue to note, occasionally a participant may feel uncomfortable with this sort of social exchange. You can usually spot them hanging on the periphery. Just like any other training exercise, I will check in with these people and invite them to participate however they feel comfortable. Sometimes, they may struggle to articulate their positives. If so, I will act as a surrogate for them. If they are clearly uncomfortable, I will let them decide if they would like to go to break early. Don't be surprised if a participant stops by to give you an affirmation as well!

Other thoughts: A Response to Ralf

The issues and theoretical influences of overconfidence are interesting considerations. The pragmatic piece of how do you manage this situation brought me to some unsolicited advice-giving (and we all know about the value of that, so use it for what it's worth): I'd juxtapose the overconfidence with their experience, probably using a double-sided reflection. For example, "So, you feel like you could quit any time you want and though you had some short-term success, you've struggled to stopped for good." I'd like to hear more about your research, Ralf.

List of Names

Day One

_____ Exercise: Used Car Sales

_____ Exercise: 12 Roadblocks in 5 Minutes (Pairs)

_____ Nonverbals only (Pairs) – Something that bothered me recently

_____ _____ Thinking Reflectively (Triads) – You mean...

_____ _____ Listening Only, Almost (Triads) – WTC or A decision I am struggling with

Day Two

_____ Warm up (Pairs) – Last Night

_____ Staging (Pairs) – Something I have struggled to change

The research described below is one of a series of studies recently conducted through the school of psychology at James Cook University in Queensland, Australia. A brief overview is provided here, however a comprehensive presentation of the statistical analyses and discussion of the findings is available elsewhere (Habib, Morrissey & Helmes, 2002b). Further details may be obtained by contacting Suzanne (Habib@jcu.edu.au).

Brief Intervention: Enhancing Engagement and Adherence in Cognitive-Behavioural Treatments for Chronic Pain

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Motivation is a critical factor in determining engagement in self-management and maintenance of treatment recommendations in cognitive-behavioural programs for chronic pain. A significant proportion of individuals fails to engage in psychosocial pain treatments and rates of adherence to treatment recommendations are low. The aim of this study was to develop and evaluate a brief intervention based on Motivational Interviewing (Miller & Rollnick, 1991) administered prior to community-based CBT pain management workshops.

The study comprised a randomized, controlled trial examining rates of engagement in treatment, and adherence to five self-management activities: exercise, activity pacing, relaxation, cognitive strategies and appropriate use of medication. The treatment group received a brief two-part intervention comprising an assessment interview and a feedback interview based on motivational interviewing and the control group received a standard pain assessment (treatment as usual) and an attention placebo interview in place of the feedback interview. Subsequent to the second interview participants in both groups were invited to attend up to five pain management group workshops.

Methodology

Participants. Participants were recruited by means of media advertisements to avoid possible variations in referral patterns from medical and allied health professionals and related motivational effects. Subsequent to screening for eligibility criteria (over 18 years of age, pain duration of greater than three months, no surgery planned in the foreseeable future, adequate literacy to complete assessment measures and not actively psychotic or suicidal), 78 participants commenced the study. The mean age of participants was 53 years ($SD = 11.58$, range = 24 - 73), 54% were female. The mean pain duration was 13.6 years ($SD = 13.2$, range = 1 - 60). The majority of participants were of Australian or New Zealander origin (85%), the remainder originated from continental Europe (8%), the United Kingdom (5%) and the United States of America (2%). Overall, participants had a relatively high level of education with 44% having had five or more years of secondary education. Participant diagnoses varied, though the majority had been given a diagnosis of disc pathology (46%) or neuropathic pain (19%). Other diagnoses included Osteoarthritis (13%), Fibromyalgia (9%), and Rheumatoid arthritis (3%). A further four percent of participants reported congenital abnormalities as the cause of pain, two percent suffered with chronic headache, the remaining four percent had pain of unknown origin (no diagnosis).

A small number of participants were currently litigating in relation to their pain (7%) or receiving compensation payments for their pain (8%). There were no statistically significant differences between the treatment and control groups on any of the demographic variables at pre-intervention.

Procedure. Ethics approval was granted for the study. Participants were randomly assigned to either the intervention or control group. Prior to interviews each participant completed a pre-intervention questionnaire comprising demographic information, the Pain Interference Scale of the Multi-dimensional Pain Inventory (MPI; Kerns, Turk & Rudy, 1985), the Centre for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977), and the Readiness to Adopt a Self-

Management Approach to Pain Questionnaire (RASMAP-Q: Habib, 2002a). The RASMAP-Q is a clinical tool which provides the framework for a structured feedback interview based on Motivational Interviewing. The RASMAP-Q pertains to five self-management activities (Exercise, Activity Pacing, Relaxation, Thought Techniques and Medication Use) and determines an individual's beliefs and behaviour in relation to each of these activities by means of short staging algorithms, and outcome expectancy (importance) and efficacy expectancy (confidence) using ten point numerical rating scales.

Subsequent to completing the research questionnaire, participants were interviewed individually by one of two interviewers, both of whom were registered practicing psychologists trained in Motivational Interviewing techniques.

Intervention Assessment Interview. The intervention assessment interview took approximately one to one and a half hours to complete. The aim of the intervention interview was to establish a therapeutic relationship, gain insight into the extent of the current pain problem and how it may be impacting on the person's life, gather information regarding current use of self-management strategies to be presented as feedback in the following session and to elicit and reflect the following four categories of change talk: (a) the client's recognition about the nature and extent of the problem, (b) the client's concern about how they are currently managing the problem, (c) the client's intention of changing in the direction of adaptive pain management, and (d) the client's optimism that change is possible. At the conclusion of the interview the psychologist provided a summary and the participant was invited to return the following week for feedback on the assessment results and discussion regarding assistance with learning and maintaining appropriate self-management strategies.

Control Assessment Interview. The control assessment interview also took approximately one to one and a half hours to complete. The control interview was based on standard pain-clinic assessment procedure and ascertained details regarding beliefs about the cause of the pain and

expected prognosis, worst, average and least pain severity ratings and factors which increase and decrease the pain. Information was also elicited relating to previous and current medical treatment and previous surgical procedures related to the pain. Additional questions were included to determine what treatment recommendations had been made and whether or not the participant was adhering to those suggestions. Participants were asked whether, and in what way, the pain affected physical exercise, leisure and social activities, sleep, sexual activity, housework, outdoor chores and relationships. Information was elicited regarding whether the participant had ever consulted anyone for an emotional or psychiatric problem and details of diagnoses if appropriate. The final question in the interview pertained to all other health related problems. Questions related to current coping strategies including the use of drugs and alcohol had been elicited in the pre-assessment questionnaire. The interview was designed to obtain information only and did not aim to elicit any motivational statements from the participants.

Intervention Feedback Interview. The intervention feedback interview was presented in two parts and took approximately one and a half hours to complete. The aim of part one of the interview was to increase motivation to self-manage pain more effectively and to build hope that such efforts will be beneficial (optimism). At the beginning of the interview, the interviewer clearly communicated free choice regarding what (if any) action the participant would take as a result of the feedback they were to be provided with. The feedback interview followed the following structure: (a) feedback provided separately for each self-management activity on the RASMAP-Q, (b) discussion of discrepancies between beliefs and behaviours on particular self-management activities in order to increase dissonance, (c) discussion of discrepancies between importance (outcome expectancy) and confidence (efficacy expectancy) scores on particular self-management activities (this was intended to increase dissonance and to allow the interviewer to ascertain whether *consciousness-raising* or *self-efficacy* strategies [or both] were required in order to facilitate change for the

activity), and (d) discussion about activities where the individual was already using self-management activities, to strengthen and support self-efficacy for change in other areas.

Part one of the interview concluded with a summary of the interview to that point, with an overview of the problem behaviour (as experienced and described by the participant) and of the participant's reactions and change-talk.

The aim of part two of the intervention feedback interview was to provide appropriate information to the individual regarding where to access assistance in learning self-management strategies. Participants were invited to participate in up to five, three-hour pain management workshops conducted specifically for the purposes of the research. Each workshop covered one of the five self-management activities described in the RASMAP-Q. In order to provide a range of treatment options participants were also informed of any other relevant services already existing in the community where they would be able to access information and assistance with learning the particular self-management activity (e.g., hospital physiotherapists, psychologists and occupational therapists and government rehabilitation services).

Control Feedback Interview. As feedback is not generally specifically provided in pain assessment procedures, the primary aim of the control feedback interview was to control for extra therapist time and attention in the treatment group (attention-placebo interview). The control feedback interview took up to one hour to complete. Whilst the therapist had a warm, empathic manner (as would be expected in a standard pain assessment procedures), there was no discussion of any detected discrepancies between belief and behaviour, or importance and confidence on any of the RASMAP-Q self-management activities and no change-talk was intentionally elicited. Subsequent to receiving feedback, the participants were clearly instructed as to which of the pain management workshops they should attend, and as with the treatment group, were also provided information regarding alternative services available in the community (this information was provided as an ethical responsibility).

After completing the feedback interview, participants in both groups had the opportunity to register for whichever workshops had been recommended by the interviewer.

Therapist Adherence to Treatment Protocol.

The interviews for both groups were taped to ensure therapist adherence to treatment protocol. A random sample of the tapes of each therapist was checked for adherence to specific treatment protocols by an independent rater (a senior clinical psychologist). The rater ensured that the therapists (1) adhered to the appropriate interview format, (2) used a counseling style consistent with Motivational Interviewing in the treatment group interviews, and (3) invited participants in both groups to attend appropriate workshops.

Pain Management Workshops. The pain management workshops were conducted by a multidisciplinary team of experienced allied health professionals. Each group comprised up to twenty participants and all attendees were encouraged to bring a spouse, family member or friend. Each of the five workshop topics covered one of the RASMAP-Q self-management activities (Exercise, Activity Pacing, Relaxation, Thought Techniques and Medication Use) and each commenced with a clear rationale for adopting a self-management approach to chronic pain.

Follow-ups. Adherence to treatment recommendations was measured at post-intervention, immediately post-workshop and at four weeks and six months post-workshop. The retention rate was 86% at the four-week follow-up and 72% at the six-month follow-up. Chi square analyses demonstrated that there was no statistically significant difference in attrition between groups at either follow-up.

Brief Overview of Findings

As the behaviour change data were categorical, non-parametric statistics were performed for all analyses. In order to correct for the large number of planned comparisons, a standard Bonferroni procedure was employed to determine the significance level required (0.05/5). Although it is important that the results of a trial be statistically

significant, statistical significance alone is not sufficient to determine the clinical usefulness of a treatment. Appropriate cutoff points for clinically meaningful differences are a much debated issue in clinical pain trials as the majority of studies attempt to demonstrate reductions in pain intensity (a subjective experience) using a range of measures without agreement on what constitutes *enough* pain relief to be clinically meaningful (Farrar, 2000). The nature of clinically meaningful differences in the present study was somewhat easier to establish. The aim was to demonstrate change in *behaviour* rather than changes in *pain*, where an individual is either engaging in a specific behaviour, or they are *not* engaging in that behaviour. Accordingly, change was considered clinically meaningful where the RASMAP-Q *median* score for behaviour within each group increased from less than four (indicating that they are *not* engaging in the activity) to four or greater (indicating that they *are* engaging in the activity).

Engagement in Treatment. The first aim of the study was to examine differences between groups in rates of engagement in treatment. As illustrated in Figure 1, treatment group participants were significantly more likely to attend workshops than control group participants. Using the Yates Correction for Continuity, $\chi^2(1, N = 78) = 7.56$, $p < .01$. Further analyses demonstrated that there were no significant associations between engagement in workshops and any medical, psychological or demographic variables.

Whilst engagement in treatment was the intended outcome, it is also important to note that failure to engage in treatment subsequent to the intervention did not necessarily indicate a reduction in readiness to adopt a self-management approach. A significant proportion of participants in the treatment group who did not attend workshops were found to be actively self-managing at the four-week follow-up. This was particularly noticeable for use of relaxation and cognitive strategies and was not evident within the control group. The results indicate that for some participants, the intervention in itself did indeed act as a stand-alone treatment. This finding supports the argument by Jensen (1996) that individuals generally know what to

do but may simply lack the motivation to do it. This appeared to be the case particularly for participants who were previously self-managing their pain (and therefore had the necessary skills) but had relapsed to an earlier stage of readiness. Clearly for those participants the intervention alone was sufficient to facilitate action.

Adherence to Treatment Recommendations. The second aim of the study was to determine the impact of the intervention on adherence to treatment recommendations (self-management activities).

Exercise Behaviour Change. A delayed superior effect was demonstrated within the treatment group for exercise behaviour change between the four-week and six-month follow-up. Change in exercise behaviour within the treatment group was clinically meaningful between post-intervention and the four-week follow-up and was clinically meaningful and approaching statistical significance between post-intervention and the six-month follow-up. As expected, the most clinically meaningful exercise behaviour change occurred within the treatment group participants who attended an exercise workshop and this change was maintained at the six-month follow-up. The control group exercise behaviour decreased between the four-week and six-month follow-ups.

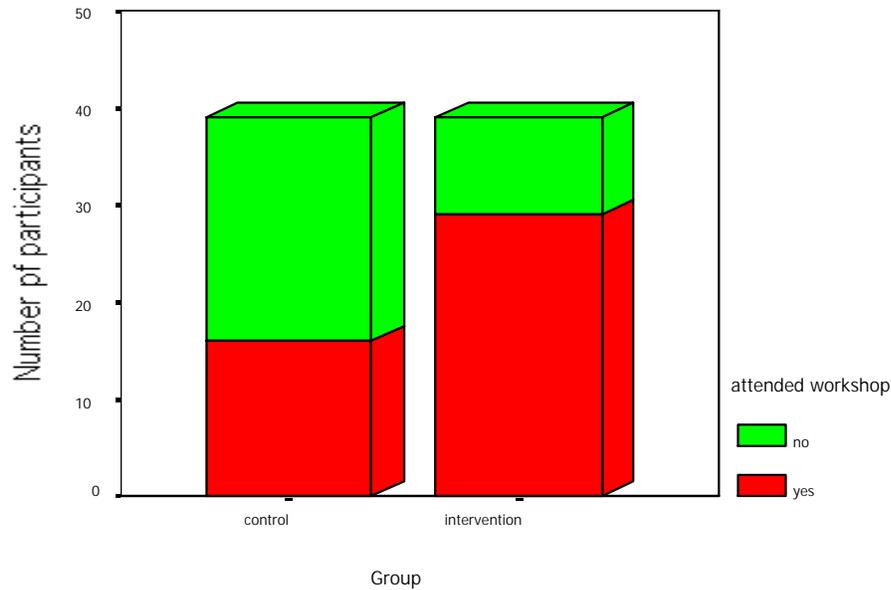


Figure 1. Proportions of participants in each group engaging in treatment

Activity Pacing Behaviour Change. A superior delayed effect was clearly demonstrated for activity pacing behaviour within the treatment group at the six-month follow-up. The change in activity pacing behaviour within the treatment group was approaching statistical significance between post-intervention and the four-week follow-up and post-intervention and the six-month follow-up and was clearly clinically meaningful. As with exercise behaviour, the greatest clinically meaningful change in activity pacing behaviour occurred, and was maintained, within the treatment group participants who attended a workshop and this change was approaching statistical significance.

Change in activity pacing behaviour within the control group failed to reach clinical or statistical significance between any of the measurement points and control group activity pacing behaviour decreased between the four-week and the six-month follow-up.

Relaxation Behaviour Change. Statistically significant and clinically meaningful change in treatment group relaxation behaviour was evident between post-intervention and the four-week follow-up ($p=.01$), between the four-week follow-up and the six-month follow-up ($p=.008$) and between post-intervention and the six-month follow-up ($p=.001$). The change in relaxation behaviour within the control group failed to reach clinical or statistical significance between any of the measurement points.

The greatest amount of change in relaxation behaviour was evident within the treatment group participants who attended a workshop. However, statistically significant change in relaxation behaviour also occurred in the treatment group participants who did *not* attend a relaxation workshop and this change was maintained at the six-month follow-up. This indicates that the intervention may be able to affect change as a stand-alone treatment for enhancing use of relaxation techniques.

Cognitive Strategies Behaviour Change. The treatment group participants demonstrated clinically meaningful and statistically significant cognitive strategies behaviour change between post-intervention and post-workshop ($p=.007$) between post-intervention and the four-week follow-up ($p=.01$), and post-intervention and the six-month follow-up ($p=.01$). No clinically meaningful or statistically significant change occurred within the control group between any of the measurement points.

The participants who demonstrated the greatest cognitive strategies behaviour change over time were those in the treatment group who attended a cognitive strategies workshop. Statistically significant behaviour change was also demonstrated within the treatment group participants who did not attend a workshop, indicating that as with relaxation behaviour, the intervention may act as a stand-alone treatment for cognitive strategy behaviours.

Changes in Medication Use. The intervention failed to engage participants in a medication education workshop and no clinically meaningful or significant change in medication use behaviour was demonstrated for those participants identified as having a maladaptive management style (primarily misuse of opiate medication) within either group at any of the measurement points. It is thought that the lack of behaviour change over time in relation to medication use is primarily due to non-attendance at medication education workshops.

Participants who were identified as having a maladaptive management style were invited to attend other workshops in addition to the medication education workshop in order to learn how to use adaptive pain management strategies as a substitute for maladaptive medication use. Interestingly, the majority of those participants in both groups who were classified as having a maladaptive management style did attend other workshops, indicating that it was the medication education workshop in particular, rather than the workshops in general that they were reluctant to attend. Clearly, the intervention focused more strongly on processes that facilitate acquisition of

behaviours rather than cessation of behaviours and this was evident in the lack of engagement in the medication education workshops.

Implications for Clinical Practice

One of the consistent predictors of drop-out from treatment in pain management programs is discrepant expectations (Turk, 1990). Providing individual brief intervention prior to participation in group programs ensures that participants are sufficiently prepared to engage in treatment and to adhere to and maintain treatment recommendations. The brief intervention described in this study provides the opportunity to present the idea of a self-management approach to pain in a non-confrontational manner with a careful and considered approach. Because this is done individually, prior to group treatment, it allows the practitioner to pay careful attention to patient beliefs and the value expectations (importance) and outcome expectations (confidence) they place on this type of approach. The practitioner has the opportunity to explore these factors in a fluid, congruent approach that enhances readiness to change. In this sense, patients enter treatment already knowing what to expect and are feeling that (a) there is value in a self-management approach and (b) that with some help, they will be able to successfully engage in and maintain a self-management approach.

In conclusion, the findings clearly demonstrate that the intervention increased rates of engagement in workshops and that attending a workshop significantly increased adherence to treatment recommendations for four of five self-management activities. These findings have important implications for the significant proportion of individuals with chronic pain in the community who are told they have to “learn to live with it”. Clearly, if our practice is congruent with the motivational needs of our clients, we can succeed in engaging a greater proportion of individuals in treatment and facilitate adherence to the self-

management activities that have repeatedly shown to be effective.

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The French Speaking MINT Group Is Born!

Jean-Bernard Daepfen, MD

The Alcohol Treatment Center (University Hospital Lausanne, Switzerland) organized a series of trainings for French-speaking substance abuse professionals during the last two weeks of June. In order to put together a maximum of competence in training MI and to have a variety of French-speaking communities represented, Cristiana Fortini from Brussels (Belgium), and Vincent Rossignol from Ottawa (Canada) accepted to join me and my colleagues, Isabelle Chossis, Florence Macheret, Ulrika Landry, and Roland Gammeter. It was a lot of fun and professionally stimulating to have seven French-speaking MINTies to conduct these trainings.

The first two days session was in Paris. We trained 23 physicians and nurses from the alcohol treatment center at “Hôpital Beaujon”, a large university teaching hospital in Paris. Cristiana, Vincent and the group from Lausanne did not really know each other and had never worked together. We were pretty anxious, each of us thinking that it could be a disaster. Actually, the disaster happened, since the taxi that was supposed to take us from the city centre to the suburb hotel where the seminar took place refused to take us there. We were late and somehow nervous when we finally started the workshop! Then, it has been kind of magic. Our interaction was great, the atmosphere was excellent, trainees participated actively, all did very well in the exercises. Vincent is thinking of incorporating an exercise called “The Parisian taxi driver” to teach how to deal with resistance.

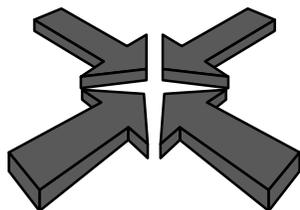
After this enthusiastic first experience, we flew to Switzerland. With people from a government agency and the University of Geneva, I had organized the annual meeting of the Swiss Society on Alcoholism – which 2002 vintage was exclusively dedicated to MI. Approximately 150 professionals from the alcohol field attended the conference. Vincent and Cristiana in French, Michael Peltenburg and Ralf Demmel in German

gave nice plenary morning lectures. Participants had a taste of MI during the afternoon workshops.

Finally, we conducted two additional workshops in Lausanne, which allowed initiating 42 professionals from the alcohol and drug fields to MI. As for Paris, these two additional workshops worked well, providing a lot of nice comments, participants requesting for additional workshops and supervision.

This very stimulating experience led us to create the “French speaking MINT” in order to stimulate and federate our efforts to promote MI in French-speaking countries, particularly to adapt teaching material from English to French and to conduct additional trainings together. We will now work to meet next year, hopefully in Provence. As francophone, we felt that this experience was the start of a long and fruitful collaboration.

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