Minuet

Motivational Interviewing Newsletter: Updates, Education & Training

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From The Desert

Bill Miller

Why Does MI Work in Some Places and Not Others?

Within the next year, NIDA's Clinical Trials Network (CTN) will publish the results of two important multisite trials of MI and MET, both headed by Dr. Kathleen Carroll at Yale. Like all studies in the CTN, these were conducted on the front lines, with MI delivered by the regular staff of ongoing community treatment programs, to the usual clients of those agencies. Thus while these are randomized clinical trials, no long leap is needed to generalize from the study to "real world" clinical settings.

The CTN conducts nationwide multisite trials of treatment methods for which there is already reasonable empirical support of efficacy. The underlying question is, "How well does it work in the real world, when delivered to the ordinary patients by the regular staff of community treatment programs?" There is a very good CTN website at http://www.nida.nih.gov/CTN/index.html.

Both of these MI studies are two-group designs. In each, the clients of community treatment programs are randomly assigned to receive initial motivational interviewing, or a treatment-as-usual evaluation session before beginning outpatient treatment for drug abuse. Also underway are two more multisite trials of MI, one with Spanish-speaking clients, and the other with pregnant drug users.

The first trial to be published will be the MET study, conducted in five outpatient treatment programs in Oregon, New York City, and Virginia. In this study, participants received (or not) three sessions of MET at the beginning of treatment. There has already been a public presentation of preliminary data, but no results are yet published. It appears, however, that there may be substantial variability in effectiveness across sites. At one level, there will be a bottom-line effect size for MI as a prelude to treatment, with primary focus on retention in treatment and on subsequent drug use. In another sense, however, these are multiple replication studies, with the same trial being conducted at several sites. With 100 participants at each site, the study also has reasonable power to detect effects at the individual site level.

The CTN trials will provide rather unique food for thought. Although the sites are in one sense independent replications, they are far more parallel than separate studies. In all four there is standard training for all the therapists, a high level of quality control for the intervention, and identical assessment and outcome measures. It would be difficult to make studies any more similar. If, in fact, studies

Editor's Choice

A MINT Value?

Allan Zuckoff

In the context of a recent MINT listserv discussion of values in MI and the ethics of practice and training, the eminently quotable **Maurice Dongier** sent me the following fragment from the founder of phenomenology, Edmund Husserl:

This absolute radicalism, for him who wishes to become a philosopher in this most authentic sense of the word, implies his submitting to a corresponding decision which will engage his life in an absolutely radical manner, a decision which will make of his life an absolutely devoted life. This is a decision through which the subject becomes self determining, and even rigorously so —to the very depth of his personality-committed to what is best in itself in the universal realm of intellectual values and committed, for his entire life-time, to the idea of the supreme Good...[T]he subject chooses [this] as his veritable 'vocation', for which he decides and is decided once for all, to which he is absolutely devoted...

Maurice noted that this appears to be Husserl's comment "about the disciplined existential practice which underlies our theorizing." I think we would all agree that Husserl sets an extraordinarily high personal standard, and we might wonder whether it is either fair or reasonable to expect so much of ourselves. Then again, given the impact we can have on the lives of those we counsel and train — and, if both the empirical literature and clinician reports are to be believed, that impact is substantial when we practice MI — we might also wonder whether it is fair or reasonable to expect any less. So: might this level of devotion, this "radical engagement," be a candidate for the role of a shared MINT value? And is it possible to practice "*agape* with a goal" without this value?

In This Issue

In his report ***From the Desert***, **Bill Miller** first considers a frequently-occurring but little-discussed conundrum of multisite psychotherapy trials — differences in outcomes among different study sites — and asks, *Why Does MI Work in Some Places and Not Others?*; he then shares his thoughts and concerns regarding systemic implementation of MI training in *An Open Letter to Arizona Probation Staff*. **Stephen Rollnick** encourages MINTies to think further about an important and, he fears, neglected factor in brief interventions, in *Let's Hope*. **Rik Bes** updates us on key issues related to the present and future of our organization in *MINT Steering Committee News*. In his first column, **Grant Corbett** offers a unique take on **What the Research Says ...About MI Skills**, and as an added bonus, provides guidelines for a new exercise to teach the key research findings he describes. This month's instantiations of our recurring features follow: **Pat Lincourt** inaugurates ***Adventures in Practice*** by describing her *Experiences in Group Motivational Interviewing*; in the ***Training Corner***, **Colin MacRae**'s *Dancing or Wrestling: Struggles in the Accreditation of a Skills Based Module*, describes the development and structure of an academic course in motivational interviewing; **Stéphanie Wahab** elaborates on the topic of an earlier listserv discussion in her ***Theoretical Exploration****, Privilege And Resistance Within The Domestic Violence Movement*; and **Carolina Yahne**, in the ***Research Round-up***, offers a heartening follow-up to her previously published study of MI with substance-abusing women sex workers, *Motivational Interviewing and a Home for the Magdalenas*. And the issue ends with **Dirk Gibson**'s reflections, cautions, and best wishes in *A Farewell to MINT*.

Looking Forward

As mentioned earlier, the MINT listserv has recently been the site of a stirring and enlightening dialogue on several intertwined, practical and theoretical issues with profound implications: what is the nature of "directiveness" in MI, and how does it show itself in our practice and technique? On what core values (if any) can we, qua MI trainers and practitioners, agree? What are the ethical implications for MI trainers of the religious or other values systems of potential MI trainees? Both because I consider these questions to be of critical importance for the ongoing refinement of the theory and practice of MI, and because I believe that the rich and subtle thinking evident in these electronic conversations should be made available to the wider world of MI aficionados, future issues of the MINUET will feature 'Virtual Symposia' presenting highlights and consolidations of the listserv discussions. I also hope that these symposia will serve as a catalyst for further published dialogues, and responses will be welcomed from any and all who wish to contribute.

As MI has developed over the past two decades, its spread across nations and cultures far removed from its Anglo-American origins has been a potent source of renewal and re-thinking. For this reason, and to promote awareness of these continuing developments among English-speaking MINT members, I'm pleased to announce that future issues will include reports not only from this year's annual MINT meeting in Portland, Maine, USA, but also from the upcoming Nordic MINT meeting in Reso, Sweden, and from a symposium on MI scheduled to be presented at the European Opiate Addiction Treatment Association (EUROPAD) in Paris, France. It is my hope that the MINUET can be a virtual home to the entire MINT membership, in all its linguistic and cultural diversity.

All of this, plus Bill Miller *From the Desert*, Grant Corbett's *What the Research Says*, and contributions from both MINTies and non-MINTies on new developments in practice, training, and research ...I look forward to editing the coming issues, and I hope you will look forward to and enjoy reading them.

that are so similar yield different answers about the effects of MI, we have another interesting puzzle to solve.

Why might MI/MET be effective at some sites and not at others? We already know from Project MATCH that MI-trained counselors differ in their effectiveness in delivering MET, and that this variability is not accounted for by differences in client severity. One possible source of site differences, then, would be therapist effects. It was also the case in MATCH that MET showed different relative efficacy at different sites. At some sites, MET was on the bottom of the three treatments (being compared with cognitive-behavior therapy and twelve-step facilitation) in impact on percent days abstinent. At others it was in the middle of the pack, and sometimes it tied with the most effective method. Average all the sites together and these differences wash out.

But should we be averaging all sites together? When one is testing a medication in a multisite trial, site differences (and particularly site-by-treatment interactions) are regarded as nuisance noise to be controlled for by combining across sites. In multisite trials of psychotherapies, however, site-by-treatment interactions appear to be the norm, though they are often down-played in published reports. Perhaps we ought to be particularly interested in these differences, which may hold important clues as to how and why specific treatments work (or don't work) when put into practice. Multisite trials are particularly interesting because, at least theoretically, the content and format of the treatment protocol are standardized across sites. So are training of therapists, adherence monitoring, and outcome measures.

So what is left that might explain

why a treatment would work at one site while at another it exerts no effect or even an adverse effect? Beyond therapists themselves, it could have something to do with the populations being treated, with institutional climate at the agency, or even geographic cultural differences. Certainly it is possible to check for systematic differences in the composition of the client samples across sites, and determine whether covarying for these can account for outcome differences. Climate and culture are harder to quantify.

Once again, we have a puzzle to solve. Beyond (and related to) the question of why MI works at all, is the question of why it seems to work at some sites but not others, and in the hands of some interventionists and not others. It seems to me that we ought to be quite interested in these cross-site and cross-therapist differences in effect, from which there may be much to learn.

An Open Letter to Arizona Probation Staff

I sent this letter to Stephen Emslie, at his request, as he undertakes statewide training with probation officers:

Stephen Emslie asked me to offer some reflections as Arizona begins to implement motivational interviewing (MI) as a "best practice" for probation departments statewide. As I understand it, probation staff throughout Arizona will be asked to attend MI training, and to use MI to "facilitate positive behavioral change in probationers" with whom you work.

Twenty-one years have passed since I first described motivational interviewing as a counseling approach. I had no idea at the time that it would come to be so widely adopted, or applied to so many different challenges of behavior change. I take no personal credit for this; I feel more like an onlooker than a leader in the amazing growth of this approach. Clearly the time was right for a change of viewpoint. In many areas, professionals are acknowledging the limitations of current ways of working, and are looking for new ways of understanding and helping. I hope that MI will be helpful to you in facilitating positive behavior change with those you serve.

I must admit to some reluctance as entire state or national systems commit to MI and require staff to be trained in this approach. There is something inherently inconsistent about requiring people to learn MI "whether you like it or not." This is not an approach that you can learn or adopt unwillingly. At the heart of MI is an honoring of people's autonomous and irrevocable right to choose how they think about and respond to reality. I don't believe it is really possible to make anyone learn MI. It's a bit like Alcoholics Anonymous: perhaps you can make people go to meetings, but you can't make them get the program or connect with a Higher Power.

Part of the challenge is that MI is not particularly easy to learn. It takes time and practice. Many people come to workshops imagining that they are going to learn some techniques, ways of tricking people into doing what you want them to do. MI is nothing of the kind. Rather, it is all about what that person sitting across from you wants to do. It is about listening rather than just telling, about taking the time to understand the other's internal reality and to call forth his or her own motivations for change.

I've also found over the years that you can't really learn MI from a workshop. Perhaps you can learn what it looks and sounds like, and decide whether you want to take the time to learn and practice it. At the beginning of workshops, I now tell people that I cannot make them skillful in MI, but that if I do my job well they will know how to learn it from their clients. The end of an MI workshop is the beginning of learning it.

You walk a fine line, trying to help and encourage probationers while also being a social agent of protection and enforcement. I believe that the two roles can be combined fruitfully, and that MI has something to offer as you walk that narrow road. In a way, MI releases you from the draining psychological burden of having to "make" people do the right thing, which is actually an impossible task. People make choices, and you cannot take that away from them. What you can do is to help them make the right choices. I wish you the very best as you consider MI as a possible tool in the important work that you do.

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Let's Hope

Stephen Rollnick

What happened to hope? A single conversation in a restaurant during the Paris training for trainers event in 2002 has stuck in my mind. It was Peter Prescott from Bergen, Norway, who asked this question, wondering this: if instilling hope is therapeutic (we agreed it was), how does one do this within motivational interviewing? Are we too reliant on an approach that leaves the changing to clients, one that harnesses their intrinsic motivation? Are we too restrained about instilling hope?

I muttered about the value of affirming and supporting self-efficacy, yet left feeling uncomfortable about this answer. Last week I sat in a coffee bar in some awe as my primary care physician and friend Chris Butler described how, the previous day, he had seen 25 patients in the morning, did house calls, and was late for afternoon surgery, and a similar number of patients. He works in one of the most deprived parts of Europe, the South Wales Valleys. He loves the work, and feels connected to the seething defiance of a people who have a social warmth and political intelligence that has produced many a hero; actors, singers, politicians and generations of people who help each other. One case from the day stood out.

This person came in and said he was feeling very much better, and had stopped drinking. Chris had to remind himself quickly about the person he had seen the week before, who had been dishevelled and disheartened, and feeling ill. Chris had taken a blood sample, and conducted an 8-9 minute consultation, mostly consisting of a physical examination. How had turned things around, Chris asked? The patient said that he owed the success to Chris. Why? Chris had apparently said, at their first meeting, as they parted, something along the lines of: *"Don't worry, we will get to the bottom of this, and I'll see you through this bad time"*. Chris couldn't remember saying this. Maybe he just gave the patient this impression of hope, in a more subtle way?

Chris is full of these stories, of brief intervention with a truly human face. I suspect that brief intervention works best if it's part of this human relationship that lies at the core of primary care practice.

So, what has happened to hope? I wonder how Peter Prescott has got on with this idea, and what others think about how we handle it?

MINT Steering Committee News

Rik Bes
Chair, MINT SC

Some Recent History: The Reorganization of the Steering Committee

In the summer of 2003, Bill, Steve, and the at-that-time operational seventeen-member MINT Steering Committee (SC) took the initiative to select a much smaller, interim SC of five MINTies, intended to operate for 24 months. In this new executive organization, Bill and Steve took on the role of non-voting participants with the (unlikely-to-be-used) veto powers of benign grandfathers.

The new SC was given the task of addressing a range of administrative, organizational, and policy issues. These would include things like setting up a formal organization that could employ people to do administrative work, making decisions about challenging questions facing our network, and clarifying what MINTies get for their dues.

Five people agreed to serve on the new SC: David Rosengren, Kathy Goumas, Gary Rose, Terri Moyers, and I. Chris Wagner started as a non-voting participant (media matters), and was given full voting power late 2003. Richard Saitz serves as a participant without voting or veto powers. David Rosengren volunteered to act as chair and to lead the new SC through the transitional phase from a much larger group to the current format during the fall of 2003.

The SC started to address the key issues we were confronted with, using a dedicated SC-listserv and regular telephone conference calls (every 3 to 4 weeks). The general principles that guided our discussions were the intention to use our 2-year tenure to move the MINT toward greater transparency, taking steps towards a transformation of the MINT from an 'organization of professionals' to a 'professional organization.' That is, we hope to create more transparency at all levels of policy planning, decision-making and financial monitoring. We felt that it would be important to allow MINT to evolve, slowly but surely, keeping a firm hold on the values that have made our work so successful. In the end, it's the spirit that counts.

New SC Structure and Procedures

In September 2003, the SC decided to adopt a rotating chairpersonship. Rik Bes started this sequence in October, and will hand over the reins to Gary Rose in May, 2004. At the same time, the SC identified the tasks of the SC chair. During her or his tenure, the chair will be responsible for:

- Setting up conference calls, establishing the agenda, and running the call
- Bringing non-conference-call matters before the SC and Advisory Group (AG) via email
- Tracking votes and reporting to the SC, AG and the MINT listserv the outcome of votes
- Updating the MINT membership on the SC
- Receiving reports from ad hoc committees that are formed
- Acting as contact person for the MINT on matters that are not otherwise assigned
- Delegating tasks to other SC, AG or MINT members, as needed
- Making executive decisions on behalf of the SC, tracking these choices and reporting significant events to the SC

In addition, it was decided that the SC would adopt the following 'fall-back' process, which could be used if deep divisions were to arise within the SC:

- Upon identifying an issue her/himself, or a receiving a request from SC members, Advisor and/or Grandfathers, the chair asks for informal input via the SC listserv and/or back-channel, with a reasonable deadline for input.
- The chair frames the input into options for the group to consider.
- The chair calls for a vote on a single issue at a time, with a voting deadline.
- If the issue is not successfully resolved, the chair identifies an intermediate procedure regarding the issue in question, while the SC moves on to the next issue at hand. The intermediate procedures could include: the formation of a sub-committee, which studies the issue further and reports back to the SC; a period of renewed discussion, after which a new vote could be called for; a call for input and support to our non-voting participants.

The State of MINT Finances

The SC has recently made an overview of the state of the different accounts that hold MINT funds. The University of New Mexico (UNM) currently holds $9835 in MINT funds. The Centre for Motivation and Change (CMC) currently has €8105 and $3060 in its MINT accounts, while about €1250 of expected revenues from the 2003 European video-tape sales are expected to be added soon. As of January 1st, 2004, we began to strive to concentrate all MINT funds in dedicated, separate Euro and US Dollar accounts at the CMC; most members will have noticed this when paying their 2004 dues. By the end of this year, an independent accountant's audit report shall be generated, covering all MINT funds held in CMC's bank accounts. (Funds held by UNM are subject to UNM's internal auditing procedures, and are outside the authority of our Holland-based CMC accountant.)

The newly introduced PayPal electronic dues payment system seems to work quite well. Some members have been experiencing some difficulties, but the vast majority of MINTies have used this system in the first 3 months of this year with no problems whatsoever. Nevertheless, we plan to upgrade the payment procedures page on the website during this summer, to further improve this preferred payment procedure.

The Question of Certification

The SC followed with great interest (and participated in) the discussion of certification of MINT trainers that occurred on the MINT listserv late last year. For this reason, we're happy to report that a Certification Committee has been formed and that, as of March, 2003, it has started its work. The committee members are: Bill Miller, Tom Barth, Jeff Allison, Mark Farrall, Rich Saitz, Laura Travaglini, Astri Brandell, and Jean-Bernard Daeppen. As the SC liaison, Gary Rose will follow proceedings while remaining in the background, listening and offering an opinion when asked.

The SC's charge to the committee was to take on the task of elaborating all sides of the issue regarding certification of MI trainers. This will, we hope, include a plan for administration of the certification process, should the committee endorse that option. Although the SC is most interested in the question of trainer certification, the committee may also choose to address the issue of certification of MI practitioners, should they believe the two to be interrelated.

Here is a summary of the Steering Committee expectations and resources for the Committee:

- Elaboration on pros and cons of certification of MI trainers (not practitioners). In other words: both (all) sides of the ambivalence.
- Summarize the key issues of the elaboration effort.
- If possible, offer a recommendation to the SC about certification, i.e., yes or no.
- If a recommendation is offered, it should be accompanied by sufficient arguments / reasons to support that position and allow it to proceed: if no, why not?; if yes, why?, and also an idea as to how.

Mark Farrall is the current chair of the Certification Committee. He has elicited members' first thoughts about the SC's questions and certification in general. These thoughts were compiled into a document that was distributed to the committee in mid-April, 2004. As of this writing, Mark is awaiting members' responses to this summarization. The Committee is aware of the SC's timeframe for reporting, and we believe it will provide us with some input in the near future.

What's On Our Plate

Looking back at the best part of a year that has passed since the current SC became active, we believe that, on many levels, good progress has been made. At the same time, we still have a number of tasks in front of us.

Establishment of a long-term plan for active, healthy and non-paralyzing two-way communication between the SC and the MINT community at large requires our continued attention. Topic-oriented working groups, comprising both MINT members and SC members, have been suggested. At the same time, there are also concerns that such groups may draw people who are polarized in their opinions, or who have limited time available for working in such a group. In general, the SC has been concerned that the listserv could become overcrowded with commentaries, which many subscribers might find uninteresting. The suggestion of establishing one or more topic-dedicated discussion boards for specific topics was made for that reason. However, we've experimented once with a discussion board, but the input and flow of discussion dried up within a few weeks. The working group structure currently seems more promising; this view is supported by the progress being made by the Certification Committee.

The restructuring of the planning and organization of the annual international TNT workshops and parallel MINT Forum meetings is currently on the SC's agenda. The ever-growing interest in participation in a TNT, and the increasing interest in joining the parallel MINT Forum meetings, is a development that's clearly noticeable over the past years. On a practical, operational level, this leads to an increasing workload for Delilah and Dee Ann at the Center for Alcoholism, Substance Abuse, and Addictions (CASAA); on the level of policy planning and responsibilities, a clear plan for the years ahead of us is needed. Generally speaking, the SC will take over a more central role in overseeing and planning both international events in the coming years. We envision 2005 as a transitional year, in which the SC will take over responsibilities that are now scattered among different people and organizations. On an operational level, the support from CASAA, CMC and local MINTies will of course continue, and the SC will continue to offer its great respect

and thanks for the many hours put in by so many.

Last but not least, the organizational development of MINT is a subject that comes up regularly, because it is related to so many other items we have been dealing with and that remain on our plate. For instance: how do we envision certification of trainers (in case that would be an objective of the MINT community) to take place without MINT being a legal entity? If we would want MINT to become a legal entity, which format would be most desirable and effective for our purposes? How would such an entity best be 'steered,' keeping in close touch with the spirit of MINT? Questions like these, and many related others, will need our continued attention as well as input from all of you.

To date, governance of the MINT has been done via a committee and through mostly informal methods, designed to be representative of the membership at large. However, the best methods to lead the MINT fairly, democratically, and effectively have not yet been determined. The revision of the SC into the current format is the first step in an attempt to explore and develop these governance issues. Although resolution of this issue is predicated on the ultimate form of our organization, it cannot await the conclusion of that decisional process to be addressed.

Meanwhile, Bill and Steve, in their role as non-voting participants, have taken a backseat position in the Steering Committee, but by no means an inactive position. Their creative, thoughtful and supportive input in our discussions has been of great value to the progress we have been making so far. They have yet to use their veto powers; on the contrary, they have stimulated and contributed to the thinking, struggling and attempts within the SC to further improve our network. Just like many of you have been doing openly via the listserv or through direct back-channel communication. Thanks to all of you!

What The Research Says . . . About MI Skills

Grant Corbett

Introduction to this Column

Welcome to this first column in a new series. The theme is exploration of Motivational Interviewing (MI) through "what the research says". As a reader of this newsletter, you will know that the MINUET is a forum for discussion of intervention and training studies, and of their implications for practice. This column will add to the dialogue by drawing on a broad base of literature. The objective will be to propose how we might translate findings to MI education and clinical work.

Available literature includes the 300+ articles and chapters on MI published to date. You will find these listed in an online bibliography (with thanks to Dr. Chris Wagner) at the MI web site (http://motivationalinterview.org/). In addition, I project that there will be 50-60 new MI-related publications in 2004.

There are non-MI studies and theoretical papers also that can add to our understanding of how to disseminate and practice MI. These are in addictions, communication, marketing, medicine, psychology, and social-psychology journals and books.

In summary, this column will draw upon both MI and related research and theory. Each article in the series will offer hypotheses and recommendations for education and practice. I will add commentary from investigators, clinicians, and trainers. Feedback, comments and questions are welcomed, to keep the content viable and relevant to your needs; email me at grant.corbett@behavior-change-solutions.com.

In this first column, I will look at what the research says about MI skills.

A definition of MI Skills

It would seem a simple task to begin by quoting a definition of "MI skills". The phrase is scattered through published articles and documents (c.f., Squires & Moyers, undated), and the instrument developed to evaluate MI competence is called the "Motivational Interviewing Skills Code" (MISC).

However, neither the MISC Manual (Miller, Moyers, Ernst, & Amrhein, 2003), nor the associated Motivational Interviewing Treatment Integrity (MITI) Manual (Moyers, Martin, Manuel & Miller, undated), define MI skills. The index to Drs. Miller and Rollnick's edited book *Motivational Interviewing* (Miller & Rollnick, 2002) also does not refer to "MI skills". Only two entries include the word skills: one is "listening skills", the other is "resistance and counsellor skill issue".

Perhaps the answer is implicit. For example, in the first edition of Motivational Interviewing (Miller & Rollnick, 1991), open-ended questions, affirmations, reflecting, and summarizing (OARS) are called "micro-skills". Miller & Mount (2001) refer to these, more recently, as "evocative skills" (p. 458). Miller, Yahne, Moyers, Matinez & Pirritano (in press) propose that "Accurate empathy is a learnable clinical skill".

Emmons & Rollnick (2001) refer to the "technical…elements" of MI as skills:

MI is based on using nondirective counselling skills such as reflective listening… The technical…elements include: (1) client-centered counselling skills, based on Rogerian counseling; (2) reflective listening statements, directive questions, and strategies for eliciting internal motivation from the client, operationalized in the form of self-motivating statements from the client. These skills are used to encourage the client to explore ambivalence about change…(p. 72).

Thus, this may be simply a problem of semantics. It may be that "MI skills" are the "principles", "spirit", and/or "methods" discussed in Motivational Interviewing, and captured in the MISC Manual by Global Scores (for Acceptance, Empathy and Spirit) and Behavior Counts (e.g., Advise with permission, Affirm, etc.).

I believe, however, that clarity on a definition of "MI skills" can help us to better understand the value of the style. As a context, *The Cambridge Advanced Learner's Dictionary*

(2003) defines skills as "having the abilities needed to do an activity". What, then, are the "abilities" needed to be a skillful MI practitioner?

Abilities and the "Spirit" of MI

The "spirit" underlying MI (Miller & Rollnick, 2002; p. 33) is an interpersonal style of the counsellor characterized by an absence of confrontation or persuasion, and acceptance of the person, communicated by empathy, respect and support. I believe that Miller & Rollnick's description of "spirit" points to two abilities needed to practice MI effectively. We will explore this by looking at what the research says about these elements of the "spirit" of MI.

Absence of Confrontation: Evolution and Neuroscience

As noted, the MI style is characterized, first, by an absence of confrontation or persuasion. Confrontation, Miller & Rollnick (2002) explain, increases client resistance (p. 244) and results in poorer outcomes (p. 7). "Reactance" is offered as an explanation for this (Miller & Rollnick, 2002; p. 18); reactance theory (Brehm & Brehm, 1981) proposes that resistance to change occurs when we perceive a threat to our freedom.

A recent paper suggests a way of understanding the mechanism involved. Porges (2004), writing from an evolutionary perspective, proposes that "physiological states associated with social support require a neuroception of safety". When a person detects safety in the face, voice, and movement of another, this activates a neural circuit that projects to the amygdala to inhibit defensive limbic functions. Only with this circuit disenabled, he states, can a person engage social support.

Thus, I put forward that one necessary ability of the MI practitioner is to enable clients to perceive safety at a neurological level. Achieving this requires the absence of confrontation and persuasion, at a minimum. However, I do not believe that helping clients to perceive themselves as safe can be reduced to a set of techniques, although the "principles" and "methods" of MI provide guidelines to needed behaviors.

Human evolution allows individuals to judge whether there is risk in interaction with another. Thus, the ability to set conditions of safety is more in the counsellor as a person; that is, in his or her thoughts, feelings, beliefs and intentions.

Acceptance: Perception of Social Value and Social Burden

Acceptance, the second characteristic of the MI style, is central also to the concept of "unconditional positive regard" (UPR). In 1957, Carl Rogers (reproduced in Wilkins, 2000) defined UPR as a:

feeling of acceptance for the client's... feelings, as much acceptance of ways in which he is inconsistent as of ways in which he is consistent (p. 255).

Recent research supports that a person's perception of being accepted (not just the counsellor's belief that he or she is exhibiting UPR) is related to health and well-being. Shaw and colleagues (2004) looked at the health effects of "parental support", which they defined as "gestures or acts of caring, acceptance, and assistance that are expressed by a parent toward a child" (p. 4). Parental support was determined from two sets of items on a mailed questionnaire received from 2,905 respondents to the National Survey of Midlife Development in the United States (MIDUS). The authors found that perceived "lack of parental support during childhood is associated with increased levels of depressive symptoms and chronic conditions in adult-hood" (p. 4).

In 2000, Reis and colleagues had 76 students make daily reports on their well-being and social activities for 14 days. The authors found that "[t]he best predictors (of well-being) were meaningful talk and feeling understood and appreciated". So, acceptance appears to affect adult well-being, whether experienced in the past or currently.

Returning to MI, Miller (2000) proposed acceptance, or the parallel concept of *agapé* (a Greek word for a self-less, accepting form of love) as an explanation for the effectiveness of brief interventions and for change described by "quantum changers" (people who reported "sudden transforming experiences"). Miller (2000), in referring to the conditions for change proposed by Carl Rogers, also underlined the importance of the client's experience:

...a sense of being unaccepted (unacceptable) inhibits change; it is when a person experiences acceptance as he or she really is that change is facilitated (p. 12).

I believe that agapé may better capture what Rogers had intended in using the phrase UPR or the word "acceptance". One reason is that, while behaviors such as "restrained tolerance" may be considered acceptance by some, UPR is not the ability to hold back one's disagreement or dislike of the client while feeling condescension; it is, as Miller proposes, "self-less". UPR is differentiating our concerns about client behaviors or beliefs from the need to accept who the person is unconditionally (c.f., Wilkins, 2000). The latter is critical, as the evidence shows, to our ability to change and our well-being.

Editors at the American Psychological Association (APA) asked for four revisions of the article in which Miller presented agapé before they accepted the manuscript for publication (Miller, personal communication, March 01, 2004). There may be psychologists who have difficulty in accepting agapé as an explanation for the effectiveness of brief intervention. However, the term may help clinicians to comprehend UPR as I believe Rogers, Miller and others experience it.

We turn now to two final questions: 1) by what mechanism might acceptance have such a significant influence on motivation, and 2) what are the implications for abilities needed as an MI practitioner?

One answer to the first question comes, again, from the field of evolutionary psychology. Allen and Badcock (2003) propose that:

...individuals are highly sensitive to how they are perceived and valued by others and this sensitivity is based on adaptive, psychological mechanisms that monitor and regulate the human drive for social belonging... (p. 891)

They argue that persons' perception of their Social Value to others (acceptance), relative to Social Burden (i.e, the belief that they are causing others to lose current or potential resources, which may lead to rejection), can affect well-being and perception. Specifically, when persons perceive that their Social Value is decreasing or that their Social Burden is increasing (i.e., when these approach being in balance), motivation is affected along with risk-taking. The proposed evolutionary function of this response was to reduce risk of further loss of social value and exclusion.

This gives us an answer to the second question on abilities. The coun-

sellor needs to be able to communicate acceptance (i.e., that a person has Social Value) while helping clients minimize any perception of non-acceptance (i.e., that they are a Social Burden, to the counsellor or others). The goal is client perception of acceptance and reduced social burden, to help them maintain motivation and take social risks. Both are necessary for intentional change.

Here MI principles and methods are relevant. Counsellor acceptance, empathy and support are central. Affirmations and signs of respect (e.g., a welcoming handshake) are examples of counsellor behaviors that can contribute to a client's perception that they have Social Value. An appropriate "reflection with a twist", or unconditionally offering support, are ways of changing perception of Social Burden.

Practice Implications

MI skills include at least two abilities: 1) the ability, through face, voice, and movement, to communicate safety to a client at a neurological level, and 2) the ability to allow clients to experience acceptance (Social Value) while helping them to minimize any perception of non-acceptance (i.e., that they are a Social Burden to others or the counsellor).

From this perspective, the "principles" and "methods" of MI are the vehicles by which abilities are practiced. A similar point was made by Wilkins (2001) when he said, "[T]he communication of unconditional positive regard is a major curative factor in any approach to therapy", and that empathy provides the "context in which it is credible" (p. 35).

If acceptance that communicates safety is a primary ability for MI practice and client change, what are the implications for your sytle and practice of MI? What changes might this imply for how you screen, admit, assess and intervene with patients? A workshop exercise (including handout) is an added extra to this first column. The purpose is to raise awareness of the abilities presented in this column, and the implications for counsellor behavior.

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Extra: Workshop Exercise

Instructions: Start by presenting the points in this article, highlighting the two proposed MI abilities. Second, ask participants (in pairs or groups) to reflect on which pair of each set of counsellor behaviors in Table 1 might be most effective in communicating safety (or threat) and acceptance (or non-acceptance) to a client, and why. Ask them to be prepared to present their thoughts to the larger group. Third, have as many participants as possible verbalize their beliefs to the larger group, allowing others to challenge MI-inconsistent responses and affirm those consistent with the style.

The right-hand column of Table 1 lists behaviors that could be described as MI skills, although various terms have been used to describe them. The left-hand column lists "roadblocks" extracted from Gordon (1970) and other sources. Please refer to Miller & Rollnick (2002) for details.

Motivational Interviewing Abilities and Skills

Miller & Rollnick (2002; p. 25) tell us "motivational interviewing is a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence." Critical to enhancing this motivation is the "spirit" of MI, which is an interpersonal style of the counsellor characterized by:

- An absence of confrontation or persuasion
- Acceptance of the person communicated by empathy, respect and support

In issue 11.2 (2004) of the Motivational Interviewing newsletter MINUET, Grant Corbett proposed that skillfulness in MI requires at least two primary abilities and a subset of micro-skills (defined by Miller and Rollnick as the "principles" and "methods" of MI). The two abilities are:

1. The ability to set conditions, through your face, voice and movement, that *communicate safety* to a client at a neurological level.
2. The ability to *communicate acceptance* (i.e., that a person has Social Value) while helping clients minimize any perception that they are unacceptable (i.e., a Social Burden to you or others).

Table 1 shows two sets of counsellor behaviors. Those in Set 1 may be seen as opposites of those in Set 2 (and vice versa). In your groups, discuss the matching set(s) of behaviors assigned. Decide which behavior in Set 1 and 2 would communicate either safety (or threat) and/or acceptance (or non-acceptance) to a client. Prepare a brief explanation **for presentation** on why you believe this behavior would have this effect. M

Table 1: Practitioner behaviors

Set 1	Set 2
Arguing with logic, lecturing	Accepting, respecting
Criticizing, judging, blaming	Affirming, reinforcing
Disagreeing	Agreeing with a twist
Being closed, non-responsive, dishonest	Being open, responsive, honest
Being cold, unfriendly, distracted	Being warm, friendly, engaged
Ordering, directing, commanding	Eliciting change-talk
Moralizing, preaching, telling	Emphasizing autonomy, choice
Not empathizing (ignoring feelings)	Expressing empathy
Withdrawing, changing the subject	Reflecting:
Questioning, probing	Simplified (content, feeling)
Shaming, ridiculing, name-calling	Amplified (effect)
Interpreting, analyzing	Double-sided (difficulties, goals)
Reassuring, sympathizing	Reframing
Agreeing, approving, praising	Shifting focus
Advising, suggesting	Suggestion given with permission
Warning, threatening	Summarizing

Experiences in Group Motivational Interviewing

Patricia Lincourt

Between 1996-2000, the agency I directed implemented a 6-session Motivational Group for clients mandated to alcohol treatment as a result of a DUI. Over those four years, during which we saw hundreds of clients and conducted at least 30 groups, we noticed a significant increase in treatment completion rates among clients who completed the 6-group series. We described aspects of this experience in a paper published in *Addictive Behaviors* (Lincourt, Kuettel, & Bombardier, 2002). However, while we discussed the content of the groups, as well as our empirical analyses of their outcomes, in that paper, we did not address the clinical experience. This article is an attempt to share what we learned in the process of providing these groups from a clinician's point of view.

A Problem and A Solution

We had decided to offer the groups in the context of a broader clinical discussion. Our agency's staff had begun to have doubts, spurred by a tenacious Medical Director, about the services we were offering to the large percentage of clients who presented to our clinic insisting that they had no problem. Most of the staff were trained in social work, and the questions raised resonated with previous training. We had always been taught to develop treatment based on the client's presenting complaint or problem. However, at that time our program was assigning those clients who denied having a problem with alcohol to receive 8 sessions of education. As the research would predict, we did not think that the education sessions had much impact on the majority of clients assigned to receive them.

One of the alternatives we discussed was to simply not admit anyone with whom we could not negotiate a realistic presenting problem. However, due to the mandates these clients were trying to satisfy, this would end up being punitive, which was not our intention. As I had read a lot about Motivational Interviewing by that time, and was trying it individually with good success, the team agreed that we would develop a Motivational Group based loosely on the MET manual from Project MATCH (Miller et al, 1992). The goal of the group would be to move clients in the direction of identifying a presenting problem. We agreed that the problem did not have to be admission of alcohol or drug addiction. We believed we could be more successful with clients who did not accept a diagnosis of addiction if they identified a problem that was at least somewhat related to alcohol or substance use-for example, a problem managing anger that was exacerbated by alcohol use.

With this in mind, we began to offer six group sessions to clients who came to the clinic with no presenting complaint. The topics of these sessions were:

1) Introduction and Opening Strategies
2) Resolving Ambivalence
3) Stages of Change
4) Personalized Feedback
5) Decisional Balance
6) Conclusion and Evaluation

In addition, each of these clients met with an individual counselor to complete the *Comprehensive Drinker Profile* (Miller & Marlatt, 1984). The individual counselor filled out the personal feedback form from the MET manual, along with a paragraph summarizing the interview.

Clinical Highlights

The group counselor presented the feedback forms in the fourth session. This was by far the most difficult session to facilitate. The task for the facilitator was to go through the profile with the group and process the reactions of group members without infringing on their confidentiality. We worried about being able to do this successfully, but found that in practice it was not at all difficult. Clients generally responded very well to this session. Facilitators stressed at the outset of the session that clients did not need to share any of the personal feedback if they chose not to, and the facilitator actually encouraged clients not to share individual scores, but to share only their reaction to the report.

What actually happened in most of these groups was that clients felt very free to share percentile ranks, MAST scores and risk factors with others. In most groups clients reported being surprised and even shocked, particularly by the percentile score. Reactions in group were very similar to those described in the MET manual, and were handled in group in the same way as they would be in individual sessions. Clients often said that they did not believe the percentile rank was correct and this was reflected back: "This really surprises you, and you feel it can't possibly be right." In response, other members would either offer realistic explanations — "I think when you drink a lot, especially at bars you spend a lot of time with people who are also in a high percentile" — or agree with the original client's perception: "Yeah, this can't be right. Who did these guys talk to, Quakers?" Either way the facilitator responded by reflecting, encouraging other members to share their thoughts, or, when it was appropriate, by providing education.

This was a session during which a lot of information was provided. Ideally, the facilitator waited for questions from the group — e.g., "What does it mean that my BAC levels show that I was drinking much more than social drinkers?" This would provide an opening for the facilitator to talk about tolerance, BAC levels and damaging levels of intoxication. It was my experience that clients accepted this informa-

tion better when it was offered in response to a specific question from a group member, than they did when the same information was offered in our Education groups. In the Motivational Group, the information had a personal context: clients had their own personal feedback forms in front of them as we discussed these issues. When no clients posed a question, the facilitator asked clients what they knew about BAC, tolerance etc. Education was then provided in that context.

My favorite group session was the fifth, in which the facilitator did a decisional balance exercise with the group. Clients were encouraged to list all possible options they had in terms of changing drug or alcohol use, and these options would be written on a chalk board. The pros and cons of each decision, and likely long-term outcome at five and ten years, were also listed. Because many of the cons of continuing to use included punishment in some form from a mandating source, I always encouraged the group to include the option of lying about use. Acknowledging this option, and allowing a discussion of it's pros, energized the group. It also was freeing to me as a clinician. One of the dilemmas with which I struggled when working with mandated clients was a frequent feeling that I was participating in a "sham," providing treatment to unwilling clients who frequently believed their best option was to just go along with probation and treatment while doing what they wanted to do. Since a portion of each group's membership was actually choosing this option, it gave them a place to talk about the positive aspects of this choice and also allowed an open discussion of the downside of the choice. I often heard clients report in this discussion that they actually believed that abstaining from alcohol would be best for them, but that they were so offended by other people telling them that they had to abstain that it made that choice much more difficult. In several of the groups, members talked about having difficulty really accepting the positive aspects of changes they made because "I only did it because I had to." It was an opportunity to support self-efficacy genuinely and in response to real client concerns. In reality, no matter how pressured a mandated client feels to make a change, they always have other options.

Challenges for the Leader of the Motivational Group

The most difficult aspect of the groups in general was staying genuine and true to the spirit of MI. I was much more likely to fall into arguing with a member or group of members than with an individual client. Looking back, there were several reasons for this. The most personal was a fear of what other group members were thinking about me. Some groups had members who were angry and ready to argue with the facilitator no matter her most positive of intentions. When these members were able to gain support from other group members, reflections, coming alongside, and summaries could be met with increasingly hostile responses. This raised my anxiety, and I would sometimes find myself becoming an "expert," or saying something sarcastic and very non-MI like. I never had a client in individual treatment identify a reflection as an evasion, but this did occur in group.

I also worried about the effect that a strongly negative member would have on the rest of the group. In group treatment, I have found that one member who is either strongly pro-change or strongly anti-treatment can affect the group in either direction. In typical US addiction groups, the facilitator tries to decrease the influence of a negative member by finding other members who will confront and neutralize him or her. Often this means having the leader purposefully give one member a higher level of recognition and bigger role for having the "right" opinion or point of view. Since all points of view were explicitly encouraged, this was impossible in an MI group, and beyond personal worries of embarrassment, it was a difficult situation to diffuse. When I was able to do it well, I did it with humor and ultimately the goodwill of at least a few members. It was sometimes helpful to turn the group to the task by saying something like, "That is a great point. I am having a couple different reactions to it, what do other members feel about it?" It also was helpful to simply stay with reflections, amplified reflections (to which I heard some "He didn't really say that" comments), and double-sided reflections (that I was often guilty of reaching for, e.g., "It must be really difficult to choose to be in a group you feel so angry about."). Overall, my sense of urgency to intervene in these cases was sometimes warranted, but more often not.

Concluding Thoughts

I really enjoyed the experiences I had in the Motivational Group, most of which were very positive. I am unsure why most of the empirical data to date do not show good outcomes for MI-based group programs. Our own experience with both treatment completion rates and anecdotal client reports was very positive; many clients who had previously experienced other, more confrontational or educational approaches gave very positive feedback to group leaders about the Motivational Group they attended. I would love to read about others' clinical experiences in MI, especially those of MINTIES who have also provided MI groups. M

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Dancing or Wrestling:

Struggles in the Accreditation of a Skills Based Module

Colin MacRae

Background

Given that recent treatment and good practice guidelines emerging from central UK Government (DH 1999a, DH 2001, DH 2002) have consistently appreciated Motivational Interviewing skills as effective and desirable, it is no surprise that employers and others concerned with workforce planning across the UK substance misuse sector should demand that training be available to meet such needs.

In many ways this was the starting position for a group of senior nurses leading an inner-city, London-based community alcohol team. Concerned with the implementation of evidence-based practice, my colleagues and I decided that Motivational Interviewing should be added to the existing service philosophy, which already included other evidence-based approaches such as Relapse Prevention and Abstinence Support.

The opportunity to consider Motivational Interviewing skills development within the service emerged when I was appointed to a new and developing role of Lecturer-Practitioner. As I was jointly appointed, with a 50/50 split between the alcohol service and a local University, the prospect of combining theory and practice arose. In the UK, it has been claimed that the integration of theory and practice is the major purpose of the lecturer-practitioner role (DH 1999b; Burke, 1993; Elcock, 1998; Fairbrother & Ford, 1998; Gould & Cooks, 1996; Lathlean, 1992; Woodrow, 1994). This opportunity to support the service philosophy, whilst contributing to the education and training agenda, led the way for the development of an "accredited" module in Motivational Interviewing skills.

The course was designed as a module of a larger, already existing programme of learning, in this case, Diploma of Higher Education/Bachelor of Science in Substance Use and Misuse Studies. Consistently, the programme evaluations had highlighted that, despite being of overall benefit to learners, there was a lack of practice-based influence, and some learners who were for the most part clinicians (predominantly nurses) found the programme to be too theoretical. Fortunately, because the programme was designed in such a way that "option" modules existed, it allowed for the possibility of developing a new option module that was practice-based in nature.

Accreditation

A separate policy emerging from UK Central Government in the last decade relates to the "massification" of higher education, with a current target of 40% of under-30-year-olds participating in higher education (HE). Similar to the experiences of the USA and Canada in the 1960s and 1970s, such targets demand that new and more flexible routes into higher education are embraced. Whilst the picture in the HE sector of the UK is still quite confusing, there have been attempts to offer guidance on flexible routes into UK HE. Arising from such guidance is the notion of "Accreditation of Prior (Experiential) Learning" (AP(E)L). Originating as a 1974 research project in the USA known as the "Council for Adult and Experiential Learning" (CAEL), AP(E)L aims to recognise what a learner already knows, including experience related to the area of study (Day, 2002). Now known as Prior Learning Assessment (PLA) in USA and Prior Learning Assessment and Recognition (PLAR) in Canada, AP(E)L not only allows for the possibility that previous learning of comparable quality might be recognised, but also that such learning might take place outside of the traditional higher education institutions.

This shift is fundamental to the development of the accredited Motivational Interviewing Skills module described below. In the southeast of the UK, guidance was issued that allows for the possibility that whole courses, modules or programmes can be "accredited" or externally validated by Universities (SEEC, 1995). In essence, this is a quality assurance process, where a course presented for accreditation needs to demonstrate that a level of academic quality similar to that of the awarding University has been achieved. As the passion for the development of a Motivational Interviewing skills based module arose jointly from clinicians and educationalists, it made good sense to consider the use of such new ways of "accrediting" modules of learning-that is, the leadership for development of an MI module could exist outside the educational institution, and therefore involve clinicians more fully.

Goals of the MI Module: Knowledge and Ability, But Not Competence

From the outset, there was a clear sense from the clinicians that the module should be equally as practical as theoretical in nature, the concern being the employers' need for a skilled workforce. The phrase, "It's one thing to know about Motivational Interviewing, but another to be a skilled practitioner," comes to mind when remembering the clinicians' desire. From the educationalists' perspective, the module had to be theoretical enough to fit the existing programme outcomes, if learners were to benefit from "cashing in" their credits of learning towards an award at a later date, e.g., Dip HE/BSc Substance Use and Misuse Studies. This tension was resolved with agreement on the following four areas of learning:

1. Knowledge of the theoretical framework that MI emerges from
2. Knowledge of the evidence base of MI practice
3. Ability to apply MI skills in practice
4. Ability to reflect on strengths and weaknesses of own practice

In essence, a combined theory-practice approach was adopted, where learners could use the theory to guide their practice, be aware of the strengths and limitations of the evidence bases, use MI skills, and reflect critically on their own practice.

A very important point here is the absence of language such as "proficient" or "competent practice". That

is not to say that the course does not provide an opportunity for learners to become more "competent," but it is to say that "competence" was not a main aim of the module, and therefore was not assessed as part of the module for a number of complex reasons.

When exploring the healthcare literature surrounding competence, the only thing that there seems to be an agreement about is disagreement as to its nature and application (Chambers, 1998; Watson et al, 2002) Concepts such as "ability", "capability", and "performance" all seem to be interconnected in complex ways, leading not only to difficulty in defining competence but also in agreeing upon the best ways to assess it. For example, in order to demonstrate competence, is it sufficient to "perform" once only, in one situation, or does it have to be continuously demonstrated in a number of different situations? I am sure that these are some of the reasons for the recent debate on the MINT Listserv concerning assessment of competence, accredited training and competent trainers!

Nonetheless, the nursing profession, along with other healthcare professions in the UK, do claim to be able to assess competence through the use of continuous assessment over three years or more. A key feature of assessing competence seems to be an agreed definition of competence and an agreed set of competence criteria. That was not the case with the development of this module. In particular, there was no room for continuous assessment, as the course was designed only to be 13-18 weeks long, hardly long enough to assess competence, if competence is something that grows and develops. A further difficulty was the question of "competent in what type of situation?" A decision was made that this module would involve the video recording of real life consultations, in order that the learning be meaningful, as all learners were current substance misuse practitioners. However, this leaves the possibility that different levels of competence might be shown, depending upon the environment and the client, amongst other factors, possibly playing a role in how the learner might perform. Furthermore, who should decide what competence is? How competent does the assessor have to be? For all of these complex reasons, a decision was taken to avoid "competence" or "proficiency" as an aim or assessed outcome of the module. So where did this leave us? To our satisfaction, it left us knowing that we could say with confidence that learners who completed the course had spent some time thinking about, learning about, reflecting on and being supervised in the development of Motivational Interviewing Skills.

Key Features of the Module

The table below outlines the key features of the MI skills module we developed.

Attendance	One Day per week for 13 weeks	
Structure of Day	Morning Tuition / Afternoon Supervision Practice Group	
Supervision	Weekly Supervision Practice Group Meetings (Groups of 4 learners), Fortnightly Supervisor in attendance	
Academic Credit	30 CAT points Level 2 (120 Level 2 CAT points needed for Dip HE)	
Programme	Dip HE/BSc Substance Use and Misuse Studies (Option or Stand Alone Module)	
Delivery Staff Involved	Three senior alcohol nurses - all TNT trained, L-P and Lecturer from University	
Setting	Delivered in Clinical Setting to make it more realistic	
Maximum Number of Learners	16	
Assessment	Formative: (Forming)	• Pre-course Transcript • 10 Min Video presented in Supervision Group at Week 8
	Summative: (Summary of Learning)	• 20-30 min Video • 2,500 Written theoretical discussion, including a critical reflection on own practice

Assessment of Learning

Despite the avoidance of difficult-to-define competence language in the design of the module, we were still left with problem of how to assess learning. The view was taken about the purpose of assessment, that primarily it should be used to help learners grow and develop, and secondly to satisfy the achievement necessary to be awarded the 30 academic credits needed if learners wished to use the AP(E)L system to further study for an award such as Dip HE/BSc Substance Use & Misuse Studies. The theoretical assessment focused on the development of academic skills such as critical thinking, in addition to content accuracy. Whilst it would have been quite easy to simply attach the credits to the theoretical component, which is much easier to academically assess, this might have allowed some learners to avoid assessment of developing skills. A pragmatic decision was reached that the assessment procedure should be weighted 50/50 practice and theory to reflect the equal importance of practice, and furthermore, that a pass should be achieved in both elements before being awarded the credits.

Left with the task of how to assess the practice component, we reviewed the Motivational Interviewing Skills Codes and considered their use (Miller & Mount 2001). However, we were dismayed by the intensity of the resources needed to use the coding system for all sixteen learners, bearing in mind that we hoped the course would not be a one off activity, but something that was sustainable. This would have included training the assessors in the use of the codes, estimated to take around 40hrs, and then watching 16 x 30mins three

times each = 24hrs = four full working days for up to three staff = 12 working days. Whilst the overall advantage would have been to make claims on levels of proficiency and to rate for client response as well as global therapist ratings, including capturing the "spirit", it did not seem feasible. Instead, the key elements of therapist MI-consistent behaviour, including using open-ended questions, reflective listening, and expressing empathy, along with working with ambivalence and using strengthening techniques, were incorporated into a 0-10 scale (unacceptable to excellent use) video assessment grid. Again, we did not intend to make claims about competence or proficiency, but simply that learners appeared able to apply their developing MI skills in practice.

Despite the attempt to find an easier way to assess the video presentations, in practice this was still difficult, with assessors taking some time to gain agreement about what each of the criteria might mean; e.g., "expression of empathy": a reflection of a feeling or a sense of understanding? Such conflicts were only ironed out with persistence on the part of the assessors to reach agreement or compromise. One of the major disadvantages of the system used was the lack of rating for "spirit" and a tendency to encourage learners to demonstrate technique, as it is more easily observed. On reflection of the process of assessing learning, it will in the future be worth considering the use of the MISC 2.0 (Miller et al, 2003), now in a more refined format and requiring fewer passes and therefore fewer hours (8hrs x 3 staff). This might well improve the reliability and validity of what is being assessed in the video presentations.

Although the "spirit" was not assessed in the video presentation, that is not to say that it was ignored during course delivery. Delivery staffs were all very keen to ensure that learners "felt" the philosophy of Motivational Interviewing. One way of attempting to address this was to engage all of the learners in a basic Salsa dance at the beginning of the module, offering something that fits with the "dancing not wrestling" analogy, whilst providing a novel way of holding the spirit in mind! Learners seemed to interact with this exercise very well, and made reference to it throughout the rest of the course.

As mentioned earlier, the main purpose of the assessment was to offer feedback and coaching to learners, with the secondary aim of deciding whether or not to award academic credit on completion of the course. However, a formative assessment was introduced at week 8, where learners were asked to present a 10-minute video presentation to their supervision practice group, who in turn offered the presenting learner feedback using the devised video assessment grid. This had many benefits to the learners in preparation for summative assessment and in understanding the criteria used to assess the video presentations. Additionally, learners were also asked to submit a transcript of a 5-10 minute video or audio session on day one of the course. The purpose here was for supervisors to get a feel for what learners were already bringing to the course, and to begin the process of offering feedback on MI consistent behaviours of the learners.

A Final Note

There is so much more that I could report on, including the evaluation results of the initial pilot module and further tensions related to designing, delivering and growing the course, but this would exceed the limits of and purpose of this newsletter. Twelve months ago, I left the London area and took up a nurse lecturer position at Birmingham University, leaving the MI skills module behind, albeit in very good hands! I do know that the course, now in its third year of delivery, continues to be in demand, and continues to seek ways of growing. M

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Privilege And Resistance Within The Domestic Violence Movement

Stéphanie Wahab

Introduction

Despite tremendous national and international focus on domestic violence, there remains little consensus among researchers and practitioners on the efficacy of interventions to address this widespread problem. No agreed-upon "best practice" for supporting and helping individuals in abusive relationships has been identified, and evaluations of batterer treatment programs demonstrate mixed results. Comprehensive interventions for survivors of domestic violence that respond both to the "complex lives and difficult choices" (Davies & Lyon, 1998) that survivors face are somewhat scarce and/or remain in the planning phases. I would like to propose Motivational Interviewing as an intervention worthy of consideration (for practice and research) for work with survivors of domestic violence. While I refer to heterosexual battering contexts throughout this article, my arguments and propositions also apply to same-sex battering.

Understanding change as a process, rather than as an event, is familiar to agencies and individuals who serve battered women. The decisions to disclose abuse, seek help, obtain a restraining order, and/or leave an abusive partner, among many others, are often made in stages with much ambivalence. In fact, we know that battered women leave and return to their partners numerous (5-6) times before they leave for good (Okun, 1986; Snyder & Fruchtman, 1981; Strube & Barbour, 1984), a fact that is frequently referenced in the literature on domestic violence, as well as in the field of practice. This fact also speaks to some of the ambivalence that survivors of interpersonal violence negotiate when making decisions about themselves and their relationships. Within MI, ambivalence, changing one's decision, going back to a partner, and staying with an abusive partner are not regarded as failures or even as dysfunctional choices; rather, ambivalence about change for survivors of domestic violence is understood as a natural part of the change process.

Most of the theories and interventions that address behavior change, including MI, focus on behaviors that occur within the individual that is, behaviors that individuals themselves have control over (e.g., substance use, nutrition, smoking, medication adherence, exercise and violent behavior). When considering the use of MI to understand and support the experiences of individuals in abusive relationships, it is vital to keep in mind that intimate partner violence occurs within the context of a *relationship*. Individuals in abusive relationships only have control of their own behavior; they cannot control the behaviors of their partners. Thus, despite taking action and changing their behaviors, they cannot always secure a violence-free life. Consequently, we must keep in mind that, if we are going to use MI to help us understand domestic violence, it is important to focus only on behaviors that an individual can control, and can choose to address.

An MI Approach: Clients Choose The Behavior(s)

Because MI is client-centered, individuals are supported to choose the behaviors they wish to address in counseling. (If a client does not choose to address behavior change, adopting the spirit of MI, rather than the entire model, may support a client-centered practice approach.) While MI may or may not be useful in addressing and resolving relational dynamics in intimate relationships, MI may likely be useful for clients who are seeking support and assistance concerning behavior-related matters. Topics and behaviors that survivors may choose to address within a domestic violence setting include, but are not limited to 1) behaviors around safety planning (i.e., restraining orders, creating safety plans, staying or leaving the abusive relationships, transportation etc.), 2) substance use (drugs, alcohol, food, medication), 3) child discipline, 4) health issues, 5) compliance with program rules, 6) self-care, and 7) employment. The elements of MI rooted in empowerment practice, such as supporting self-efficacy, empathy, and unconditional positive regard, may also support other empowerment-based interventions utilized in domestic violence settings.

The Current Approach: Privileging Leaving

Domestic violence interventions, in one form or another, typically embrace and focus on the act of "leaving" the abuser (Peled, Eisikovits, Enosh, & Winstock, 2000) as the preferred outcome. For instance, the focus of individual and group counseling for battered women is, more often than not, to empower individuals so that they may eventually free themselves by leaving the abusive relationship. My practice experience in the states of California, Washington, and Utah revealed that many shelters both demand that women not have any contact with their abusers while they are in the shelter, and frequently deny them reentry at a later date if it is known that "she returned to her abuser." Similarly, domestic violence research outcome measures systematically focus on whether an individual "left" and/or whether she "went back" (and if so, how many times).

By implicitly and/or explicitly imposing "leaving" as the desired outcome, however, counselors and service providers inadvertently replicate the same controlling behaviors that clients experience with their abusive partners. This is not to argue that battered individuals should not leave their abusive partners; however, service providers and researchers must recognize that individuals may not always prioritize, for numerous reasons, leaving the abusive relationship. And, even when they do prioritize leaving, they may not be ready, and/or may lack the motivation and confidence necessary to leave.

Arguments against the critique of "privileging leaving" frequently revolve around the idea that measuring leaving is the only indicator of

intervention success available. One of the reviewers for a journal that reviewed the manuscript from which this piece draws, stated that the utilization of an indicator such as leaving an abusive relationship is important for the morale of the staff providing the intervention. This statement begs the question, whom do we choose to privilege through service/research creation and provision?

Certainly, it is much easier for practitioners and researchers to focus on leaving, because that is what we have known to focus on. Perhaps we have no other indicators of behavior change for battered individuals, because we view ourselves as the experts on the lives of battered individuals, and because we have narrowly defined our focus in our attempts to help. Perhaps, by dismissing and/or not paying close enough attention to those voices who have stated that they didn't want to leave, we have missed opportunities to learn about and create alternative interventions that support a broader diversity of survivors.

While its potentially negative effects have been minimally explored in the domestic violence literature, privileging leaving may contribute to individuals feeling additionally trapped in violence relationships. Individuals from marginalized and oppressed communities — including low-income, immigrant, refugee, and disabled communities, as well as communities of color — do not always have the resources or access to resources necessary to leave, and ultimately live independently from their abusive partners. Undocumented women, women with pending immigration cases, and women with children are especially vulnerable to lacking the assistance necessary to leave an abusive relationship. Latina immigrants constitute a particularly vulnerable group; Hass, Dutton and Orloff (2000) report that, due to language difficulties, stresses of acculturation, lack of information, and fear of the court systems, many Latina women are reluctant to seek assistance. In addition, different ethnic and religious cultural groups embrace values, beliefs, social structures and laws that make it exceedingly difficult, if not impossible, for domestic violence victims to leave. Consequently, interventions and services that explicitly, or even implicitly, privilege leaving abusive partners, further isolate and exclude those who may have limited options to begin with.

Finally, women frequently desire and choose to stay with their partners, despite their desire and efforts to live an abuse-free life. Remaining in an abusive relationship does not inherently mean that one accepts violence. Similarly, leaving an abusive relationship does not mean that the violence will end or even be reduced. In fact, it has been reported that women are more likely to be killed when they are estranged from their abusive partners than when they live with them (Berk, Newton, & Berk, 1986; Pagelow, 1984; Riggs, Caulfield, & Street, 2000; Saunders & Browne, 1990; Wilson & Daly, 1993).

Placing the issue of "leaving" or "not going back" at the center of interventions and research is thus problematic for numerous reasons. First, it is inconsistent with client-centered work, as it imposes a "one size fits all" value assumption. Second, it privileges an outcome that may or may not be consistent with the client's needs and wishes. Third, it assumes that the helping professional knows what is best for the client. Fourth, it does not treat individuals as the experts on their own lives. Fifth, it obscures service providers' ability to explore and engage multi-cultural attitudes and practices towards intimate partner violence. Sixth, it dismisses the many strategies and tactics that women have reported engaging in order to deal with their partner's violence.

The Potential Benefits of MI With Survivors of Domestic Violence

In October of 2003, I presented a paper similar to this one at a national domestic violence conference in the U.S., where I was virtually scowled at (and somewhat dismissed) by members in the audience. What I did not notice at the time was who was doing the scowling (and some hissing). Upon completion of my presentation, I found myself surrounded by all of the women of color who had attended the talk. They LOVED the idea of MI and wanted to learn more. I felt that what they loved about MI was that it created a container for practitioners to move away from a "one size fits all approach" to domestic violence interventions. It was at this time that the faces of those who scowled and hissed came to mind: white, educated, middle-class women. Suddenly, the reasons why I chose the word '*privilege*' in my argument/presentation became clear to me, as did the '*resistance*' that is evoked when people with privilege are called to task.

Rather than stress, demand, or even silently wish that individuals leave their abusive partners, perhaps we might make greater attempts to take possession of our projections, countertransferences, and agendas. In so doing, we may become more capable of meeting the diverse needs of clients, rather than those of practitioners trying to avoid burnout. Interestingly enough, I have trained administrators, advocates and counselors who work in battered women's shelters, and most (if not all) eventually stated that, once they learned to let go of feeling responsible for the clients' lives and choices, they felt that MI alleviated feelings of frustration, hopelessness, and judgment, feelings that contribute to burnout. Specifically, they found that the rulers helped, both for assessment and for exploring ambivalence. Many have mentioned that learning to listen better, without judgment, helped them empathize more with their clients. One counselor mentioned that before she learned to listen well and explore ambivalence, she could not understand why women still want to be with their abusers, and even continue to love them, while they are being abused. Rolling with resistance is another MI technique that administrators, advocates and counselors have found useful. By not trying to manipulate, control, and coerce battered women to make behavioral changes, they came to feel less burned out, and noticed that clients seemed to trust them a bit more.

Conclusion

Regarding individuals as experts on their own lives is particularly challenging for practitioners when clients are engaged in behaviors and/or situations in which their safety or even their lives are at risk. While I may personally wish and hope for a survivor of domestic violence to live a violence-free life, I'm in no position to make it happen, nor am I responsible for ensuring long-term safety for individuals. By imposing my will, values and/or agenda, I risk alienating the client, as well as facilitating greater resistance to change. I also close the window of opportunity to learn with and from someone who is living her

life as she knows it best.

Once again, I am not suggesting that we not support individuals who wish to leave their abusers. Rather, I suggest that we embrace MI to help **us** support individuals to evaluate for themselves their levels of risk, options, and decisions. Rather than act as advocates *for* survivors of intimate partner violence, we may consider being advocates *with* survivors. While respecting client autonomy and using MI within domestic violence situations is not without its challenges, I believe that MI has much to offer the field. The directive nature of MI may provide a valuable tool to help bridge the gap between client-centered support and advocacy. Within an MI framework, individuals are seen as the experts on their own lives, and they are supported to explore their perceived risk, resources, limitations, and strengths, at their own pace. This approach does not assume that all individuals in abusive relationships are in immediate physical and/or life-threatening situations, nor does it assume that they all need confidential shelter, restraining orders, or counseling. It neither assumes that all individuals want to leave their partners, nor that they "should" do so.

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Research Roundup

Motivational Interviewing and a Home for the Magdalenas

Carolina E. Yahne

An Albuquerque agency, Health Care for the Homeless, helped with recruitment for the Magdalena Pilot Project funded by the National Institute on Drug Abuse. The agency provided an office in which to conduct the Motivational Interviews with 27 women street sex workers, as well as an office for the 4-month follow-up interviews with 25 of those same women. At follow-up, the women were using less of their self-identified target drug, doing less sex work, and doing more lawful work. Their priorities were to meet basic needs, such as food security and decent housing, with the long-term goal being regaining custody of their children.

Using the findings from our Magdalena Pilot Project (Yahne, Miller, Irvin-Vitela, & Tonigan, 2002), staff members at Health Care for the Homeless wrote and won a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). With the grant they were able to lease an apartment building in Albuquerque that now houses 14 Magdalenas. The site is leased from the Albuquerque Mental Health Housing Coalition. This program, called Tierra del Sol, enables the women to get harm reduction treatment, case management, and perhaps most importantly, a safe and stable place to invite their children for visits and to increase their chance of regaining custody of their children. Currently I am serving as Chair of the Tierra del Sol Community Advisory Board.

The Tierra del Sol outcome is gratifying because it represents what our research can do when applied to real world problems like homelessness, drug abuse, prostitution and violence. The Magdalena Project was conducted in my neighborhood in Albuquerque, so it was literally "close to home". It was an offshoot of the parent grant "Motivational Interviewing in Drug Abuse Services," from the National Institute on Drug Abuse, for which William R. Miller and I were co-investigators. We had already recruited inpatients and outpatients; we were curious to see if MI would work with non-patients-people who had not sought treatment, but whom we recruited through street outreach.

The 27 women whom I interviewed told me at intake that they might want to get substance abuse treatment and reduce their risk of HIV/AIDS, but only after they had some basic needs met, with the priority being decent, affordable housing. When the project's graduate assistant (Irvin-Vitela) set out to conduct the 4-month follow-up interviews, we were worried that we would be unable to find many of the participants, for the very reason that they had no stable address, telephone number, or contact information. To our amazement and delight, 25 of the original 27 women found us for the follow-up meeting. The Motivational Interview at intake had succeeded in communicating its designed spirit, to be collaborative, respectful, and engaging. Several women thanked us for listening to their stories, and for not branding them with the usual pejorative labels.

The staff at Health Care for the

Homeless (HCH) who had helped us to recruit the participants paid close attention to our Motivational Interviews and to our results. Our findings reinforced their observations that one of the most powerful motivators for the women was regaining custody of their children. Yet most treatment centers that included housing did not allow children. Thus, the HCH staff wrote their grant proposal to include housing that allowed children to visit and ultimately live with their mothers. Tierra del Sol has a playground, and case management includes the children's schooling needs and health care. This is a powerful incentive for the mothers to engage in and adhere to treatment for their substance use and other concerns. This use of research results to inform community advocacy and activism seems like the ideal outcome for our work.

A second reason this outcome is gratifying is related to Everett Rogers' (1995) notions about the diffusion of innovations. Because Irvin-Vitela brought the perspective of Community and Regional Planning to our psychology expertise, she widened the view of the project. The community organization (Health Care for the Homeless) was able to closely monitor what worked with Motivational Interviewing, and adopt/adapt it for their purposes. Thus, MI is being "reinvented" as an innovation that is now diffused into our community in a slightly different way from its original form, and the voices of the Magdalenas living at Tierra del Sol are being heard.

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A Farewell to MINT

Dirk D. Gibson

Recently, I announced on the MINT listserv that I would be leaving the MINT, as I have purchased a river rafting business and will be trading my hospital office for a tent in the wilderness. I received an overwhelming response of well wishes, as well as requests that I share my reflections as I prepare to leave the field of the behavioral sciences after 16 years and as a member of MINT since 1998. So, without any further background, I will share the following thoughts.

MI is an important body of work and practice for the field of Behavioral Health. I believe it will stand the test of time, and continue to make great contributions to helping people make positive changes in their lives.

The amount of research that is conducted related to MI is incredible, and it is great to know that there is a constant pursuit of knowledge. It gives this work credibility. However, I sometimes wonder if the balance is equitable with practice and application sharing that goes on. Research findings are great guiding beacons; however, I also enjoy research that looks at something that is already working and why, rather than creating a theory and testing it. Hopefully, the MINT will keep breeding an atmosphere that encourages pursuit of the applications in both an intuitive and scientific way.

It seemed to me that, in any audience I was training or learning from, there were always those who were naturals at the approach of MI, those who could learn MI, and those who might never quite get the spirit of MI. I always felt that being competent and technically skilled were not quite encompassing of what I was trying to impart to the learners or what is needed to practice MI effectively. That is why I used Monty Roberts' horse training tapes, to show both technical skill and that "way of being" combined. I think MI places a stronger emphasis on this area as well. I also recognized that certain people will not "get" this approach. I am not sure why this is, but I know that if you do some of the skills taught in MI without the underlying spirit and a sense of genuineness, the results can be negative. However, I will never forget the patient who participated in one of my large group overview trainings with clinicians, and wrote me a note saying if her therapists did not learn this way of working with her, that she would teach them…which gave me great hope.

I have valued CASAA's training videos greatly. Thank you to all the people in the videos for being brave enough to demonstrate MI — it really helps people learn. I hope the tapes get updated. I would love to see shorter segments that name the technique and point out reminders in subtitles as the sessions take place. Also, some process points after each segment, to lead into practice exercises, could be helpful. Maybe there is a grant out there to help fund a bigger production budget.

In my time as an MI trainer I have worked with 7 different Native American tribes. There is not enough room in this newsletter to share all I have learned from these beautiful people. But I do want to share some

thoughts on what their selfless ways taught me about training Native Americans in MI. MI fits well with Native American culture. The tribes I worked with felt a kinship with the respectfulness and compassion that comes from MI. However, you must take the time to build strong relationships; MI is not fast food, nor is the path to working with Native Americans. For example, short-term workshops are not effective; you must commit to long term relationships, as there is a need inherent in the tribal structures to continuously repeat, review, and rebuild. You will need key people in each tribe to help you translate the concepts of MI and match them up with their culture (true for any culture). Certain reflection exercises do not translate well, as the members of the tribes I worked with reflect all the time, naturally, when engaging in a conversation. And, of course, each tribe is different, and one needs to take the time to get to know and respect those unique qualities to effectively work with them. I hope we will see MI combined with some of the new best practice research being done regarding Native Americans.

I also have seen great potential with adolescents, conduct disorder and criminal justice populations, and now I am using some of the applications in organizational development. Being a great leader is also about being a great listener, and leading people through continuous change takes ongoing development in intra- and interpersonal skills. Hopefully, that work will continue.

I have enjoyed the breadth and depth of the MINT listserv and the international community; it truly has become a solid foundation of collective knowledge and intellectual quality. It seems that being considerate of others allows for members to leave their egos at the door; I hope this feeling continues to be nurtured, so that more knowledge will be shared and created at the speed of change challenges. I am concerned, though, that MINT faces a crossroads with the issue of certification, and I would say, Be careful not to damage the spirit in an attempt to protect the soul… What actual good will really be accomplished, and at what costs?

MI allows for and recognizes the nature of people in helping them move along the path of change, and therefore it is attractive on the level of making sense and being effective. Steve and Bill manifest this as a balance of style and approach that constantly ends up where it needs to be; you see it when they talk about MI and when they write about MI. How divine was it for the two of them to get together and give birth to this effort…

As for the future, I do not know where MI will go, but I will offer you one story from the past to help guide and remind us of the importance of what we do. In 1993, I had been the director of this hospital's Behavioral Health Program for several years, and was fully engaged with the fairly new and strong Managed Care Companies in what felt like a battle to stay in business. I remember one day reflecting that maybe the insurance companies were right about our effectiveness in behavioral health. Maybe I should quit defending our approaches; perhaps it was time for me to step down and let someone smarter steer this ship through the storm. After all, the defining question for me was, "Is the program I run good enough for my own children?", and the answer, quite honestly, was, "No, it is not." So I began mentally preparing to leave it all behind. Then, just a few days later, a physician who had recently joined our team gave me a book and said, "Here, I think you should read this. It is what you do naturally, and it has some good research behind it. Maybe we could teach it to the staff and use it here." That book was *Motivational Interviewing*, and the minute I started reading it I knew that now we were on to something that will work… Well, it kept me around for 11 more years; our program grew stronger, and we came to have great effectiveness and patient satisfaction rates. And today, as I depart, thanks to the shift in approach and concepts of MI, it is good enough for my own children. M