MINT Bulletin

Motivational Interviewing Network Of Trainers

Volume 12, Issue 1
May 2005

From The Desert

Bill Miller

On the Road Again

I have the distinct feeling that MI is going somewhere, moving toward and becoming some part of some larger process or end. MI is not an end in itself. Rather, practicing and teaching MI contributes to something larger, serves some deeper meaning or purpose. I find that people are drawn to MI because we *recognize* it, experience in it a connection with something that is deeply right and human. Done well, MI enacts in relationship something that is difficult to describe in mere words. We acknowledge this in part through emphasis on the underlying spirit as collaborative, evocative, and honoring autonomy.

What I am arguing here is that it's not MI that is important, so much as the underlying *menschenbild*, compassion and altruism that give life to MI and MINT. I am not interested in promoting MI, so much as this way of being as a helper and human being. Now I'm getting way out on a mystical limb (sorry Steve), but I do feel a small part of some larger, positive wave. We caught that wave (now Steve is happy) with MI, but MI is not the wave itself. I'm not entirely clear what the wave is, but it feels right to me in a world where there is so much darkness. As a younger man I wanted to make the world better is some big way. It seems to be my nature, however, to do it one person at a time. I feel, in the words of Teilhard de Chardin, "on a road of which I am more and more certain, toward an horizon more and more shrouded in mist."

Is MI Directive?

At the annual MINT meeting, Guy Azoulai asked me about a problem he was having in translating MI into French. We traditionally describe MI as both client-centered and directive. The "client-centered" component poses no problem in French, because of familiarity with the work of Carl Rogers. It was the "directive" component that was causing trouble because, as Guy explained, the meaning of the French equivalent term is very top-down, expert-driven. In other words, to use the French equivalent for "directive" would be to imply something inherently inconsistent with MI. "But," he said, "we do have a word that means 'semi-directive,' and it is much closer to your description of MI. Would it be all right to use that instead?"

All right? I'm so fond of the idea that I think I'll start describing MI in English as "semi-directive." That's not a term I've ever seen in English, but it is certainly understandable and actually sounds to me more like what Steve and I meant in the first place. This is also consonant with Steve's recent innovation in describing three normal styles of communication (see Rose, Rollnick & Lane in *MINUET 11.3*). The "guide" mode is precisely semi-directive, incorporating both listening and instructing. A guide is someone who works for you, and takes you where you want to go. To be sure, the guide offers instruction and options on how to get there, but also listens

Editor's Choice

A Continuing Evolution

Allan Zuckoff

For some time now, and beginning well before I assumed the editorship in 2004, the *MINUET* has been moving away from its origins as the "newsletter" of the Motivational Interviewing Network of Trainers (that function having been made increasingly redundant by the advent of the closed MINT listserv), and towards a broader role in the life of our community and beyond. With this issue, we acknowledge and mark a moment in this evolution by renaming the publication *MINT Bulletin*.

In discussions with and among the members (and "grandfathers") of the Steering Committee, a clear consensus emerged against trying to turn the *MINUET* into a "journal," with all the formality and sense of finality that term implies. Rather, we hope that *MINT Bulletin* will be a place where readers can find new ideas or even conceptual frameworks, accounts of training experiences and novel exercises, descriptions of extant research on MI as well as current trends and work in progress, advances and struggles in MI practice-all put forth in

the spirit described by Bill Miller in last issue's **From the Desert:**

[A] dance of possibilities, of half-baked ideas and whimsical, wistful commentary... a safe haven for loving dialogue without diatribe, for critique without competition.

In This Issue

In this installment of his **From the Desert, Bill Miller** ponders where MI is going, adopts a new word to describe it, and reviews a recently published book on a psychotherapy that shares intriguing commonalities with it. **Pat Lincourt** then describes a novel approach to the challenge of increasing the receptivity of an agency's culture to MI training in ***Preparing Supervisory Staff to Implement MI.*** This is followed by a ***Steering Committee Update*** from current SC chair **Terri Moyers**, and **Grant Corbett's *What the Research Says...About Change Talk-Part II.*** Then, in the ***Training Corner***, **Tad Gorske and I** describe a variation on Terri Moyers' popular adaptation of the "fishbowl" exercise, ***Team Consult Warm-Up: A Blending of MI, Psychodrama, and Group Process.***

The remainder of the issue is given over to the special section, **MINT Forum 2004**, which presents the proceedings of our annual meeting, held last October in Portland, Maine. **Jacki Hecht**, who took the lead in organizing this very successful meeting, generously agreed to serve as co-editor for the section, and introduces its contents on page 12. In the pages that follow, you will find contributions by **Bill Miller, Stephen Rollnick, Stephanie Ballasiotes, Tom Barth, Steve Berg-Smith, Marci Campbell, Carol Carr, Cathy Cole, Carol DeFrancesco, Chris Dunn, Jacque Elder, Denise Ernst, Christiane Farentinos, Hiro Hiroaki, Eugene Hoffman, Jon Krejci, Gary Rose, David Rosengren, Rich Saitz, Stefan Sanner, Dee-Dee Stout, Lesley Tinker, Timothy Van Loo, Mary Velasquez, Chris Wagner, Stephanie Wahab, Harry Zerler, and me** — a veritable cross-section of MINTies new and old. Rather than try to describe the richness and variety of these contributions, I will only say that, to my mind, they beautifully exemplify the spirit of creativity, openness, and (not unimportantly) playfulness that I hope will continue to pervade issues of *MINT Bulletin* yet to come.

Looking Forward

This issue comes out halfway between MINT Forum 2004 and this year's scheduled MINT Forum in Amsterdam, The Netherlands. Like many of you, I am already eagerly anticipating the heady mix of new ideas, creative applications, and downright silliness (cf. 2003's Synchronized Swimming Olympics) that has characterized these meetings. I hope that reading the proceedings of our last MINT meeting whets your appetite to attend the next one, as it does mine, and makes you look forward to seeing the pro-

and knows that the journey is your own. A guide is semi-directive, or perhaps directive with permission.

Another option being considered is to describe MI as goal-directed. The idea of "client-centered with a goal" seems to communicate the essence, and the issue of goals (aspirations, intentions, investments) has been lively in discussions of the ethics of MI. In any event, I'm having second thoughts about describing MI as "directive," even in English.

***The Integrity Model*: A Review**

Anyone who has studied the psychology of motivation and learning may recognize O. Hobart Mowrer as the 1950s formulator of the two-factor theory of learning. What fewer know about Mowrer is that toward the end of his long and distinguished career, well after he had served as President of the American Psychological Association, he was developing a new theory of personality and an existential psychotherapy centered around integrity. His concepts seem to have arisen through his interest and involvement in the mutual support group movement, particularly the spiritual 12 Step groups of Alcoholics Anonymous (Mowrer, 1964). Because Mowrer published only a few conceptual articles on integrity therapy (Mowrer, 1966; Mowrer & Vattano, 1976), the primary caretakers of its knowledge and practice have been his later graduate students. Happily, one of his students, Nedra Lander, has taken the time to provide this book describing integrity therapy, in collaboration with her own student, Danielle Nahon (Lander & Nelson, 2005).

The Integrity Model is a book for and ultimately about therapists. The extended title offers the hook that may attract therapists to read it: *The Integrity Model of Existential Psychotherapy in Working with the "Difficult Patient."* Lander and Nahon present their model as a way of understanding and dealing with therapeutic impasse and "difficult" clients. In a way, this may be unfortunate, because integrity therapy seems to me a promising approach for a broad clientele, and not only for those whom a therapist happens to find difficult. Imagine if motivational interviewing were presented just as an approach for handling difficult cases.

The integrity model begins with Mowrer's basic premise that many of the problems in living that people bring to psychotherapists are symptomatic of "integrity violations." Low self-esteem, depression, anxiety, burnout — any of these may reflect an integrity crisis arising from the person's failure to live

ceedings of the 2005 MINT Forum in this year's third issue.

In *MINUET 11.3*, I introduced a new intended section of letters, comments, and the like, entitled **Feedback**. The absence of such a section in this issue is cause for mild embarrassment (for me) and (I hope) a call to pens and keyboards (for you). I encourage you, should you find something in this issue that tickles your fancy, makes you angry, or anything in between, to consider a response in these pages that could initiate a "dialogue without diatribe." And remember: nothing makes an author happier than knowing that his or her efforts have stirred a reaction, no matter of what kind.

Finally, a belated comment about the belated nature of this issue. While many factors contributed, I am fully responsible for bringing out this publication according to its intended schedule. To all those who contributed articles, my apologies for the delay in their reaching their intended audience; and to those who enjoy these articles, my promise that you may "look forward" with confidence to the timely publication of *MINT Bulletin* in the months and years ahead. MB

up to and honor his or her own core values and the implicit contracts involved in human relationships. "Conscience" is the traditional term for this phenomenon, and guilt the emotional experience related to integrity violations. Lander and Nahon describe guilt as "one of the healthiest of human emotions," a warning light that one is stepping beyond value bounds. Self-esteem, they say, is developed by living with integrity. Or conversely, as George Carlin quipped, "Most people with low self-esteem earned it."

I balk at the idea that all psychological symptoms are a product of integrity violations, but I do think it is a reasonable hypothesis to entertain in clinical work, as illustrated by case examples in their book. To add one of my own, I remember a psychology professor who came to class one day with his head tilted over to one side. In the course of the hour, it fell farther to the side until finally it rested on his shoulder. He had lost muscle tone in his neck, and was unable to maintain his head in its normal position. Over a period of months he came to class in a neck brace to hold his head erect. Medical exams yielded no explanation, but psychotherapy did. He had been having an extra-marital affair, and he literally became unable to hold his head up!

Mowrer originally developed integrity therapy as a treatment for substance dependence, to be offered only in group format. He was influential in the conceptual development of Synanon and Daytop Village, where his compassionate "integrity group" approach unfortunately devolved into emotional haircuts and attack therapy.

The heart of integrity therapy is existential — that human behavior is under volitional control. One thinks immediately of the exceptions, but it is a basic assumption of Western societies and law that we choose our behavior from among options. Self-direction by choice is also, I believe, a basic assumption underlying motivational interviewing.

In essence, integrity therapy seeks to bring the person's daily actions into alignment with his or her core values — a kind of moral-ethical chiropractic. The authors quote Mower as often saying, "If you don't like the way you feel, change your behavior." To live with integrity is to behave in ways that are consistent with the values that one seeks to follow and serve.

Like Scott Peck and Karl Menninger, Mowrer also contributed to a psychological understanding of evil.

MINT Bulletin

Editor
Allan Zuckoff

MINT Steering Committee
Terri Moyers, Chair
Rik Bes
Kathy Goumas
Gary Rose
David Rosengren
Chris Wagner

In Association With
William R. Miller
Stephen Rollnick

Submissions
Inquiries may be forwarded to
Allan Zuckoff, Ph.D.
University of Pittsburgh Medical Center
Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213 USA
Tel.: +1 412-246-5817
Fax: +1 412-246-5810
Email: zuckoffam@upmc.edu

The MINT Bulletin is published thrice yearly by the Motivational Interviewing Network of Trainers (MINT), an international collective of trainers in motivational interviewing and related methods who have been trained as trainers by William R. Miller and Stephen Rollnick. The MINT Bulletin is made available to the public, free of charge, via download at The Motivational Interviewing Page (www.motivationalinterview.org) (Chris Wagner, Ph.D., webmaster). Publication is made possible in part by funding from The Mid-Atlantic Addiction Technology Transfer Center, primary sponsor of The Motivational Interviewing Page.

From The Desert ¦ continued

Mowrer assumed that humans are predisposed toward and have the capacity for both good and evil, and continually choose between them. Here his *menschenbild* departs from the natural health model of Rogers, and more closely resembles classic Judeo-Christian theology of human nature. Much influenced by Harry Stack Sullivan, Mowrer also understood integrity in the context of social relationships. "We view the life task of the human being across all developmental stages as that of moving from the narcissistic to the altruistic position." What keeps us on beacon is the discomfort of integrity violation. Living with integrity, Lander and Nahon say, teaches us "how to resist being ruled by one's dark side — and how to deny others access to it."

I recognized, in reading this book, the same frustration that I usually feel in reading existential therapists. The text is very thin on exactly what the therapist *does*. They describe an "integrity drill" with which they begin therapy, that includes a values clarification process: exploring values, placing them in hierarchy, "owning" them (are these my values, or some one else's?), examining how one's daily choices promote or defeat core values, and taking responsibility for one's own choices. Yet this is nothing like a practical "manual" on integrity therapy. Don't look for "how to" instructions.

Yet there is so much in this book that rings true for me, and I sense that it contains some pieces that have been missing in motivational interviewing, and in psychotherapy in general. Exactly what is it, for example, with which we seek to make problem behavior discrepant? In developing discrepancy, what are our allies? Surely they are the person's own values. I resonated to quotes like "We cannot decide for the other what the best solution for them will be," and "We find addicts to be a fairly easy population to work with." There are gems of seasoned wisdom throughout the book. MINTies will find the authors wrestling with many familiar and fascinating issues: resistance, therapeutic impasse, client-therapist value clashes, burnout, character, diagnostic labeling, organizational climate, peacemaking, and a "way of being."

In a field replete with hundreds of named and largely unevaluated psychotherapies, I do not readily become interested in or enthusiastic about yet another approach. Yet after four decades of receiving, providing, teaching, reflecting and writing on psychotherapy, I found in *The Integrity Model* new encouragement that I am beginning to understand some fundamental processes of human healing. It challenged me to set aside accustomed frameworks, and to think more broadly about what is unique to human nature and change. Lander and Nahon bring together many pieces of the puzzle that is always on the horizon for me when I am designing, conducting, and trying to understand my own research.

MB

Lander, N. R., & Nahon, D. (2005). *The integrity model of existential psychotherapy in working with the "difficult patient"*. London: Brunner-Routledge.

Mowrer, O. H. (1964). *The new group therapy*. Princeton, NJ:: Van Nostrand.

Mowrer, O. H. (1966). Integrity therapy: A self-help approach. *Psychotherapy: Theory, Research and Practice*, *3*, 114-119.

Mowrer, O. H., & Vattano, A. J. (1976). Integrity groups: A context for growth in honesty, responsibility, and involvement. *Journal of Applied Behavioral Sciences, 12*, 419-431.

Rose, G.S., Rollnick, S., & Lane, C. (2004). What's your style? A model for helping practitioners to learn about communication and motivational interviewing. *MINUET, 11.3*, 3-5.

Preparing Supervisory Staff to Implement MI

Patricia Lincourt

Last year a large substance abuse treatment system hired me to train 60 supervisory staff in MI. The agency's administrators wanted to start by training supervisors in order to strengthen their awareness of MI and increase the "buy-in" of these key staff, in support of a more global plan to train all 600 line staff in MI.

The training was designed in two, 2-day sessions of 30 participants each, with a follow-up session for each group to focus on implementation and supervision issues. Represented across the two groups to be trained were supervisors in treatment modalities including detox, inpatient, outpatient, intensive outpatient, and vocational rehab programs. Some programs had already trained staff and others were just learning MI themselves.

The first phase of the training, a standard 2-day basic MI workshop delivered to each group, went well and was well received. There was very little question that the attendees were willing to implement MI, and that they were supportive of the philosophy. What little dissent there was on this point was muted by the presence in both trainings of mid-level administrative staff clear about their desire to implement the model. However, most supervisors reported that

they expected a lot of resistance to learning MI from the line counselors they supervised.

The challenge I faced in designing the follow-up, implementation session was figuring out what to do with a diverse group of supervisors that would satisfy those who were already implementing the model, as well as those who had not even considered an implementation and were in fact just contemplating what it might mean for their staff and clients. The approach I took was influenced by discussion on the MINT listserv at the time about values and MI. I also was very interested in a question raised by Dr. Miller in *MINUET 11.2*, about why some sites in clinical trials were successful while others were not.

Having worked in several different substance abuse agencies over my career, my hypothesis about what makes MI "work better" in one place over another has to do with the climate, "readiness" of the staff and acceptance of the model throughout the layers of the agency. It seemed to me that, in implementing MI, programs often take a rather non-MI compatible approach. They may implement the new model with little or no preparation, and when they meet resistance in line-staff, respond to it in an authoritarian way — a "Well, we're doing this now, and if you don't like it you can leave!" response. Unsurprisingly, this leads to increased resistance rather than increased motivation, and ultimately a failed attempt to implement the model. So my goal was to prepare the supervisors to assess readiness and plan for implementation. I essentially wanted each supervisor to leave with a plan, beginning with assessment and an implementation model that included a lot of preparation and involvement of the staff.

The Implementation Session

I decided to work with supervisors to identify different aspects of "readiness" and develop a plan for implementation that included all levels of the organization, and that would also respect the views of each member of the staff. The day was planned as follows:

1. *Brainstorm values of line staff, supervisory or mid-level staff, and administrative values; then, as a group, compare and contrast the values held at each level.* It was interesting to find that two independent groups tended to identify similar common and contrasting values. Line staff were seen as valuing making a difference, being recognized, receiving a paycheck, and feeling good about self. Supervisory staff were seen as valuing excellent client care, career advancement, receiving a paycheck, and opportunities for educational and self-improvement. Administrators were seen as having the most contrasting values, with compiling good statistics, increasing productivity, and maintaining funding as the main values.
2. *Identify values individually.* Each participant was then asked to identify the top three values for themselves, staff, and administration.
3. *Find commonality.* The group was broken into triads and assigned the task of finding commonality in the values. One of the most interesting aspects of this exercise (and it happened in both sessions) was the number of groups who reported back in the debriefing that they could find a lot of commonality between line staff and supervisors, but very little between administration and supervisors or line staff. As a group and with the help of all the MI this writer could muster, the groups were able to see how attention to the survival of the agency supported the work of the line staff, even if focus on productivity alone led to a perceived compromise in quality of services.
4. *Present a way of assessing organizational and staff "readiness" for change.* The first model presented was an adaptation of Maslow's hierarchy of individual needs to organizations. I honestly do not know if anyone has adapted Maslow's hierarchy to organizations previously, but it made sense to me and seemed to complement the values discussion. I will say that I was inspired to include this model after reading the chapter on the role of values in MI in *MI2*. At the bottom of the pyramid, of course, is the organization's financial health; next is safety, in terms of a professional and supportive climate free of harassment and other behaviors that make staff feel unsafe; next, that the agency has an attractive and comfortable environment that shows respect and caring for clients and staff; then, professional development and training; and finally, self-actualization like that attained by organizations that are able to truly find and live out their mission, adjusting to adversity and contributing in a way that meets the ideals of the mission statement and advances the field in which they exist.
5. *Present the adaptation of SOC to assess organizational readiness.* The Stage of Change model was presented as a way of assessing program readiness in much the same way as it is used with individual clients. We talked about various ways of assessing this, including a staff survey based on a tool such as SOCRATES adapted in language to reflect willingness and openness to learning and implementing MI.
6. *Conduct a "consultant exercise."* The group was broken into three large sub-groups. They were told to imagine that they were paid consultants for a community agency-each group was given a different

scenario describing an agency that wanted to implement MI. The consultants' job was to make a plan for the agency, taking into account what was covered earlier in the workshop. The groups at this point were inclined to develop a plan that began with assessment and included ideas of how to identify what was important to individual staff members at all levels, including use of surveys, focus groups, informal meetings, and observation. The plans created by the groups were elaborate and included more attention to preparation than to actual implementation.

Final Thoughts

I believe that many programs fail at implementing MI or other innovations despite the best intentions and substantial talent of staff. What I have learned about successful implementation I have learned the hard way, by trying to implement ideas on the strength of my own enthusiasm while forgetting the importance of what MI teaches about preparation to change, the validity of everyone's point of view, and the power of evoking plans for change from those who will be making the changes. I was pleased enough with the outcome of these implementation workshops to want to share the experience with readers of the *MINT Bulletin*, in hopes that the ideas described may help others be more effective in bringing MI into existing organizations. MB

References

Miller, W.R. (2004). From the desert: Why does MI work in some places and not others? *MINUET 11.2, 1-2*.

Wagner, C.C. & Sanchez, F.P. (2002). The role of values in motivational interviewing. In W.R. Miller & S. Rollnick, *Motivational interviewing: Preparing people for change.* 2nd edition. New York: Guilford.

Steering Committee Update

Terri Moyers
SC Chair

Hello MINTIES (and other interested readers)! Exciting things have been happening in the MINT Steering Committee the last six months. Perhaps the most telling sign of progress is the fact that the MINT SC now has a regularly scheduled conference call (spanning several international time zones), and rules for establishing a quorum when votes are needed. The addition of regular "meetings" has meant that we have been able to make progress on some complex issues that are important to you.

First of all, we tackled the issue of who should be training at the next TNT in Amsterdam, since Bill and Steve will not be the lead instructors. Because we had many excellent teachers volunteer to donate their time, we were able to concentrate on forming teaching teams that offered an international flavor, complementary teaching styles, and represented both men and women. In keeping with the MINT spirit, we also tried to select individuals with a history of giving more than they take from the MINT. Our teaching team for the Amsterdam TNT will be David Rosengren, Kathy Goumas, Karen Ingersoll and Jeff Allison-an outstanding teaching ticket! Bill and Steve will be serving as "friendly grandfathers" for our teaching teams during this important transitional year. Hotel venues for Amsterdam have been formalized and the first independent TNT run entirely by the MINT is shaping up nicely; more information will be coming from Rik Bes and the CMC group soon.

Your Steering Committee has also been active in investigating the issue of certification for MI trainers. There is a diversity of opinion about this matter within the MINT-no clear mandate has emerged. To help us resolve this ambivalence, a small working group of interested individuals has been drafted to provide information and options to our group. This working group needs our support, no matter how we feel about the issue of certification, because they are coping with a staggeringly complex set of questions. Accordingly, the SC has moved to provide a bit of administrative support in the form of access to conference calling resources, to allow information-gathering to move forward. Your dues at work!

Other issues on our plate include drafting of MINT by-laws, serving as advisors for the newly renamed *MINT Bulletin* (now under the excellent editorship of Allan Zuckoff), establishing procedures and policies for the payment of MINT dues and review of applications for MINT-sanctioned TNT's. Last, but not least to your hardworking SC, is the issue of how to rotate membership on the SC so that new members come on board in a gentle and sensible fashion and old members get to retire and take it easy. Our long-term goal is to spend our free time at MINT meetings visiting with you, our friends and colleagues, instead of having meetings with each other.

It has been my pleasure to serve as your MINT SC Chair and I hope to see you at the Amsterdam TNT for the best MINT meeting yet! MB

What The Research Says

About Change Talk: Part 2

Grant Corbett

In Part I of this column, William R. Miller explained why he included evoking client "change talk" (called "self-motivational statements" in his early writings) as part of Motivational Interviewing (MI) (Corbett, 2004). Based on his reasons, I proposed three areas of theory and research to explain why eliciting these statements may motivate change. Two of these were explored in that column.

What we found was that asking a person about their reasons to change and decisional matrix (i.e., how they perceive the costs and benefits of a new behavior) may be critical to the effectiveness of change talk. Why?

It appears that people need to bring attitudes and perceptions into active memory to change. So how does motivation result from a person making salient (i.e., bringing to the top of the mind) the following (Miller, Moyers, Ernst & Amrhein, 2003)?

1. Desire to change
2. Ability to change
3. Reasons to change
4. Need to change
5. Taking steps toward change, and
6. Commitment to change

We are just beginning to understand this. Paul Amrhein and colleagues' seminal paper (2003) on commitment language is an example. I will discuss that study in the next issue, along with practice recommendations based on the research reviewed in this series.

In this column, I want to propose that evoking change talk is about helping people to access and verbalize their intentions, decisional balance, and discrepancies in the context of their "preferred self". However, we have not yet discussed the third area of research, proposed in Part I, that may help us to understand the need for evoking change talk. This is Cognitive Dissonance Theory.

For reasons that will become clear, we will begin by looking at the relevance of the "preferred self," and then, cognitive dissonance for change talk.

The Preferred Self

Several writers have commented on the importance of working with a person's self-view. For example, Miller proposed that in MI, "we lend clients another perspective, a mirror, a chance to step safely outside of their own frame of reference and to see themselves with new eyes." (Miller, 1998; p. 5). I interpret him as saying that we want people to access the person they want to become or that they want to avoid being. This is the "preferred self".

Tom Barth, Peter Prescott and Tore Boertveit (2000) spoke also about working with a person's preferred view of self in MI:

> ...one can focus on the difference between the client's 'preferred view' of himself and 'the dominant view' [how they believe others see them]...What you need to do is to give feedback on 'the preferred view' (using empathy and affirmation), explore times when the client is/was viewed as he would like, and talk about what the client can do to make others see 'the preferred view'. (p. 4-5)

Miller (2003) pointed to the benefits of clients acting as-if they were the person of their "preferred view" to motivate change:

> ...In MI the focus is on evoking self-motivational speech: If you talk as if you're going to change, you're more likely to do so...As my client on the Chicago tape observed, 'Fake it till you make it'...I suspect that there is wisdom in this approach, which appears so persistently in natural language, fiction and clinical writing. (p. 4)

Dolinski (2000) provides some evidence for change occurring through acting as-if. Additionally, Norman and Aron (2003), in a study of university students, demonstrated the importance for motivation of the self being "available, accessible and under one's perceived control" (p. 505).

The foregoing suggests that it is the person's "preferred self" that we want to evoke (i.e., make accessible) and work with in MI. Recent writings on Cognitive Dissonance Theory also support this conclusion.

Cognitive Dissonance Theory and the Preferred Self

Cognitive dissonance was mentioned specifically by Miller as a reason for including change talk in MI (Corbett, 2004). Festinger (1957) defined cognitive dissonance as:

> ...the existence of nonfitting relations among cognitions...(that is) any knowledge, opinion, or belief about the environment, about oneself, or about one's behavior. (p. 3)

So Festinger's theory included cognitions about the self as a cause for dissonance. Stone and Cooper (2001) discussed, more recently, the role of the self in Cognitive Dissonance Theory in presenting their Self-Standards Model (SSM):

> The SSM predicts that the evaluation of behavior may be based on generally shared, normative considerations of what is good or bad, foolish or sensible, moral or immoral, or it may be based on personal, idiographically held considerations of what is bad, foolish, or immoral — *standards that are connected to individual representations of the self* (emphasis added)... [B]ringing to mind certain aspects of the self can influence the degree to which people will justify their behavior or use their self-knowledge as a resource to reduce their discomfort. (p. 231)

Again, we see reference to two points. The first is to the importance of "bringing to mind" (i.e., making accessible in memory) particular aspects of the self and standards of behavior in resolving dissonance. The second is reference to a "possible self" or "preferred self/view", described by Stone and Cooper in terms of shared or idiographic "representations of the self".

What Stone and Cooper are saying is that the salient self may be used to justify behavior (which we

might call "resistance", if accessible standards support the problem behavior) or to resolve dissonance in the direction of change (c.f. McIntyre, Lord, Lewis, & Frye, 2004). What I believe is necessary for the latter to occur is that change talk questions and OARS [see side bar] bring to mind, first, a person's "preferred self", and then, discrepancies with that self in the form of:

1. Others' views of what behaviors are normative (which may include what the client believes is the "dominant view" others have of them), or
2. Behaviors, including those in which they have been engaging or have failed to engage.

   The person may choose, then, to resolve dissonance by initiating or modifying behaviors that will help others to see their preferred view, or to act in alignment with the person that they want to be or that they want to avoid becoming.

The foregoing may seem to be what you know already about MI. However, in practice, we may identify behaviors that are of concern but assume that the self of relevance is available and being accessed by the client. We may come close in eliciting a person's values, but values and their priority are relevant only in the context of an accessible "preferred self". If that self is not activated in memory, asking a person how their values align with behaviors of concern is unlikely to create dissonance (Rokeach, 1979).

An example may help. One of my staff, a social worker, spoke with me about a client who attended appointments regularly because of his wife's concerns regarding his cannabis use. "I know that he is in Precontemplation or maybe Contemplation, yet he never misses an appointment", she remarked. "We worked through the decisional balance exercise and talked about taking small steps, but he hasn't changed his drug use."

After hearing a few minutes of background, I suspected that the client's dissonance was not about marijuana use (i.e., about his drug-using self), but whether to remain in his marriage (i.e., about his spousal self). There might not be a problem, in his mind, if he and his wife separated. Once the social worker addressed his ambivalence about the marriage, they made progress in decision-making about drug use. So we need to help clients be clear about the self with which their behavior may be in conflict.

I propose that dissonance (i.e., discrepancy) will not be resolved unless the "preferred self" is made accessible through change talk, and clients perceive the benefits of the new behavior as personally relevant to and discrepant from a "possible self" that can be achieved.

Practice Implications

To end, the practice implication is to listen for, evoke and speak to a person's "preferred self" as you use the skills and techniques of MI. The authors quoted in this column provide insights on how this can be done. I would recommend, also, that you read the cautions about working therapeutically with a person's selves outlined by Cooper (2003, pp. 147-150).

As mentioned, we will look in the next issue at Paul Amrhein and colleagues' study (2003) of commitment language, and its relevance to change talk, along with practice implications of the research reviewed. We will begin that column by considering how the definition of change talk is evolving. That will be the last of this three-part series.

Comments and questions on this column are welcomed by writing me at grant.corbett@behavior-change-solutions.com. MB

Change talk, confidence talk and commitment talk can be elicited by a number of proposed questions. For example, a counsellor might ask:

- Evocative questions: "What do you make of that?"
- About the pros and cons: "What is good and not so good about ...?"
- For elaboration: "Could you tell me why that was a concern?"
- For the worst-case scenario: "What is the worst that could happen if...?"
- Clients to look forward: "If you didn't take this medication, what ...?
- Clients to look backward: "Have there been other times when...?"

The tools for working with responses have the acronym OARS: (1) Open-ended questions, (2) Affirmations, (3) Reflective listening and (4) Summaries (Miller & Rollnick, 2002)

References

Amrhein, P. C., Miller, W. R., Yahne, C., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. *Journal of Consulting and Clinical Psychology, 71*, 862-878.

Barth, T., Prescott, P. & Boertveit, T. (2000). European blend. *MINUET, 7.1,* 2-5.

Cooper, M. (2003). "I-I" and "I-me": Transposing Buber's interpersonal attitudes to the intrapersonal plane. *Journal of Constructivist Psychology, 16*, 131-154.

Corbett, G. (2004). What the research says...about change talk: Part I. *MINUET, 11.2*, 9-10.

Dolinski, D. (2000). On inferring one's beliefs from one's attempt and consequences for subsequent compliance. *Journal of Personality and Social Psychology. 78*, 260-72.

Festinger, L.. (1957). *A theory of cognitive dissonance*. Stanford, CA: Stanford University Press.

McIntyre, R. B., Lord, C. G., Frye, G. D. J., & Lewis, S. L. (2004). False memories of attitude-relevant actions. *Social Cognition, 21*, 395-420.

Miller, W. R. (1998). From the desert: Last installment from the wetlands. *MINUET, 5.3*, 1-6.

Miller, W. R. (2003). From the desert: Crossing cultures. *MINUET, 10.3*, 1-5.

Miller, W. R., Moyers, T. B., Ernst, D., & Amrhein, P. (2003). *Manual for the Motivational Interviewing Skill Code (MISC) Version 2.0*. Retrieved September 19, 2004 from http://www.motivationalinterview.org/training/MISC2.pdf.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change.* New York: Guilford Press

Norman, C. C., Aron, A. (2003). Aspects of possible self that predict motivation to achieve or avoid it. *Journal of Experimental Social Psychology, 39*, 500-507.

Rokeach, M. (1979). *Understanding human values: Individual and societal*. New York: Free Press.

Stone, J., & Cooper, J. (2001). A self-standards model of cognitive dissonance. *Journal of Experimental Social Psychology, 37*, 228-243.

Team Consult Warm-Up

A Blending of MI, Psychodrama, and Group Process

Tad Gorske & Allan Zuckoff

Introduction

This exercise is a warm up to Theresa Moyers' "Team Consult" exercise, a training method that allows MI trainees to role-play the use of MI techniques in a less threatening and intimidating manner. The warm up exercise is designed to allow trainees to psychologically prepare themselves for the role-play by "exercising their empathy muscles" and then brainstorming ways to use MI with a difficult or challenging client.

Brief Background

The Team Consult Warm-Up is adapted from two approaches, Balint Group Supervision and Classical Psychodrama. Balint groups were started by Michael and Enid Balint, two psychoanalysts who began seminars for general practitioners in London around the 1950's. The goal of Balint groups was to help physicians understand the psychological aspects of their patients' problems by focusing on the doctor-patient relationship. Balint groups are unique in that the goal is to explore the dynamic workings of the doctor-patient relationship in order to learn how the mutual influence affects the treatment process. An effective Balint group brings this relationship to life in the group context and essentially re-enacts the dynamic in a form of supervisory parallel process. This process then becomes evident for all to see and begin working through for more effective and open ways of experiencing the patient and the relationship in general.

Classical Psychodrama was developed by Jacob Levy Moreno, a Romanian-born physician who pioneered the use of group process and dramatic methods for resolving psychological conflicts. In Classical Psychodrama there are three distinct phases of group interaction. The first is the **warm up**, which may be a general discussion or group exercise that focuses on a theme or issue of a particular group member. The goal is essentially to psychologically prepare the group for action. The **enactment** dramatizes the problem of the group member who initiated the discussion or theme. The group leader (or director in psychodrama) guides the group member and other members to an enactment of the drama through various psychodramatic techniques. While the techniques themselves are important, the leader must pay attention to various group processes and interactions so that the drama is enacted in a way that leads to successful resolution and continually develops the cohesiveness of the group. Finally, the **sharing** represents the closure portion of the drama, where group members share their feelings and perceptions of the drama and the conflicts. The group leader's job is to facilitate openness and self expression.

The Team Consult Warm-Up blends the process of a classical psychodrama with the group facilitation techniques of a Balint supervisory group. The process should be open and flexible within the following suggested structure.

Guidelines

1. Introduce the Team Consult exercise, in which all observers will be asked to provide suggestions for an interviewer during a role-play designed to provide a practice opportunity in the use of MI skills with a difficult or resistant client.
2. Have trainees divide into groups. An ideal number is 8-12 for each trainer. Once the group has formed, identify a group member who would like to volunteer a difficult or challenging client. Once a group member (who we'll call "the Volunteer") is identified, instruct the Volunteer to provide some basic information about the client, keeping in mind the importance of confidentiality and not relaying any identifying information.
3. Have the Volunteer identify the motivational challenge that s/he faces in working with this client. Examples of motivational challenges include: ways to lower the client's resistance, identifying a focus for treatment, trying to engage a non-verbal client, and so on.
4. Once the Volunteer has satisfactorily described the client, the group leader then initiates a group discussion of the client. The suggested format for the discussion is as follows:
   a. ASKING FOR FACTS: The group leader instructs members that each one of them is allowed to ask *one question of fact* about the client, in order to gather further information and facilitate understanding. The leader's job is to limit members to one question of fact and not allow the group to fall into a fact-finding mission. Once each member has had one turn asking a question, the group leader asks the Volunteer to step back from the group (literally moving his or her chair away) and to become temporarily an observer of the group process whose job is simply to listen to the upcoming discussion.
   b. EXERCISING EMPATHY: The group members are instructed to figuratively *become the client* and, one by one, to speak what the client is thinking and feeling. The goal is to have group members identify with the client's experience in order to facilitate empathic understanding. The group leader's job is to model the use of empathic understanding and reflective listening in a group process,

in order to facilitate group cohesiveness and a mutual understanding among group members of the client's internal process. The group leader may offer reflective statements and summarizations of individual members' statements, or of the communications of the group as a whole. Once the leader senses that the group has offered a sufficient number of empathic statements, the leader can offer a grand summary to shift this part of the group process.

c. IDENTIFYING MI TOOLS: The group now shifts to a brainstorming and problem-solving approach. The leader instructs group members to identify the motivational challenge the client presents, and to discuss how MI could be used to address this client's needs. The job of the leader is to facilitate the group process by maintaining a flexible MI focus and encouraging not only ideas but also specific MI strategies that could be used to help the client. The group leader should model OARS in addition to eliciting specific MI strategies identified by group members. The leader can then end the discussion with a grand summary of the member's perceptions of the client and the MI strategies identified as potentially helpful.

d. BRING BACK THE VOLUNTEER: The leader then invites the Volunteer to return to the group and offer his/her thoughts and reactions to what s/he heard in the group process. The Volunteer will be asked to give his/her impressions of what s/he believes would be helpful to the client after having heard the group discussion. The leader should model the use of OARS and incorporate the Volunteer's reactions into the reactions from the group as a whole.

e. SHIFT TO TEAM CONSULT: At this time the leader shifts to the team consult exercise. It is suggested that the Volunteer play the role of the client and that other group members volunteer for the role of the therapist.

At this juncture, the role play should progress with the already established Team Consult exercise. Ideally, the warm-up has allowed group members to experience the delicate challenge of entering the client's world and then distancing themselves in order to find ways to motivate and move the client through the process of change by clarifying and resolving ambivalence.

Example of a Team Consult Warm-Up

During an advanced MI training, the authors conducted a Team Consult Warm-Up with a group of experienced therapists. The following is an abbreviated description of the process of the first author's group during the training. At this point, a Volunteer has already been identified.

Leader: *I'd like to thank all of you for being willing to participate in a Team Consult exercise with a difficult or challenging client. I'd like to give you a brief description of how we will proceed. An important part of doing a role-play is the ability to psychologically "warm up" to the upcoming action we will take part in. With your permission I will guide you through this process. If there are no questions before we start, let's begin by asking our Volunteer to please give us a description of the client we will be role-playing today, keeping in mind not to disclose any confidential, identifying information.*

(Volunteer gives a brief clinical description of the client she was working with.)

Leader: *Thank you. Is there anything else you would like us to know about this client before we move on?*

(Volunteer acknowledges that she has finished her description. Leader provides a brief descriptive summary of who this client is, and then moves on to the next phase of the warm up).

Leader: *Ok, now what I would like to do is go around the group and give everyone an opportunity to ask one question of fact that you would like to know about this client. Please limit yourself to one question.*

(Group members take turns asking one question of fact about the client. Examples of questions asked about this particular client reflected issues or relationship problems, years of substance use, emotional concerns, issues of abuse, and others. After each group member's turn asking a question, Leader offers another brief descriptive summary of the client from the new information that has just been gathered. Leader then shifts focus to the next phase of the warm-up.)

Leader: *Thank you, everyone, for your participation. I would now like to ask that the Volunteer become a group observer for a period of time. Therefore, I'm going to ask that you move your chair away from the group slightly because I would like you to be a distant observer for the next stage of our group.* (Volunteer moves her chair away from the group about a foot or so). *Now, this is a chance for the rest of the group to "exercise your empathy muscles." I am going to ask that you use the information you have just heard to "become the client." I would ask that you actively place yourself in the client's shoes and speak in the first person as if you are this client. In doing so, I would like you to say what you are thinking and feeling at this time.*

(Group does a good job of actively identifying and "becoming" the client, so very little coaching by Leader is needed. Each member makes a reflective statement about how s/he is thinking and feeling as the client, and Leader uses active reflective statements to further facilitate empathic understanding by individuals and the group as a whole. In doing so, Leader not only reflects individual statements, but also group themes:

Group Member 1: *I feel sad and hopeless, like nothing will make things better.*

Leader: *You feel trapped; you can't see a way out.*

Group Member 2: *I don't feel I can change this, I've been at this over and over, and I don't know what else to do.*

Leader: *I'm scared, I've been here before, nothing has worked, what else is there?*

Group Member 3: *I feel inadequate; I don't have the ability to change this.*

Leader: *I feel so down on myself and my confidence is so low.*

(Leader then offers a statement to the group as a whole reflecting a common theme.)

The group is saying that this is a person who looks ahead and feels hopeless and scared because of past failures, and her confidence is very low because she feels she has few personal resources to make any changes.

(Group members nod in agreement. Other group members offer empathic statements, adding to what has been said already. The exercise ends when every member has offered an empathic statement; Leader may also end the exercise when s/he feels that the group has sufficiently empathized with the client to have truly touched the client's personal world within the limits of the exercise. Leader offers a grand summary of the empathic statements, then thanks the members again for their participation and shifts the group to a more problem-solving approach.)

Leader: *I want to thank the group for your participation in "exercising your empathy muscles" with the client. We are now going to shift focus and begin to ask ourselves, Given what I know about this client, how would I work with this person and what MI skills would I use to try to help this person with his/her motivational challenge?*

(Leader facilitates a group discussion of specific MI skills group members would use to help this client, in addition to a hypothetical process that might occur while working with the client in resolving the motivational challenge. The discussion is lively and fruitful, and ends with the agreement that the therapist would need to validate where the client is in his/her change process, while actively listening for issues of self-efficacy and helping the client discover personal resources (e.g., confidence scaling, looking forward/looking back) and use these resources to take small steps toward change. The therapist's job is to avoid falling into the traps of "gloom a deux," premature advice giving, and underestimating ambivalence. Upon completion of this group brainstorming, Volunteer is asked to come back into group and share her thoughts on what she has heard from the group. Volunteer states that the exercise was extremely helpful in allowing her to enter the client's world more deeply, and she that realizes she needs to push and cajole the client less, and instead step back and periodically re-enter the client's world while encouraging small steps toward change. Volunteer identifies some specific MI strategies she feels would be useful, specifically more reflective listening along with open-ended questions designed to explore issues of self-efficacy and the imagination of small changes. She particularly thinks the strategies of "looking back" and "confidence scaling" would be helpful. Group shifts into the Team Consult Exercise, with the Volunteer playing the role of the client. The exercise is particularly powerful, because the Volunteer is affectively involved and does a marvelous job of playing the client in a very realistic way.)

Final Thoughts

In this example, the Warm-Up seems to have had the added benefit of allowing the Volunteer to deeply enter the client's world, while maintaining a level of detached objectivity that enhanced her ability to coach other group members as to what interventions would be most effective in exploring previously identified issues. The outcome of this process was that the group member role-playing the therapist was able to move the "client" toward a hypothetical change plan designed to make very small steps toward enhancing self efficacy. The team consult process continued for well over an hour, each group member seemed truly involved and interested in the process, and there was a group cohesion that seemed to reflect the attitude, "We are going to work together to figure this out." Upon completion of the exercise, the group members were appropriately exhausted, yet energized at the same time by having fully engaged in the process and worked toward a common goal. The Volunteer expressed the sense that the exercise had been very helpful to her, and would guide her work with the client in the near future. Though we do not expect such near-ideal outcomes each time it's used, our impression thus far is that the Warm-Up is has the potential to enhance the effectiveness of the team consult exercise. MB

Introduction to the Special Section

Jacki Hecht
Section Co-Editor

This year's MINT Forum marked our **8th annual meeting,** and we got off to a great start with the Red Sox winning the World Series the night before the meeting began! Starting as an informal get together with a handful of MI trainers, the MINT Forum has blossomed into a gathering of close to 80 trainers who have accumulated a wide breadth of knowledge and experience in training a diverse array of counselors in various settings. This year's forum in Portland, Maine, brought together trainers from Japan, Sweden, Germany, UK, Ireland and New Zealand, as well as those coming from various states in the US and provinces in Canada. After returning home and reflecting upon the meeting, I felt a renewed sense of enthusiasm and confidence to continue doing the work I do. Grateful for this boost, I started thinking about what it was about this Forum that helped lift me up in this way.

What I have come to value and appreciate most about the MINT Forums is the respectful and genuine way in which we all interact and support one another. In a nutshell, it's the modeling of quality MI interactions. And while it should be no surprise that such experienced trainers would interact in this way, it is noticeably different from other forms of communication that are more common in many workplaces and professional meetings. For example, rather than present our experiences as definitive findings, the majority of sharing at MINT Forums is done for the primary purpose of gaining feedback and new ideas from our esteemed colleagues, while enlightening others about our work in progress. The demonstration of training exercises and sharing of products and processes that we have developed are intended to stimulate discussion and generate new ideas so that each of us becomes engaged to think about ways we can apply these approaches to our own work. The genuine desire to share and help one another maintain high quality standards is evident in some of the topic discussions at this year's Forum, such as MI Certification and Coding, and continues daily in the thoughtful and provocative listserv discussions.

Upon reviewing the written comments we received, it appears that many participants had similar experiences. While only 25% (21/80) of participants provided written feedback, the majority rated the meeting between 8 - 10, when asked *"How well did this Forum meet your needs?"* (on a 10-point scale, where 10 was Extremely Well).

Some of the comments provided included:

- *"I loved the openness, interactions and flexibility of the forum. I hope it stays casual as well."*
- *"Nice balance of exercises, panel vs. lecture; informal networking slots could be spread out"*
- *"I felt nourished by the presentations, sharing, structure and energy. I loved all the training ideas/exercises."*
- *"Went a long way in meeting my needs; would have liked more networking (as a new MINTie); could have exercises grouping participants by state/region, work setting, new members with older members to create opportunities to discuss their work and to encourage collaboration."*

While we had roughly 80 participants, the meeting still maintained a small feel, with numerous members facilitating sessions and demonstrating training exercises.

As we think about preparing for MINT 2005 in Amsterdam, we invite all MINTies to contribute your ideas for presentations, meeting format, and ways to continue fostering networking and collaborations.

I hope you enjoy the contents of this special section of the *MINT Bulletin*, which is intended to provide a summary and historical account of the discussions that were initiated in Portland, Maine. May the reading of this newsletter strengthen your resolve to continue contributing and sharing your own thoughts and ideas; as each perspective helps to broaden our understanding of the complex issues so many of us are working with.

Thanks to all of you who attended this year's Forum and to the many others of you who continuously encourage and energize me through your thoughtful comments on the listserv.

And of course, special thanks to those of you who graciously volunteered to facilitate and summarize a session at the Forum. Without you, this special section wouldn't be possible.

Hope to see you at MINT Forum 2005 in Amsterdam!

Toward a Theory of Motivational Interviewing

Bill Miller

This plenary presentation described an emerging theory of MI's effectiveness. This PowerPoint presentation is posted on the MI website. Although MI did not emerge from systematic theory, research over the past 20 years has suggested and supported certain components of a theory of behavior change.

In simplest form, a theory of MI posits that MI will increase client change talk and resistance, which in turn influence behavioral outcomes. Verbalized resistance favors status quo, whereas expression of change talk, especially commitment language, favors change. There is good evidence that MI dramatically increases change talk, and diminishes resistance (commitment to status quo). There is also strong evidence that expressed resistance is inversely predictive of behavior change. There were serious problems, however, with the hypothesis that change talk would predict behavior change. Several studies found no such relationship.

That was before Paul Amrhein brought his psycholinguistic expertise to analyze MI sessions. He found that it is specifically commitment language, rather than change talk in general, that predicts change. Desire, ability, reasons and need all predicted increased strength of commitment, but did not directly predict behavior change, which tended to happen if and only if commitment strength increased over the course of an MI session. We had been looking at the wrong parameter (mean instead of slope) of the wrong metric (frequency instead of strength) of the wrong variable (change talk instead of commitment language) during the wrong part of the session (we had been analyzing the first 20 minutes of sessions, whereas it was commitment strength at the end of the session that predicted behavior change). Thus, with Amrhein's data, there is support for all four of the hypotheses of the initial model: MI increases change talk, MI decreases resistance, resistance favors status quo, and a specific form of change talk-commitment strength-predicts change.

Yet is it just saying the words that causes change? If we have people chant, "I will change, I will change," will that have the same effect? Or is it that something shifts inside, and that internal event is signaled both by commitment language and by subsequent behavior change? And if there is some internal shift that gives rise to change, then clearly MI (selective reinforcement of change talk) is not its most common cause. At most, MI hastens or prompts the internal shift that also can happen for many other reasons.

Here then is an alternative thesis, that when clients are given the conditions for change described by Carl Rogers, particularly accurate empathy, ambivalence tends to resolve in a positive direction without specific directive help. There is good evidence for this thesis, too. This is the basic theory of Rogers, whose work provided early support for this general thesis. Therapeutic alliance and therapist empathy predict behavior change in many treatment approaches, not just MI.

These might be seen as rival theories of the efficacy of MI, but they can also be understood as complementary. Both are supported by experimental evidence. It seems to be true that the basic spirit of MI-its client-centered heart-is itself a potent facilitator of change even without consciously directive methods. It also seems to be the case that specifically evoking commitment language through an MI process further enhances change. Even outside MI, evoking specific "implementation intentions" increases the likelihood of corresponding behavior change. Here, then, is an "added value" theory of MI: that much good is done by the client-centered core of MI in itself, and that effects on behavior can be further enhanced by consciously, intentionally reinforcing change talk and rolling with resistance.

One study by Sellman et al (2001, *Journal of Studies on Alcohol, 62*: 389-396) provides a rare test of the added value of directive MI. They compared a nondirective client-centered approach with the semi-directive style of MI, in counseling 125 alcohol outpatients in New Zealand. In this randomized trial, there were trends favoring MI, and on one dependent measure a significant difference (return to frequent heavy drinking).

Terri Moyers' most recent research (in press in *Journal of Consulting and Clinical Psychology*) also provides support for an added-value view of MI. She found that global ratings of MI spirit strongly predicted client behavior change. MI-specific counselor behaviors contributed significant additional variance in predicting outcomes. And then the surprise-so did MI-inconsistent behaviors such as directing or giving advice and raising concerns without permission. *Only in the presence of the overall MI spirit*, these more directive therapist behaviors, conceptually proscribed in MI, actually increased the likelihood of behavior change. This points to an interaction between specific therapist strategies and the presence of the overall spirit of MI-again, a kind of added value understanding of how MI works.

Chances are we're at an infant stage in understanding how MI actually works. Studies of this kind, merging careful attention to therapeutic processes with careful documentation of outcomes, seem to be the next wave of needed research to untangle the puzzles and develop a working theory of motivational interviewing.

Steering Committee Report

Progress & Agenda

David Rosengren

The Steering Committee (SC), as part of its mission to increase direct communication and transparency with the MINT membership, provided an update to the conference. To accomplish this mission, there was a scintillating slide show accompanied by well choreographed remarks by three SC members (Gary Rose, Chris Wagner & David Rosengren) in what some consider the high water mark of the conference; or perhaps not.

What did transpire was a brief history of the origins of the MINT and the MINT Steering Committee, which provided the organizational context for the current form of the SC. The SC began in Newport, RI, as an effort to help a growing group manage its affairs. This group was not elected, but rather volunteers who chose to rise early for a breakfast meeting to address the unglamorous business of organization business. Over time the organization grew and so did the SC, with an eye towards diversifying so as to better represent its constituency. Eventually the organization grew sufficiently large that a more efficient structure appeared necessary.

The original SC, which had by now grown to 15, was dissolved and a smaller group was reconstituted. Bill and Steve invited this smaller group to serve with the specific mandates that the service be time limited, the group develops a self-sustaining structure for the MINT, and the group figure out methods for replacing itself. Bill and Steve serve as advisors and were given veto power by the group. (It should be noted that Bill and Steve have never used this veto and have asked that this privilege be removed. This request had not yet been acted on by the SC at the time of this writing.) Rich Saitz and Chris Wagner were also nonvoting advisors. However, given Chris' role as developer and caretaker of the webpage and the listserv, the group felt he should have voting privileges. The other voting members are Rik Bes, Kathy Goumas, Terri Moyers, Gary Rose, and David Rosengren. The chair of the committee rotates on a six month cycle. Terri Moyers began her time at the helm as of the close of this MINT Forum.

Since the last MINT Forum in Crete the SC has made remarkable progress. Here are some of the accomplishments. These have also been reported in prior MINUET pieces.

- Established a new SC with a rotating chair, established voting rules, and set-up a monthly conference call with voting members. An SC listserv is used for discussion between calls.
- Wrote an article that communicated to the larger MINT group the history of MINT and the SC.
- Developed a near-term plan for SC communications about SC operations and decisions with the larger MINT that includes MINUET articles and yearly reports at the MINT meeting.
- Working on a long-term plan for active and healthy but non-paralyzing two-way communication with the larger group. Issue specific discussion boards have met with limited interest when deployed, but the SC does use the listserv and the MINT Forum to solicit information and opinions from the membership.
- Participate in choosing the location and planning of the MINT Forum 2004.
- Plan the MINT Forum 2005 and beyond. The SC selected Amsterdam 2005, Aug 28-Sept 3rd, after a review of other European locations, including Sofia. CMC is handling financial matters and registration. There will be two TNTs that share common content. Bill and Steve will serve as coaches, but two former TNT trainers, selected by SC, will lead. The SC began soliciting input for the MINT 2006 location at this Forum.
- Reviewed current (i.e., dues paid) MINT membership, removed non-dues paying members, determined MINT financial assets, and then developed a clear plan for management of MINT funds and reporting of financial activities to the SC and the MINT membership. CMC will collect dues, manage MINT funds and will provide an independent auditor's report to SC yearly. However, a budget has not yet been established.
- Revised the dues system to include a fee for listing on the trainer's webpage. This additional fee helps to offset the costs associated with maintenance of this page and responding to training requests. Dues are moving to an all web-based collection system.
- Clarified the system for accepting new MINT members, established criteria for a MINT qualifying TNT, and are currently working on a method for evaluating MINT qualifying TNT requests.
- Established an advisory group of MINT members (with a SC liaison) and tasked to determine if certification is an option that the MINT should pursue. If the answer is affirmative, the group was to indicate for whom this would apply and what mechanisms would be used to accomplish it. Chris Wagner established a special listserv for the group and they were asked to provide a report back at this meeting.
- Finally, the SC agreed to make the MINT Training Manual available to the public.

Despite the progress, there remain large, unresolved issues included a revised mission statement, a clear organizational structure (e.g., creating a legal entity), a recommended method for governance and rotation of SC members, and resolution of the certification issue. At the end of this fascinating presentation, a brief discussion broke out, and then we'd had enough and trudged off to lunch.

Distance Learning

Cathy Cole

Forms of Distance Learning

Seven forms of distance learning were discussed:

1. Group teaching via conference call

➢ Cathy Cole offers this as basic MI class. Format: 8-12 one hour conference call classes; participants pay the cost of the conference call; conference call lines are purchased by Cathy at a cost of $10/call. Class notes are provided via email. Each class has some didactic material and some practice / application, often emerging from the questions of the group. Class size is limited to 10, and fewer than 3-4 is too small. Continuing education credits are offered via certificate from the National Association of Social Workers (application required). Course fee is currently priced at $480 for the 12 hour course. This will increase. The course is currently offered Winter and Fall each year.

➢ Stephanie Ballasiotes has done group MI teaching for the Women's Health Initiative (WHI) project via telephone conferencing.

2. E-newsletter

➢ Cathy Cole writes an e-newsletter about one time/month discussing some MI concept; it is also used for marketing her trainings. For a sample, see http://www.cathycoletraining.com

3. Web page

➢ Harai Hiroaki hosts an "Ask the Expert" web page, on which he invites professionals to ask him questions about MI and other clinical topics.

4. Telemedicine via live video

➢ Maurice Dongier does video medicine interactions with patients.

5. Blackboard

➢ This is a purchased conferencing system. Teaching is done via material presented and questions posed via a message board; audio is available; this is a relatively expensive package to purchase and is generally used by large organizations.

Giving Feedback Exercise

"Just the facts, ma'am"

Chris Dunn

Goals:

1. To practice giving feedback simply and clearly, without advising, interpreting, arguing, or defending the data.
2. To learn a 3-step Feedback Formula for staying in the spirit of MI.

Structure:

30-60 minutes, triads (counselor, patient, and observer/scribe), 3 rounds so everybody tries each role once.

Materials:

1. Cue up MI videotape D (Feedback and Information Exchange) to:

➢ Bill's description of feedback as part of FRAMES discussion at the beginning of the tape)

➢ Demonstrations of feedback: the guy with glasses and beard gives a young man drug and alcohol feedback and nicely avoids argument by mostly reflecting (show only part of this feedback session)

➢ Steve's discussion with Terri of Elicit-Provide-Elicit, emphasizing it's how we give information that matters

2. Feedback chunklets to give patient (see pre-scripted feedback chunklets):

➢ Write 1 or 2 feedback chunklets on board or use pre-scripted chunklets

Tips:

➢ Works best with only 1 feedback chunklet per round

➢ More than 2-3 minutes and they run out of things to say and begin talking about taking action

6. Email support/direction

- Stephanie Ballasiotes has utilized this in the WHI project, encouraging clinical staff to pose questions to the group. Stephanie also poses a question on the WHI list, invites participants to respond to her within a time frame, then summarizes and posts the responses without editing them.

7. Phone coaching

- Stephanie Ballasiotes, Cathy Cole, and Carolina Yahne have utilized this approach for providing some supervision/coaching for folks who have completed an MI training. Phone coaching was one form of follow-up utilized in the EMMEE study.

Pros, Cons, and Challenges

Cons: How do we know what participants are learning (but, is this really any different than in a live workshop?). An issue in general is the compliance of any workshop participants providing tapes/transcripts for evaluation. Also, participants like to get away from the home base.

Pros: Time/cost for participants can be less when the cost of travel/per diem is not a factor; it provides greater access for rural agencies with small budgets; trainees can often commit one hour/week more easily than larger chunks of time; learning small amounts of information allows for incremental learning and the chance for interim practice; there is easier access for disabled workers; some learners enjoy the lack of public exposure.

Challenges: The teacher has to have good social skills and the ability to handle a group 'blindfolded'; listening skills of the teacher have to be really sharp; the teacher has to know how to read silence, when to involve and when to teach.

- You can use the same exercise to practice giving **information** and **advice**.

Instructions:

1. *Setting Up the Exercise*

- "Please break into groups of 3: one Counselor giving feedback, one Patient receiving feedback, and one Observer taking notes."
- "Pretend that you are somewhere in the middle of a brief intervention. You have already 'joined up' and done some listening to the patient's views on the status quo."
- "The **Counselor's** task is follow the Feedback Formula (see sidebar):
  - Ask permission to give feedback.
  - Explain the meaning of the feedback you are about to give, such as the range of possible scores and what they mean, etc.
  - Give only one fact and then ONLY REFLECT the patient's responses. Do not argue, defend, interpret, or advise.
  - FOLLOW THE FEEDBACK FORMULA. DO NOT IMPROVISE."
- "The **Patient's** task is:
  - Respond naturally. Act resistant or concerned, whatever you feel like doing."
- "The **Observer's** task is:
  - Use the Debriefing Checklist (see sidebar) to take notes.
  - When the role play is over, tell your counselor what you noticed."
- "You will do 3 Rounds so everybody gets to be the Counselor."

2. *Conducting the Exercise*

- Allow 3-4 minutes maximum to give 2-3 feedback facts and reflect patient responses (stop them).
- Allow 3-4 minutes for Observers to debrief their Counselor and for the triad to discuss what happened (stop them).

MINUET Actual Symposium

Values and Motivational Interviewing

Allan Zuckoff, Harry Zerler, & The Values Symposium Panel

What follows is a transcription of a recording of a plenary session of the MINT Forum. Allan Zuckoff served as moderator; Harry Zerler made the recording and transcription. Permission was requested from and granted by the participants and attendees to record, transcribe, and publish these proceedings.

Allan Zuckoff (Moderator):

A few months ago a discussion on the Listserv began to consider questions of the place of values in motivational interviewing, not so much specifically in the way that they're usually thought of as far as eliciting the client's values, and helping the client recognize discrepancies between his or her behaviors and those values, but more at the issue of the therapist's values and what role that plays in motivational interviewing. And it touched on issues including what it means to be directive in MI, and are we then, if we are directive, in some way inserting our values into the discussion, and if so what does that mean and what are the implications and how should we be thinking about this. And so this discussion went on for a while, and drew a lot of interest and engagement, many people responded, and I had the sense I didn't want it to get lost, so I contacted just about everyone who participated in the discussion individually and asked them if they would be willing to participate in the Virtual Symposium which many of you know was published in the last *MINUET* (applause) . . . I had asked Bill [Miller] whether he would be willing to write a stimulus essay to weigh out his approach to thinking about this. And then the other issue that was in play was "Who should we train?" Actually, the whole discussion started with a message from Stephanie [Wahab] [asking], should I train this particular group given the values that they have? What does it mean to say that we are going to teach MI to people with these values or who are trying to implement certain values, is there a tension between MI and those values? And that sort of really got the ball rolling. Bill was kind enough to agree and he wrote the essay, and then some 23 other people including myself responded, and then Bill responded

- *Do Whole Group Debriefing*:
  - "Observers, what was the best reflection you heard? Why?"
  - "What was the hardest thing about being the Counselor?"
  - "What did you notice as the Patient?"
  - "What are the most important feedback chunklets you give to your patients?"
  - "What is most difficult about giving these facts to patients?"
  - "Take a few minutes to write out a script of an important feedback chunklet you will give a patient when you go back to work on Monday...."
  - "What responses are hardest for you to handle when you give patients feedback?"
- Do 2 more rounds

Observer's Debriefing Check List

Please tell the Counselor:

1. Did he/she gain permission to give the feedback?
2. Did he/she explain the meaning of the feedback clearly enough to pique the patient's curiosity and ensure that the patient would understand the feedback chunklet that was to immediately follow?
3. Did the Counselor stick to the facts and only reflect?
4. Did the Counselor present only one fact?
5. Did he/she successfully execute the 3 steps in the Feedback Formula?
6. Did the Counselor attend to the patient's verbal AND nonverbal reactions?
7. What did the Counselor do best?
8. Tell the Counselor something to encourage him/her. Thank you.

to our comments, and that's how we did the Virtual Symposium. And I thought that what might be helpful and interesting would be to ask the members who participated in the Virtual Symposium who would be present at the meeting today to participate in this live symposium. And so this is the way it's going to work: each of them is going to have up to 4 minutes to briefly in some way summarize or express an idea or a couple of ideas related to this question of values in MI. I gave no kind of guidelines or limitations or restrictions; it's completely how they want to approach it: it may reflect some of what they've written in the Virtual Symposium, it may jump off in a different direction, I didn't try to exert any control over that. And then after that, Bill will comment on the statements that have been made, and after that we're going to open up the floor to discussion and hopefully we'll have a lot of time to involve you in discussion and get your own thoughts about this. I'm hoping it will be a lively hour or so. With that said, I guess the simplest way to do this would be to start alphabetically, which is how I presented the Virtual Symposium in the *MINUET*, which means that Tom Barth is going to start . . .

Tom Barth (Panel Member):

I was going to ask for more than two minutes because I think slow and talk slow, but now I got four, and I'm not going to talk about what I wrote in the Minuet because that was sort of what was just at the top of my head at the moment. There's some shortcomings in it . . . As several people have said, of course it is impossible in principle to be free of values, so that's just immediate, and especially, can we think of MI as being value-free? And I think that's something important because this thing we're talking about, the spirit, seems to be even more important than we thought; as far as I can see it has certain values: very strong deep values, we're trying to use to help other people, so being value-free would sort of be taking the spirit out of the work the way I understand it. Also when I do training sometimes, you know the depressive trainings, where you go round listening to people doing role plays and they aren't doing MI, they aren't reflecting, they have closed questions and then I code it further afterwards and they aren't doing MI, and they give you very nice feedback afterwards that they've learned a lot (laughter from audience), and sometimes I want to get

Feedback Formulae:

(Choose one to practice)

Alcohol Use Disorders Identification Test results:

1. Your AUDIT score can range from 0 to 45. People who score from0-7 are in a "Low Risk" category for suffering negative consequences from their drinking. Those who score between 8 and 20 are at "High Risk", and those who score between 21-45 are at Very High "Risk" of suffering from how they drink.
2. Your AUDIT score was 14, which puts you in the "High Risk" category.
3. What do you make of that? (Listen and understand).

Blood Alcohol Level at time of injury:

1. When you came to the ER, your doctors ordered a blood test to determine how much alcohol was in your body at that time. We do this for all injured patients at this hospital. People's alcohol level can range from 0 to .5. Most people know that .08, which is a little higher than normal social drinking, is the legal limit for driving. A level of .15 to .20 is where most people begin forgetting parts of what happened when they were drinking. .2 to .3 causes most people to feel that the room is spinning and to vomit. .4 to .5 is the lethal level.
2. Your alcohol level was .23 when you were in the ER, which is about 3 times the legal limit.
3. What do you make of that? (Listen and understand).

Diabetes and the HbA1c lab result:

1. HbA1c is a lab test of your blood, which is a very good indicator of how you are managing your diabetes and to avoid complications. This test tells us what your average blood sugar level was over the past 3 months. Most patients with diabetes are between 6 and 13 on theirHbA1c test. 6-7 is excellent for people with diabetes, because it means that your average blood sugar was between 100-120 over the past 3 months. If someone's score is higher than that, then it means their sugar levels have been getting high enough to cause complications.
2. Your lab result was 8, which means that your blood sugar has been getting a little bit higher than the ideal.
3. What do you make of that? (Listen and understand).

what's going on here? And they like it, they feel they are learning important things, and what they actually are telling me is that they like my values and my attitudes and they are trying to incorporate it in what they already think they are doing. And I think also that is an effect of having the workshop even if they don't really very much change, at least I trust I am comforting myself by thinking that, without clarifying values in practice. And this consult every now and then: if I want to help a person change in a certain direction, should I tell her or him? I say yes, of course, what's the problem? And very often it's there on my door, "Drug Counselor," so they know what it's about, and if it isn't on my door I am very careful to tell them what's in my head. And it has never been a problem. I remember once Vaughan Keller had a piece on the Listserv about informed consent. And it had a paragraph describing what MI is: it's a special way of listening and you reflect certain things and certain things you choose not to reflect, talk about ambivalence, because you want to have an effect and so on, and he wrote it as an example of how one couldn't inform clients about what's going on because it would take sort of the bottom out of the method. And it looked like of course you can't, but I started thinking about it and, Why can't you? And I tried it out sometimes; sometimes people asked me what are you doing, what is your method? And I would read them that paragraph, that Vaughan made; and it makes sense and it doesn't take any of the effect out of the method, and we know about this in our role plays, don't we? We know they're doing motivational interviewing to us and still the role plays, in this group, in this room, they actually have an effect, so I don't see the problem of clarifying values and I think we should. And I think the last point is we should be conscious of course about how much our values influence and give direction to what we're doing. My belief is that if the values influence too much, if there is a very very heavy influence of values, get out of there! That's what I say when I supervise people, that's what I try telling myself: if I have a strong, strong interest in getting something to work, I'm probably not at my best. So I should leave this to somebody else. And if it's too low, I'm not very interested and there's the risk of the spirit running out of my Motivational Interviewing. If it's somewhere around the medium, this is the U-shaped curve you know, if it's around the medium, look at the specificity related to the kind of issue there is. So I want to seriously wish that a client makes decisions that will be wise in her life, a sort of general broad unspecific kind of a value, and there is usually not very much problem about that, but to have a value that they should change or start a certain behavior in a certain direction is very specific and then I think we need to look at what kind of an issue is this? There is the issue of suicide, and I feel that to be very specific about which direction I want them to change and why and I'll tell them; if the issue is divorce or abortion or that kind of thing I feel I have no right whatsoever to be specific about the kind of direction that decision should take and I tell them. And in between: so with drug use I ask them the usual things we're talking about and it's in between also, that I have an idea about priorities of changing this behavior in that direction might be helpful, but I leave much of it to them, and if they think in their lives it's impossible or not interesting to change their drug use I say "OK, what else is on your list, what do you want to start with?" Thank you.

Chris Dunn (Panel Member):

When I read Bill's piece about informed consent I started thinking in my own clinical life what I would have to do to play it by the book, and I realized that after doing a lot of brief interventions in the same setting I had either shaped myself or allowed my patients to shape me to a point where I was no longer going out of my way to set the stage before I talk, and it was easier not to. So after I wrote that piece in the *MINUET* I thought I would try going back and giving a more informed consent, so I sat down and wrote a list of everything that I *could* possibly, like Tom said, tell them. And that would be that, they are an injured patient in a trauma center, I walk in the room, and I introduce myself, tell them who I am, tell them that I'd like to talk to them about a confidential topic, that has to do with their use of drugs or alcohol, that this discussion might make them uncomfortable, there's even a chance it might make them drink or use drugs *more*, but I think it would probably work in the other direction; but that's an empirical question, and that the hospital will bill you $140 for this and almost no insurance company will pay, but then neither will you because you're Medicaid (laughter from audience), and it won't hurt you, and that was my rationalization, it won't hurt your credit rating at all, you won't pay, you won't pay the co-pay, oh, and that I have to put a diagnosis on there, Alcohol Dependence, Alcohol Abuse, Alcohol Disorder NOS ... Okay, so then I didn't come anywhere near doing all those things, but I did start walking in a room and trying to slow down enough to get their permission to talk. And what I noticed is that, they don't care in general, now not everyone, but in general people, once I raise this topic, they have something to say about it right away. It's usually a defensive topic, a defensive opening remark, kind of like setting up a Sicilian defense on a chess board. But they want talk about it, so I don't believe that the bottom falls out, I don't believe you could tell anybody anything that would make the bottom fall out of MI, not because it's more

powerful than anything else, just that the change mechanism is powerful enough that if whatever we're doing when we do MI stimulates that change mechanism it will move ahead whether we gave an informed consent or not, whether we were transparent about what we're going to try to do or not. So just in my own conscience I feel like I've cleaned up my clinical act a little bit. But I certainly don't go down that list, I mean they signed a consent form for anything that's going to happen in that hospital, when they come in, when they were unconscious or intubated or whatever, so no one explains what's going to happen when you go down for a CT scan, I'm going to draw some blood, I'm going to flush your line now, let me tell you what's going to happen, this may cause ... They don't do that, you couldn't operate that way, there's too much to do. So I'm still ambivalent, but I'm a little cleaner than I was.

Hiro Hiroaki (Panel Member):

Thank you for this opportunity. I guess some people have already read my part in the *MINUET*, and basically what I was talking about was decision analysis. It's a part of the indication I learned from [Evidence Based Medicine], decision analysis is that you have to make a decision, clinical decision making-to give a drug or not, observe the costs, pro and con, and to calculate both sides we have to first calculate what treatment outcome is preferred, specification, so the importance scale: so if the patient rates recovery from depression is very very important, 100%, and also you can calculate by the specific treatment so the percentage of success is 100%, also another option is the percentage probably 50% of success if you just observe, so this is very clear. However, the probability may be you do not know how much will be the percentage of your success. Probably a good example is abstinence. In some institutions abstinence is the goal or the patient's value. What if the success rate of abstinence is below 20% or 10%? Very low. Do you still seek that value even if the patient chooses to seek abstinence? And actually in practice usually we do not know —it's easier to rate the importance scale, but it's very hard to measure specifically the probability of success. Then this is a usually ambivalent situation, and I sense sometimes I value the patient's value, that is sometimes I value the patient's estimation of success. If the estimation is quite wrong or even the counselor or therapist himself does not know the real (accurate) estimation (probability of success) so it's a very ambiguous situation... I feel like valuing the client's value means I have no responsibility to choose the consequences because I have no knowledge of what outcome would be apparent a year or two years later. I feel that sometimes if I value the patient's value it's kind of an excuse that we don't ask permission, that we do not know the exact probability of what will come.

Jonathan Krejci (Panel Member):

I got interested in this because of a discussion about directiveness, and I actually got involved because I made the mistake of answering my e-mails (laughter from audience), but I realized that unlike some people I'm fairly comfortable with the directive aspects of MI, and then I realized because I hold a fundamentally client-centered view I have to have some basis for doing this. And I was triggered to think about this in part because of Bill's contribution in the *MINUET* where he talked about two hypothetical clinics: so there was Clinic A which would hire me to go out and train their staff to work with pregnant substance abusing women, with the explicit goal of helping women decide not to use substances during their pregnancy. Clinic B would hire me to train their staff to work with women who are pregnant who are contemplating an abortion with the explicit goal of helping them to decide to carry their pregnancy to term. And Bill suggested that more of us would be comfortable, and I believe this is accurate, more of us would be comfortable with Clinic A in part because we share the values of Clinic A... And that made sense to me, but it made me think about it a little more deeply, and I came up with my own hypothetical example, and let's pretend that Clinic C, it wouldn't be a clinic, but Group C came and approached me and said we'd like you to train your staff to work with our door-to-door volunteers to go persuade undecided voters to throw George Bush out of office... (laughter from audience) Now as far as my values I'm fine with this, but would I accept the assignment? And my answer is I would not accept the assignment, and why is that? That's because I could imagine, much as I despise George Bush, I could imagine a decision to vote for George Bush being the outgrowth of a value or a deeply held moral vision or some kind of ideal, and it's harder for me to imagine the decision to use substances coming out of the same kind of value, so it led me to the conclusion that for those of us who are comfortable with the directive aspect, perhaps it's not because we are preferring one value over another, perhaps it's because we have sort of a higher value which says in the realm of behavior anything that adheres to a true value sort of trumps anything that's just an attitude or as *MI2* says a preference for experience... So that was my sort of resolution of why, especially in the area of drug and alcohol abuse, I can be comfortable being directive, because I believe that in the majority of cases substance abuse isn't the outgrowth of that kind of morally held value. But I also recognize that this is an assumption, and if I'm wrong then we have a pretty

serious ethical itch, because then I'm really in the position of saying well, I'm going to try to be directive with the aim if guiding you toward one value, but I'm not really sure what I have to support my decision to choose that value I wish to guide you to.

Richard Saitz (Panel Member):

My name is Rich Saitz and for those of you who don't know me, I'm a primary care physician, and I tell you that because I think that the answer to this question for me is really bound in the context of practicing MI in a primary care setting, as Tom said where there's a "sign over the door." So what role do values play in the practice of MI? The question presumes that they do play a role and I think that they do, they play a critical role, and so since they do that or I or folks I'm training in primary care settings simply need to recognize that they're there and be explicit about them… Now most of the time maybe what I get caught up in is, I assume patients are aware of what my values are when they come to see me in a health care setting. And I assume that they know that I'm going to counsel them to drink less if they're drinking excessively or to eat better if they're not eating quite well enough and maybe I should be a little bit more explicit about that. And I have to say it hasn't kept me up at night and I think the reason it hasn't kept me up at night, is that I guess I just can't make people do something that they don't want to do. I may be able to change something they're doing or help them change something but it's only in the context of their really truly wanting to do so, so that's why it doesn't bother me so much. So in my last few seconds I just want to say that the issue is for me the context that either folks are aware they are getting that informed consent, because of the sign on the door, or because I'm making it explicit and that it's not only that they're informed, it's their expectation when they come in of what direction I'm going to give them, and if they're not aware, clearly aware of that I should make them so, but the direction is there and the values are there.

Chris Wagner (Panel Member):

I have a couple of slides but that's because I'm a somewhat complex thinker and a very simplistic rememberer… I see what Richard means because all of these thoughts are similar to what I'm thinking, and the very hypothetical example Jonathan describes had crossed my mind as well, and I wanted to be able to escape the dilemma I was in but I couldn't either. I was kind of irritated after I read Bill's piece, not at Bill, and not because of what he wrote. But what it did to me was led me to, as Jonathan suggested, prefer one over the other and at the same time I wanted to discount that this was just my personal values because that didn't feel right to me, and so I tried to come up with a rational understanding for what was happening. I tried to think about it a little bit more, and I thought that what I do is in a context, as Rich says, of practicing as a licensed clinical psychologist. The issue to focus on for me was choosing direction in a therapeutic clinical or training practice, and where it ground out for me was this difference between my personal values and what I consider the professional values that I have some responsibility to uphold as a licensed practitioner who has a social contract with my government to do what I do under that banner. So I'm bound by laws, I'm guided by ethics. I think of ethics in a couple of different ways: *virtue* ethics and *principle* ethics; one essentially looking at individual situations trying to figure out what's the best possible outcome, what are the greatest risks; the other, principle ethics is, you know, using codes of ethics across situations and following those. So I looked at my state, which doesn't have an explicit code of ethics for practitioners, but it does refer me to my professional organization, the American Psychological Association, which in their code of ethics says "a psychologist's work is based upon established scientific and professional knowledge of the discipline." So whatever my personal values are, I feel like if I'm performing in the role of licensed psychologist I'm duty-bound to follow those [professional ethics]. So I just tried to flesh that out a little bit, and for me it came down to things like *professional consensus* about an issue, explicitly in this case for me the DSM system, not that there's complete agreement on it but it seems to be an established professional document to guide decision making; *scientific evidence;* and *high quality theory*. That last one we'll just skip over, there are ways we can evaluate theories but we don't have time to get into that. So I thought about these two situations, perinatal substance abuse and an abortion clinic; the laws I won't get into, they're different by different states, so I don't know that they guide. In some states there are some issues around substance use while pregnant and in others not. The professional consensus thing and the DSM, when I thought about this, in perinatal substance use there are two symptoms in the DSM system related to substance abuse that I thought apply: *use is physically hazardous*, and *failure to fulfill major role obligations*. And these seem to me provide a basis for me to go in a certain direction, which is essentially away from symptoms or towards symptom reduction. I don't know of anything about abortion that's a professional consensus in terms of which way someone should go, or that it represents a psychopathology of any sort to make a decision one way or another. *Evidence*: there's a lot of evidence around perinatal substance

abuse everyone knows: fetal alcohol syndrome, birth defects; evidence around a parental burden based upon having a child that has these symptoms, the amount of money it takes, child care, effort, these things, and then there's some issues around guilt, of having essentially a deformed baby. There is also some research on guilt, traumatic reactions when people have an abortion; this I think is, my sense is, based on convenience samples, so I have less trust in it; I'm not really sure what the epidemiological base would be, how often this would happen, how often it would not happen. And so it guides me in a way, and I feel like I should talk with someone I'm working with about that issue, but I don't have a real strong basis to make a recommendation very strongly in one way or another. And then theory, we won't get into this much, but humanistic theory focuses on autonomy and helping people to have greater autonomy and greater freedom to choose what they do. I couldn't think of any theory that really applies to a decision about abortion. So just to wrap up, for me, if clients' values provide a basis for direction that's fine, I say proceed with caution because I'm more likely to resonate to certain values than with others, and I need to be careful about which ones I'm responding to. I'm not okay about endorsing direction based upon the client's family values or religious vales that they may be associated with, unless and only if the client is explicitly adopting those as their own. And finally counselor values, for me my own personal values should provide a basis only if they're grounded in what I think is well-established scientific or professional knowledge.

Stephanie Wahab (Panel Member):

I feel like I've already taken my share of public space in my community here and so I want to make my comments as brief as possible, and I thought that I would simply share some insights that I've had about my process through this whole experience. And the process began months back when I posed a question to the Listserv specifically dealing with who we should, or I should and shouldn't train in MI, and I asked this question because I was troubled and very much trying not only to navigate my own values but more specifically values that are embedded in motivational interviewing, and how to negotiate those with the values that I felt inside this particular agency that was asking for training. And for those of you that may not remember, I was asked by an organization that was connected to a church, they wanted me to train their mental health providers, and they wanted to use MI to get people to stop masturbating, viewing pornography, and then ultimately as an alternative perhaps to a period of therapy, so using MI to help to get non-heterosexual people to be heterosexual. And so of course I read the contributions in *MINUET* with a lot of curiosity and I was hoping in every case to find some kind of help and guidance about what I should do, and interestingly enough after having read all the contributions I still had my question about, Are there groups that I/we should or shouldn't train, but then I read Bill's [response] piece and became unstuck. And Bill's piece, which I think was an incredibly succinct synthesis of all of our pieces but also an incredible reflection of our pieces, helped me see something that I had written in my piece, and specifically it had to do with his observations about perhaps there are some meta-principles in motivational interviewing, and those being the right to self-determination and autonomy. And as I thought more about these I had this light bulb moment: and I thought oh, well, maybe there isn't a right and a wrong about who we should train and not train, and I thought more about these meta-principles of self determination and autonomy and I thought about my personal and professional commitments to these concepts, and I started thinking that it might be silly, and even hypocritical for me to teach, and practice respect for self determination and autonomy only in certain contexts. So consequently, the writings and the dialogues around this topic have allowed me to see and learn what I really believe, and that is that each individual has the right and the ability to make decisions for themselves regarding what's an appropriate decision or fit, and I have decided not to train an organization that I feel perpetuates oppression, because of how I view that connection with motivational interviewing.

Bill Miller (Discussant):

It's a tough task to reflect on a thoughtful panel like this, although not quite as difficult as trying to decide what to write in response to 23 articles (audience laughter). It was kind of overwhelming. I guess one thing that occurs to me is, we wouldn't worry about this if MI didn't work, that we're concerned about this because we believe, as Chris indicated, that we're messing around here with some change mechanisms that are fairly robust, I mean not inevitable and not, I think, not autonomy-depriving, like this fantasy of hypnosis and so forth, but nonetheless things that really do have an impact on behavior. And if that weren't so I don't think we'd probably be engaged in worrying about where we should practice this or where we should train it. And the question then arises beyond what kinds of ethical scenarios should we be practicing this in, in our own clinical work, what decisions do we make about who we teach this to, who we don't teach this to. It's not as if the methods are a secret and nobody can find out about them unless we teach them because these are fairly accessible materi-

als anyhow; nonetheless, you do make decisions about where you put your own personal time and talent in terms of helping people to learn it. So that's some of the dilemma: that we believe we have something that does exert influence, and we want to be careful about how we use that. Some of this touches on the chapter Steve and I struggled with on the ethics of using MI itself. I certainly concur with Tom, I think it's impossible to practice value-free MI or therapy or anything like that. If you're conscious of the process and dilemma you have a chance of trying to keep your balance, in the situation where you really don't want to tip it one way or another, where you truly do have equipoise. We know enough about the language of influence to know how to not inadvertently tip it in one direction without realizing it, but that's a tricky task to keep your balance. It's harder I think to try to practice value-free MI or value-neutral MI than to do the directive aspect of it. The things that we said in the second edition are: First be clear with yourself and then with your client about what your aspirations are, what *your* hopes are. I work under a sign that says "Center on Alcoholism, Substance Abuse and Addiction," so there's not a lot of mystery about what people are going to talk about when they walk in the door, but be clear what those aspirations are. Do you have an opinion about what a better outcome would be for this person? And sometimes you don't, but sometimes you do, sometimes there's a pretty clear opinion, and it gets clearer, like the one Tom talked about and that we talked about on the Listserv, suicide prevention, although not crystal clear. But in addition to opinion there's that issue of personal investment, how invested are you in a person taking a particular outcome. And the more invested you become, Steve and I think, then the more difficult it is to keep your ethical balance in doing MI. You can be too un-invested, I guess, which is to not care what a person does, that's not a particular problem for folks in this room, I think where we have to watch more is at the place where we're starting to get a little too personally invested in what the person does. It seems to me that whatever a person is doing currently is of some value to them. I mean the reason why people are continuing to use drugs or drink is that it holds some value for them, and yet we say, "Well maybe it's not consistent with their higher values," because we're trying to discern different levels of values within the client, and perhaps try

The Affirmation Activity

Jacque Elder

Overview:

This experiential activity works very well in groups larger than 20 participants, and though it is not directly related to MI training, it is a great way to end a long, long training day. I experienced it myself at a retreat I was participating in, and believe that it is the least intrusive and meaningful group activity I have ever experienced. It is helpful to save this activity after the trainees have had a chance to get to know each other a little.

Purpose:

To allow people to affirm other participants anonymously, and receive affirmations anonymously.

Set-Up:

- All the participants sit in a circle facing one another. There must be room around the chairs to allow participants to move in back of the chairs freely.
- Pass around a roll of toilet paper and ask each participant to tear off enough toilet paper to wrap around his/her own eyes, thereby acting as a "blindfold."
- Silently divide the group into fourths. If, for instance, you have 40 participants, know that you will pick out a group of ten to begin the exercise.
- If you can provide some nice relaxing background music, that would be ideal.

Instructions:

- Say: "Everyone is to put on their blindfold, and close their eyes. Soon I will go around, and tap 10 of you on one of your shoulders. If I tap your shoulder, you are to take off your blindfold and stand up. The rest of the group should remain seated with their blindfolds on."
- Go around and randomly tap the shoulders of 10 (or one-fourth) of the participants.
- Say: "Now, I have just picked my first group of "tappers." For the next couple of minutes, I will be reading some personal attributes or descriptions that may or may not describe some of you. The tappers are to tap the shoulder of every person sitting down that they believe possesses this attribute. You are to remain seated, and allow the experience of knowing that someone in the group believes that you possess this characteristic. So, attention, tappers. You will be moving around the outside of the

to conform them to their own higher values, and the values card sort process that we do is in fact an attempt to identify, rather than assume, what are the things that a person has a more ultimate concern about that they may be sacrificing in terms of their immediate behavior. And I think there is a real question of whether you can use MI to persuade a client to do something that truly is not consonant with their own values, and my answer to that tends to be no, I don't think so, I think you need to find something in the client that sides with your perspective, and if that isn't there you're simply not going to succeed in persuading the person, or moving the person to take action in that regard, but I'm not certain about that. I think it's inescapable that we're simply going to be more comfortable promoting values that are more like our own, and that decisions that we make about the clients we work with and the people that we train do have to do with our comfort with what's being promoted or pursued by that person or that trainee, and that does bring me back to asking if there is a higher set of values beyond my own personal values that I should be checking my practice against. And that's where some of my writing went. We do seem to have an implicit value of self-determination and autonomy, we side with that in people-it's not a universally shared value, by the way. I sense one of benevolence, of some sense of fairness in how things proceed and in this organization certainly a value of something beyond fairness, not only not claiming your share of time, as Stephanie said, but giving it away to somebody else, at least for ourselves we seem to value that. There's some value to protect the vulnerable, to try to step in and do some righting where the temporary circumstances may leave someone vulnerable to a long-term consequence or indeed to death. And then I think there's some value for horizon, for looking at the longer term interest and the more ultimate and higher values that the person has that may be overridden by immediate gratification, or decisions that are being made in the short run, so to try to understand and side with the person's longer term wishes and goals and desires perhaps more than siding with their immediate behavior. No answers there, but I didn't expect to have them, those are my thoughts.

Allan Zuckoff (Moderator):

Thank you to all of the panel. What I'd like to do

circle gently tapping the shoulder of any person you believe fits this description. Once all the tappers have finished tapping for one word, I will then say another word or attribute."

- Once you have read a few words, and the tappers have gone around once for each attribute, say: "OK, tappers, thank you. You may now take your seat, and put your blindfold on."
- Once all have put their blindfolds back on, say: "Now I am going to tap the shoulders of the next group of tappers, so if I tap your shoulder, you can stand up and take your blindfold off."
- Pick your next group of tappers, and repeat the process of saying (one by one) several attributes, taking time to let all the tappers tap all the folks that they want to.
- Repeat this sequence, making sure that everyone has had a chance to be a tapper.

Suggested List of Attributes

·Smart
·Gentle
·Spiritual
·Charismatic
·Insightful
·Clever
·Articulate
·Strong
·Beautiful
·Wise
·Spontaneous
·Adorable
·Talented
·Brave
·Joyful
·Bold
·Humble
·Reflective
·Funny
·Perceptive
·Attractive
·Discerning
·Patient
·Aware
·Honest
·Contemplative
·Committed
·Intuitive
·Snazzy dresser
·Appealing
·Sincere
·Faithful
·Intelligent
·Dependable
·Centered
·Reliable
·Thoughtful
·Trustworthy
·Considerate
·Devoted
·Warm
·Stable
·Kind
·Steadfast
·Entertaining
·Loyal
·Credible
·Reasonable
·Sensible
·Knowledgeabe
·Witty
·Astute
·Sharp
·Creative
·Responsible
·Punctual
·Lovely
·Loving
·Skillful
·Playful

now is to facilitate a discussion, so any of you who have comments to make, you're welcome. If you have questions for the panel or comments on a particular panel member's comments you would like to direct to him or her, that's also welcome; the panelists are also welcome to comment on each other or question each other or question the commenter, and I would like this to be as free-flowing as possible. Oh, and we have about three-and-a-half minutes (laughter from audience). Actually, we have a little bit of time, we have about twenty-five minutes to talk if you like...

Chris Farentinos:

I was just going to pose a question, it's a struggle for me to respond, and I like so much what I heard, that I guess this is something I would like to pose to you guys: What do you say when people in the audience where you're teaching MI ask you or point out to you, 'Well, but this is manipulation.' Is it just a semantic discussion between what is *manipulation* and what is *directiveness*? Or not?

Chris Wagner:

Just briefly, I think there is some semantics related to this. There's a negative connotation for many people, I know, to the word manipulation, and they go beyond the explicit meaning of it; but I wonder about those who talk about informed consent in this context, that if direction is explicit the patient or the client understands what's going on and is making an informed decision, where manipulation implies to me that someone is being influenced without their knowledge or awareness.

Kathleen Sciacca:

I think that question comes up a lot based upon the readiness, so that the person who's in pre-contemplation, for example, and we have orders to move them from there, when they're not really usually giving us consent to do that, we're not telling them, 'You're in this stage and now we're going to work to move you out of it.' I think that's where trainees begin to question the manipulation aspect of it because the client is really not informed, it's something that we're taking upon ourselves to pursue ...

Chris Wagner:

I don't know if you were responding to me... I think of the Dance issue, it's an interactive process...

Kathleen Sciacca:

I was just responding to the manipulation issue, as I hear it from trainees.

Bill Miller:

There are moral connotations to the term manipulation and two of those, I think, are that there is a goal, maybe a hidden goal, that is an unworthy goal, in what's being done, most often a self-serving one when people use that term and so it engenders a discussion about what's the goal in what's happening here, and is that a goal that is a worthy goal? It's just the very values discussion that we're having. And then the second is the objectification of the person: that manipulation kind of implies a 'one controlling another' perspective, which I think is quite the opposite of a value we share in MI, not to objectify and control and constrain people, but rather to help them explore their values and pursue those values and make decisions and determine their own course. So In a way it's just a moral judgment on what's being done. One of the things that was said on the Listserv discussion recently on Monty's tapes was, 'Monty's manipulating the horse.' Well, there are interpersonal or interspecies interactions that are going on that are having effects, yes that's so. Is it an unworthy goal? Is it an objectification that eschews relationship and instead places the other at one's disposal at their own expense? It doesn't look that way to me. I think those are the questions that are being raised, or, Is this self-serving? Is this serving a goal that is not a worthy goal? Is this something that makes the person a mechanistic object to be controlled or manipulated?

Jonathan Krejci:

I think to some degree all conversation is manipulative, to the extent that I'm not explicitly avowing what I'm doing, so if I smile at you, I'm not going to say, ' I'm smiling at you because I want you to like me,' I'm just smiling at you. I realize that's sort of a trivial example, but I think there's an element of truth to that, that a lot of what we do, the fact that we're not explicitly avowing it, doesn't necessarily make it manipulative. But if it comes up in trainings I also emphasize the importance of letting go of the outcome, that my job is to form some sort of tentative opinion about what might be a reasonable outcome, but to also to maintain a kind of respect that lets me let go of that outcome if that's not what the person's aiming for.

Dave Rosengren:

So, my question is — I didn't get all the way through the 23 articles, so this may have been addressed, I just haven't gotten that far yet —but the question is this, with regards to research training, when we're getting therapists up to speed to gear things towards the ends of a specific goal — getting reductions in HIV STD rates, getting reductions in drug or alcohol use, all those kinds of things, we're training therapists but we're training therapists with particular goals in mind and with values that the research project endorses, and I just wondered, How do you handle the qualms

that therapists express about that?

Chris Wagner:

I don't know the basis of the qualms you're referring to?

Dave Rosengren:

The idea that we have a specific goal in mind, and that we are working towards trying to get this person to do that even if they state that that's not what they want to do, that they may feel compelled to work harder to reach that goal, because that's their job.

John Baer:

I can just say that we struggled with this, we're doing a project with homeless adolescents and using brief interventions and motivational techniques to try to get harm reduction and service utilization, and just in supervision of counselors I think we have to do this kind of exercise we're doing now about values, to make sure that we're all on the same page. Because participants are not asking for this service, they're not coming to our clinic saying, 'Help me reduce my harm.' We're going to *them*, which is a common thing, which is one of the paradoxes of prevention, to do that work. I think I was surprised initially by the need to do that kind of values work with the people I was supervising. I had just assumed that we 'd written a grant, we're doing this work. But I think it's a struggle and I think we have to respect that the people that we train and supervise are struggling with it, and it's continuing to inform us as we go along.

Dee-Dee Stout:

It occurred to me that one of the things we were talking about with manipulation, as well, and I see this the opposite way of what you're talking about right now: that the folks that I'm training are more anxious to force people to do certain things, and in order for me to train them it's to help to guide them away from that idea, and yet obviously then I'm imprinting my own values on that, so it becomes this interesting conundrum for me around that. One of the experiences that I had was in a treatment facility in SF run by an old friend of mine, a world famous place. And I'm in the middle of a training and he asks me to do a role play and I said, sure. And he said, Well, pick this person and I said OK, I didn't know but two of the people I was training, and the guy came up and then the person who's running the clinic says, "Well, now I want you to work with him and show me what MI would do to get him to quit smoking." I was absolutely stunned. The poor man was terribly embarrassed obviously, you know this is in front of his boss, and I had to quickly think of something to get my old friend the heck out of there, and play off something and I made a joke of some kind and sort of shushed him out of there and got him out of the room and then just went into another kind of role play and took a break. But it occurred to me this is what I come up against all the time and I don't know if it's just California where I do most of my training, but it happens constantly, with that idea. How do I hold both of those ideas at the same time and be respectful of all of it and stay in an MI ethos?

Anthony Mascola:

An interesting situation related to therapists' concerns about directionality came up in our training for trainers yesterday. We happened to do a role play on eliciting change talk and by, I think, a little bit of a mistake, there was an exercise that came up where it was: 'Think about something that you feel two ways about,' and that instruction was paired with an eliciting change talk statement. But it provided a very nice discussion for our group, because it was something that didn't have a clear outcome for the therapist, and we stopped at that moment and had this discussion that I think we're all having now, and I think this is probably going to be something that's going to need to be discussed every time someone is planning to use the intervention. Somebody was thinking about whether they should leave their job, for example, what side do you pick on that one? There's no clear outcome, that's something you as a therapist are going to be required to do 8,000 times a day in your clinical practice. I think it's very important to have this thought-provoking discussion every time you engage in MI, and I think it's very important that you make your directionality explicit. I'll tell you about a concern I have: there's a study in press right now where MI was used as a recruitment strategy to recruit people into a research study, and that to me suggests that there was not a lot of thought that had gone on before that, because I feel that's an inappropriate use of this method. And I think that every moment that we sit down with somebody we need to think in this same way, I don't think it's ever going to be clear, but that thought process really should occur and it should occur in our trainings, and I thought actually, serendipitously that role play caused us to discuss this, and I thought that was great

Mary Velasquez:

We use one session of MI to encourage people to enter alcohol treatment, is that an inappropriate use of MI?

Chris Wagner:

It depends what's happening in the alcohol treatment (laughter from audience).

Chris Dunn:

I think that I can hear a dis-

Rolling Out the Rug of Resistance

A Reflective and Interactive Tool for Introducing and Discussing the Concept of Resistance in MI Training

Stefan Sanner and Timothy Van Loo

Goals: To increase awareness of the concept and presence of resistance in client-counselor exchanges

Materials: Whiteboard or flip chart, handout with the chart below can be helpful for the participants.

Structure: Allow about 30 minutes, including taking inventory of participants' suggestions of resistance utterances.

Instructions:

1. Depending on the mix of background within the participants in the group, it may be helpful to begin the exercise with a short presentation of the concept of resistance in MI and how this in some ways differs from how resistance is viewed in other fields such as psychotherapy, psychoanalysis, physics, economics or whatever area you feel comfortable in comparing.
2. Once the scene is set you can begin by requesting from the participants how "resistance" tends to be expressed. Most likely things like anger, disappointment, fear, shame and the likes will come up in the discussion. These aspects are noted in the center field of the chart below. Summarize, elicit more examples, until the list seems to be complete.
3. The next step is to ask the participants what in the client/counselor exchange could lead to increasing the level of resistance. These aspects are noted in the left field. Elicit, summarize, complete.
4. The next step is to ask the participants what in the client/counselor exchange could lead to decreasing the level of resistance. These aspects are noted in the right field. Elicit, summarize, complete.
5. The final step is asking the participants to recall and write down maybe two or three examples of utterances from their clients that may be seen as expressing resistance. Depending on the size of the group, these utterances may perhaps be written on a flip chart. These sheet(s) of resistance utterances may be used in a number of ways in further exercises.

Increase	Resistance expresses	Decrease

easer saying you know, You work with the people that I work with, and you spend a couple of hours with his guy. You can call it a disease or not, you can call it pathology or you can deny the existence of psychopathology for good reasons, but when you work with someone who's had a half a million beers as opposed to some one who's had five thousand beers, and he's been anoxic or hypoxic four thousand days of his life, and his whole personality is woven into massive alcohol consumption, and he goes on a big old drunk for a couple of years and he wakes up and says 'I don't want to go to treatment.' You know you feel like the guy's a kid whistling in the dark, you feel like the guy is fucked, you know I am very sympathetic with people who say, 'We give him as much autonomy as we can but if we can get his family and his boss into this room we're going to force him into treatment.' And frankly folks, MI doesn't get those guys into treatment, they, it's like men and boys or something like that. If you can force someone into treatment then in a month they might be more alive, then if you said, 'Look it's up to you,' and he says 'Thank you very much, it is up to me, Good day' and he walks out to his death. So the more sick or the more screwed up somebody is or the more neurologically or biochemically impaired, whatever adjective you want to use, the more ethical allowance I would give myself to try to manipulate someone into treatment, because people die slower in treatment. You know, when it's some college kid that can take or leave a beer, that's different. At some point, and I think

our measurement is so busted you can't even measure a two by four; people pick up a Stanley tape measure and they're going to read it different. Well, assessing the severity of addiction or loss of control, boy, it's really complicated, and like Bill says, the most you can say is, 'The higher your score on this, the less your chances of being successful, or the less your chances quitting on your own, or the less your chances of cutting down successfully.' It's just like, the more problems there are the more problems there will be. That's the only thing you can really say. So I think that there's an awful lot of complicated things going on when people decide to get better, and I think when counselors decide whether to pull a quick one to get somebody into treatment or not, there's also a lot of complicated things going on. So I have fewer answers than I did a minute ago...

Chris Wagner:

And I would just add to that I don't know what evidence there is for Chris's assertion that forcing people into treatment is more effective than a motivational interview in this kind of circumstance. I'm not saying there isn't evidence, but I don't know of it. To go back to my way of thinking, if there is a framework, and to the extent that impaired thinking is a symptom of pathology, in my system, and how I think about things and what's ethical, that's a target that's ethical for me to influence in a directional way towards improvement. Just as when we were talking about suicide recently on the Listserv I felt that similarly, about depressogenic thinking, when people have a framework of thinking that colors the specific content in a pathological way, in my way of thinking it is ethical to attempt to influence that in a way that improves it.

Steven Andrew:

I first wanted to say that I was sorry, Stephanie, about your answer. I was hoping that your answer was different, when you said you wouldn't train them, that that was your final choice. I was sorry that was your answer because my answer was I'd *like* to train them. And the reason I'd like to train them is because I'd like to be in that ambivalence with my values and their values... I think of all the ways that we can go in to people's lives with whatever values and beliefs they have. Having been a person who despises prison, for instance, I am really fortunate to be able to train prison guards. I can't tell you what a feeling it is when I hear the door lock. But I want to go through that feeling in an effort to expose the belief in the human spirit. One of the problems in the whole conversation is the belief that we *can* influence a human spirit to do something or not, and I'm not so convinced no matter how much we say we can or can't, I'm not really convinced that we can give a model to people that's going to make them, or even influence them, to change unless they want to, unless there's some even small bit. I have to say I'm fairly radical about that because I believe in their inherent goodness, even if their final decision is that I'd like to die, that I drank one million beers and I'd like to drink one more, and I would like to say no to you, and I'd like you not to take over my life. I just hold that really hard, and that's what brought me passionately to this circle, was because underneath that's an inherent value, that inherently everybody's doing good and it isn't my decision to decide what is good or not.

Harry Zerler:

Also responding, Chris, to the points you raised, I think anytime that we reduce another person's autonomy we reduce our own, we reduce *everyone's* autonomy, and that decision needs to be taken with a grave sense of responsibility; also, if you invoke that as a justification for coercive treatment I think we understand it's unlikely to provide the result that we're seeking because we still don't have the *relationship* that's at the core of what's going to change that process for that troubled person. And finally, I'm always very wary of taking any steps where I find that what I'm doing is that I'm really responding to my own anxiety, my own frustration, the frustration of other caregivers, the family, rather than respecting what my patient is saying.

Chris Farentinos:

I don't think we need to think about coercive measures, differences the criminal justice system has in place such as mandating people into treatment and those kinds of things, in a duality, as opposed to actually working towards this intrinsic motivation that somebody would have. There is a dialectic process that we all go through, and we are all inserted into a larger cultural set of rules and regulations and morals, values, etcetera, that actually regulate us from the outside in, and you know, Freud would say that creates our superego. I don't see a duality here, I see that you can have a synthesis in terms of that, when somebody's mandated into treatment for instance or coerced into treatment if you will, and once this person is actually in treatment you can actually have that be a boundary that, on the outside you have those extrinsic motivators and pressures and yet you can work within the boundaries of your MI skills and that set of values and beliefs, and skills, to actually then explore what is it that this person wants to do and then respect their autonomy. So I don't see that as a discussion that leads to a duality, I see it much more as a synthesis of what we are already doing, because most of us work with mandated clients here anyway.

Glenn Hinds:

I suppose for me what comes out of this is that there's no global set of values which everybody in this room managed to stick to, but a few people on the panel who resonate for me particularly: with Stephanie who talked about what she went through, that she went to herself to find out what felt right for her, and if it didn't feel right to her, she didn't do it; which I think is what Tom was saying, if I'm working as a practitioner and I don't feel that I'm in the right place for my client, the best thing I can do for my client is to walk away and give it to somebody else who can be there for them; and I found Chris's last gem very provocative, because it's a real, literally life and death issue, which you know, here we are talking about MI stuff and that's real-life stuff there, How can I help this human being get another day on earth? And if it means me taking him by the collar, is that what I need to do? And that's a personal value, and for some people it's the right thing to do and for others it's not, and that's the conflict that these issues bring up for us all. So I appreciate what you've all had to say, thank you.

Allan Zuckoff:

Maybe in a way it's coming full circle. I was struck just now that the reflection on Stephanie's process, was that she turned to herself, she considered all of these different ways of thinking about the issue and then ultimately turned in towards herself and asked herself what fit and what felt right for her, and then made that decision. And it seemed to me like a really nice description of the process that we're trying to create in our clients and of what motivational interviewing is intended to be. That ultimately we may be asking them, we may be directive in various ways by trying to ask and encourage them to consider alternate perspectives, to see things from another angle, to think more deeply and differently about the behavior they're engaging in and how it fits with what really matters to them. And I think much of the time people don't do that, or we do it in our everyday life sort of briefly, because there's so much rush and so little time. And we all in our day to day practice, and many researchers in their rush for funding, and we, in our own lives, kind of go along making rapid decisions and looking very briefly at something we feel torn about and then looking away. And that what MI does for me is, it creates a space in which we are gently but firmly pulling the client into staying with something that is uncomfortable to stay with, and looking and not making a rapid decision, but reconsidering and ultimately testing that decision against what's inside them. And I like this very much because it's consonant with what I wrote in the Virtual Symposium, which goes back to Rogers' original theory of values: that it is not values, but valuing, the process of valuing, that we need to respect and encourage in the client. That values may come and go and change, that values may be more or less imposed from outside, but Rogers, as you know, believed that ultimately each of us has this internal process of valuing, and that, if we are more inclined to trust it and to attend to it, then we are more likely to move in healthy and self-actualizing directions.

With that I would like to thank our panelists and all of you for participating both in this discussion and in the Listserv discussions and the MINUET symposium. I trust this is not the end of this discussion but only a moment in it, and I look forward to further opportunities to talk about all of these things with all of you. Thank You!

Acknowledgements: I (AZ) am deeply grateful to Harry Zerler for his spontaneous offer to record this session, and his heroic efforts in transcribing it.

MI TNT Track for Supervisors - New Demand or Not?

Organizational Implementation of MI

Christiane Farentinos

Breakout Session Main Ideas

This breakout session was intended to raise awareness of the growing demand for supervisors' or managers' training on organizational implementation of MI. I shared my experience with three different Alcohol/Drug and Mental Health clinics on training and post-training consultation around issues of culture change and MI sustainability.

Oregon and other states are starting to include the use of evidence-based practices (EBP) as a mandate for publicly funded programs, which is a big incentive for agencies nationwide to seek technical assistance on implementing EBP such as MI.

MI trainers from the MINT group have a variety of experiences helping agencies implement MI, and they could pool their resources and knowledge and promote a separate day during the MINT Forum to train other MINTies or supervisors in the field in the specific skills and strategies to promote successful implementation strategies and organizational change.

Some of the lessons learned through helping agencies implement MI:

- Small group supervision (up to 5 therapists) with tape review, tape rating and role play during the one hour weekly supervi-

sion is very efficient and effective.

- Administrative supervision (vacations, schedules, chart review, compliance with administrative rules, etc.) must be *entirely separated* from clinical supervision/ MI skill building sessions
- Clinical supervisor must be an expert in MI and relentlessly optimistic about organizational change over time (patience, patience, patience...)
- New hire interviews need to include two observations of the candidate doing group and individual therapy. This practice will help with ascertainment of *reflective listening, empathy, style and group facilitation skills*
- Results: increase in MI-proficient staff; reduced burnout; clinicians motivated to work for agency; improved supervision reputation; increased clinician retention rate
- Two-day training is not efficient (duh!)
- Add an initial four-week study group for supervisors before a one or two-day workshop (study main chapters of the Miller/ Rollnick book and discuss in seminar format, doing small role plays with OARS)
- Add a workshop for supervisors prior to the clinician workshop-supervisors begin to feel more proficient than the counselors they are supposed to supervise
- Add a minimum of 6 separate consultations for supervisors and clinicians, with demonstrations, case-discussion, role play, feedback, review of concepts and videos, training on the MITI tape rating instrument
- Include tips on how to supervise modeling MI in supervisor consultation

Some proposed goals for a separate supervisor or consultant training:

- To capacitate professionals who can train MI and can help agencies develop successful implementation strategies
- To train supervisors who can *monitor fidelity and competence in MI (use of MITI)*
- To help the Alcohol/Drug field attribute importance to clinical supervisors in order to successfully implement and sustain evidence based practices

I have written a 'Training Guideline for Supervisors' manual. After a talk with Bill Miller, I have decided to make it available to interested individuals on the MI website. I will revise the manual prior to posting it on the website, and all MINTies will get an email once it is available.

Discussion Notes

Some advanced MI trainings have included basic coding, feedback, how to monitor, etc., and there is some desire to do this. The audience liked the idea of incorporating this type of training because advanced clinical skills are different from MI implementation skills.

However, licensing rules may require specific clinical supervision around specified skills, and may limit how we approach MI supervision. All these models and issues need to be addressed in "doing it" — specific to profession, agency, setting. Therefore, coaching organizations to implement MI is very different from training supervisors in the MI skills only.

Participant Comments

- We tend to assume MI should be supervised like we do with other staff. Perhaps a change in approach to supervision is needed. We tend to be very positive about feedback to the client with MI, but tend to use negative, critical feedback in training individuals learning MI.
- Example: calls from corrections asking for training of all staff of #200 in a one-day training. The trainer responds by making a case that smaller groups and more training time is needed. This response leads to someone else who is willing to train the large group on their terms underbidding and doing the training. This raises issues of fidelity and frustration with trainers who appear to have less integrity in their approach to training, and what role MINTies should have in these discussions.
- There is a need to develop/address program underpinnings required to implement MI in this environment. It is not just teaching MI to the organization, it is also looking at agency practices, paper work, style with clients and all of these other aspects of the program. It is, in a way, assessing agency stage of change for a successful implementation.
- Another issue is the use of MI to do clinical supervision with staff/employees. This is problematic at times.
- The money in health care settings is ok, but not thick. Contracts usually include money to be used to support keeping skills up and helping with implementation. This has worked very well and sometimes leads to the organization getting to the point that it feels change is implemented and staff is happy, perhaps before the end of the contract. Contracts then end "early" due to the fact that the agency is feeling ready to "take it from here." Those can be a problem for the consultant, but may very well mean a good job done.
- Small doses of training are

sometimes provided to coaches or change champions with in the organization. Trainers need to think about the challenges of how to deliver small doses of training to coaches that may or may not be clinical supervisors. What would that look like? What are the skills required to know what is a good dose of MI (e.g., protocols written to deliver MI through the role of coaches would influence implementation and change). This should include: promoting spirit, small changes in communication styles, and providing an environment for integration of MI into the other clinic practices. Use of the word "champion," rather than coach, would get away from the idea that "supervision" is being provided.

- An example of a request to train 500 people in one hour: You can present the options: 1 hour for 500, 1-hour training and 2 half-day trainings for champions. They may choose the one-hour training, but usually agencies come back to the concept of more training and a slower and more involved implementation process.
- There is variability in coaches and supervisors, in how they "get" MI. This makes it complicated when leaders include some that don't get it. This is one of the issues with the train-the-trainer model.
- Providing guidelines for training as a resource for less experienced trainers would be a great idea.
- The idea of guidelines is helpful. Sometimes supervisors and management are initially willing to require that staff show a certain level of skill, and then, at the end of training, the administration decides they have had enough training, even when staff have not acquired the skills yet. This leads to the idea of an instrument like the MITI that can measure level of competence.
- Using the EMMEE research, as evidence for what is evidence-based practice in the field of training and implementation, could be helpful.
- Negotiate the contract depending on the resources. It is important to assess agencies' objective(s), up front. The challenge is to honestly communicate the level of training it will take to reach these objectives. Knowing agencies' objectives and goals is a must if you are going to work with an agency to implement MI.
- This is not unlike Rogers' implementation with early adoptions of the method. I also think of a nursing example, the NCAST — Nursing Child Assessment Satellite Training developed by Katherine Bernard of the University of Washington. This is a parent child interaction assessment with objective scores. You can find it on the web.
- If systems are going to change, managers must buy into that concept and hire clinicians who demonstrate empathy, listening skills and client-centered style. Chris' agency, ChangePoint, Inc., only hires clinicians after observing them work two times.
- Changing cultures have common struggles. For example, it is really difficult to change the culture of corrections, and many corrections administrators have hired MI trainers; the results are mixed.
- The sheer amount of inertia in organizations makes it hard to implement MI. There is something that pulls people from the whole process; counselors tend to fall back on their old ways of doing counseling. For instance, intake/ assessment in agencies tends to be anti-MI and very much focused on data-collection. ChangePoint Inc. included in its assessment 30 minutes of OARS before getting into data collection. We also reviewed all communication to clients/letters to patients, to make sure they included motivational statements and were client-centered and did not use probation officer language. These were all revised as part of the implementation process. We also trained the front desk and receptionists in the spirit of MI.

Acknowledgements: Thank you to Linda Frazier for volunteering to take notes on the discussion that appear above.

Should MINT Certify MI Trainers and Practitioners? If So, How?

Rich Saitz & Bill Miller

This well attended "early risers optional discussion" (7:45 am) drew about 30 participants (a growing number as the clock approached 9), and was facilitated by Rich Saitz, with Bill Miller taking notes.

The goals of this session were to encourage discussion among MINT members about certification, and to develop recommendations for the MINT Steering Committee (SC) regarding pursuit of certification or maintaining the status quo. Rich presented the history of certification within MINT: Discussions spontaneously arose on the MINT listserv several years ago, then a "certification advisory group" was created (a smaller listserv of "volunteers" [some were more voluntary than others…] to facilitate progress)(to advise the SC). Notes summarizing these discussions were prepared by Annie Ogletree, Jeff Allison's administrator, and these were shared with the group in Portland. There were brief flurries of activity on these lists expressing opinions and discussing

issues in favor of and against certification. There were long periods of electronic silence. This was described (in Bill's words, echoed by others) as "a good example of how ambivalence can be immobilizing."

The large group split into small (e.g., 8 people each) groups to generate a list of "goals of certification" were it to be pursued. Reporters shared the lists with the large group. The reason for the focus on goals was that the listserv conversations had focused on pros and cons but there had been little clear delineation of the goals that were to be met by certification (and whether or not those goals could be better met by some other means). Then Rich distributed a first draft of what certification might look like written by Bill Miller, again to generate discussion.

The remainder of the time (the majority of the session) was used to discuss (encouraging as many points of view and as much participation as possible) the pros and cons of certification and any recommendations to the MINT SC, avoiding in general issues of practicality/feasibility (though these could not be entirely ignored). Here are the major themes that emerged.

Goals of Certification

Consumers, program directors, and state agencies are largely clueless as to what is required for competence in MI. Yet all of these constituencies make daily decisions about where to seek help, what counselors to hire, where to refer clients, or whom to hire to provide MI training. The MI website page listing questions to ask when hiring an MI trainer already gets about 3,000 hits per year. Such constituencies are looking for some guidance and assurance of competence of MI practitioners and trainers.

Meeting Practice Needs. One possible goal of an MI certification program, then, would be practical: to simplify, clarify, and inform these everyday decision processes about MI competence. Certification in itself does not ensure continuing adherence to good practice, but does inform decision-makers that a certified person was able to meet a specified level of standards of proficiency. One-time certification does not address staying current in the field, an issue most often covered by continuing education requirements to maintain certification.

Promoting Quality of Practice and Training. Closest to the mission of MINT would be a goal of encouraging and promoting quality of practice. Certification is

"Setting the Stage" Exercise

Chris Dunn

Goals:

1. Learners will experience how difficult it is to be asked about personal issues.
2. Learners will plan how they will start brief interventions in their own settings.

Structure:

Dyads for 10 minutes, 10 minutes to debrief. Do only one round (don't change roles and repeat).

Materials:

Didactic chunklets (see sidebar)

Instructions:

1. *Introduction*

a. "Eliciting sensitive information or starting a discussion with a patient about a private topic happens often in medical or social service."

b. "We in these fields become desensitized to this fact, because we do it so often."

c. "This exercise is designed to draw your attention to the process of getting a brief intervention started. Many trainees tell us that getting started is the hardest part."

2. *Set up the exercise:*

a. "Please get into dyads and decide which one of you is going to be the interviewer and which one the interviewee."

b. "I am going to hand out separate, secret instructions to each of you. Please do not show your instructions to your partner."

c. "After reading your secret instructions, please begin the interview. I will stop you in 2 minutes."

3. *Conduct the exercise*

one possible, very tangible method for MINT to promote quality practice and training. A certification program would attract practitioners and trainers, and in turn help them to understand and meet standards of practice. Clearly many practitioners sincerely believe that they are "doing MI" or "teaching MI," when in fact their work does not approximate what MINT would regard to be good practice. A certification program raises awareness of standards of good practice, and encourages practitioners and trainers to meet them. (Certification should not be confused with the policing function of licensure, which seeks to prevent anyone from practicing who does not meet prescribed standards.) If successful, a certification process could decrease low-end variability in MI practice and training, and decrease trainee dissatisfaction. There is an analogy here to current quality assurance procedures in evidence-based medicine. In addition to promoting the development of high-quality training and trainers, the presence of a clear certification process could also increase acceptance of and confidence in MI by governmental and funding agencies.

Promoting the Integrity of MI. A third related theme that emerged as a possible goal of certification is to protect the integrity of MI. The more "bad practice" proliferates, and the more "MI training" is provided that does not represent the true spirit and method of MI, the more the method itself is watered down and discredited. Practitioners "try it" and find it doesn't work. Consumers receive services that are described as MI, and are dissatisfied. Program and state agencies fund training in MI, and find that it makes no difference in outcomes. Practitioners attend training and come away with mistaken views and no better skills. Even without policing efforts, certification can establish and communicate standards of good practice.

Discussion also reflected that the goals of certification may vary depending on what candidates are being certified to do. For example, the nature of certification standards and procedures might differ in:

- certifying therapists to provide "pure" MI within a clinical trial
- certifying counselors in an agency to provide MI within the context of ongoing practice
- certifying supervisors to develop MI competence among counselors they supervise

a. Dyads perform the 2-minute interview.

4. *Debriefing questions for all participants after doing the interview:*

a. "If you were the interviewee, what did you notice that your interviewer did to 'set the stage'?" (Warned you that a sensitive topic was coming up? Asked your permission? Merely started asking the questions?)

b. "As the interviewee, what approach would you have preferred?"

c. "As the interviewee, what were you feeling or thinking immediately before you figured out what the topic was?" (Feeling apprehensive? Feeling curious? Thinking that the topic coming up was important?)

d. "If you were the interviewee, imagine you had very abnormal bowel movements. Which would have been easier for you: To politely refuse to answer a given question or give an incorrect answer to create the impression that your bowels are working normally?" (Easier to fudge the data than to assertively risk disappointing your interviewer?)

e. "If you were the interviewee, which would have been easier: To answer those 'quantity/frequency-type' assessment questions or to answer the following question: 'On a scale of 0 to 10, how important is it to you to change the status quo of your bowel movements?'" (What, if anything, about the latter question puts you more at ease? Does the latter question allow you open up about those aspects of the topic most important to you?)

f. "If you were a patient being asked about your use of drugs and alcohol by a stranger on your medical team, and you knew that your consumption was well above normal, how would you want to be approached?" (Would you prefer to be asked permission to discuss the topic? What type of questions would you prefer? What demeanor on the part of the interviewer would most likely win you over?)

- certifying trainers to provide a brief introduction to MI and its evidence base
- certifying trainers to develop clinical skillfulness in trainees from a variety of contexts

Hazards of Doing Nothing

In good MI style, Jeff Allison specifically enjoined MINT to consider not only our concerns about undertaking a certification process, but also concerns that arise from doing nothing. These turn out mostly to be the inverse of the goals described above.

Multiple Standards. The demand for MI certification is already present and growing. Without a single authoritative source of certification, there will surely be a proliferation of procedures and practices for establishing/claiming proficiency in MI. It is likely that some of these would be for-profit business ventures capitalizing on the level of demand for MI certification.

Confusion. One result of this is public and professional confusion as to what constitutes MI, who is providing good practice. In this environment, economics are likely to favor hiring trainers who will train the largest number quickly, and at the lowest cost. It is difficult to promote good practice if there is not a recognized professional organization to define it.

Dissipation. A possible further outcome of the above is a loss of integrity of MI, and a dissipation of its spirit and method. The meanings of MI could become so broad and diverse as to become meaningless.

Standards of Practice

Some of the above goals and concerns would be addressed by the development of clear standards of practice and/or standards for training. This seems a manageable first step that is entirely consistent with the mission of MINT. In response to an earlier Steering Committee request, Steve and Bill have already drafted (and sent to the Steering Committee) such standards for MINT-sponsored Training of New Trainers events. The same process could be followed to generate practice standards for various types of MI training, and for the practice of MI itself.

Discussion here emphasized that MINT values diversity in styles of training and practice, and that standards should focus on those components and core competencies that are deemed by MINT to be essential. Such standards could be drafted now, and continue to be shaped as new research evidence emerges.

Participant Instructions for "Setting the Stage"

(Tear along dotted line)

Instructions if you are the INTERVIEWER:

Don't show this card to the other person. You have 2 min. to get the following information from your partner and circle the correct answer. You must get this information!

1. How many bowel movements have you had in the past 30 days

1-5 *6-15* *16-30* *30+*

2. How often are your bowel movements painful:

Never *Sometimes* *Often*

3. Is your stool typically:

Watery *Soft* *Well-formed* *Hard*

4. How many minutes does a typical BM take you:

1 *3* *5-15* *16+*

WHATEVER YOU DO, DO NOT OFFEND your INTERVIEWEE!

Instructions if you are the INTERVIEWEE:

1. Don't show this card to your interviewer. This interview will last only about 2 minutes.

2. Please do not answer any questions if you don't want to answer. But…

3. WHATEVER YOU DO, DO NOT DISAPPOINT your INTERVIEWER, because you are their patient, and you want them to take good care of you!

One such issue on which there was good agreement is that MI trainers should themselves be able to model and competently demonstrate the method of MI. This implies proficiency in the practice of MI as a prerequisite for becoming an MI trainer. At present, we do not formally assess practice proficiency prior to admitting applicants to a TNT, but we do intentionally screen for conditions meant to be proxies of practice capability, namely having had training in the method (ideally from a MINTy, and having had adequate time and opportunity to practice MI (ideally with supervision). We generally do not admit self-trained individuals to a TNT, nor those without experience in using MI in practice. Although participants at the Portland meeting could envision training circumstances where practice proficiency might not be needed (e.g., giving a one-hour data-based introduction to MI), it is unlikely that people who would limit their training to such events would seek certification. In any event, standards of good practice could be formulated by MINT for various types and levels of training.

MINT could also develop standards for the evaluation of MI training. For example, although informative, paper-and-pencil evaluation forms completed by trainees will not provide reliable information about the effectiveness of training. How would an agency that has contracted for MI training know the effectiveness of that training. Here the idea emerged of training to criterion performance (as is usually done in clinical trials), rather than relying on a fixed dose of training and assuming it is sufficient to establish competence. At present, there is no known alternative to observed practice. The VASE technology presented at this MINT meeting (see separate article) seems promising, but research is needed to determine the extent to which practitioners' written responses to VASE items predict proficiency in observed MI practice.

Related to the development of practice standards, MINT could also define reasonable expectations from various types of MI services. For example, what might one reasonably expect from various levels of training: 1 hour, half day, 1-2 days without follow-up, addition of feedback, addition of coaching, etc. (We noted that the current information on the MI website regarding questions to ask a potential trainer gets about 3,000 hits per year.) What benefits might a program manager expect from investing in MI training, or hiring an MI-competent supervisor or counselor? Similarly, what might a consumer expect when seeking the services of an MI practitioner? What should a consumer experience during motivational interviewing?

The Business of Certification

Providing certification is only one means for promoting the above-described goals. It is complex undertaking, and there is also no guarantee that implementing certification would, in fact, achieve the stated goals. Those present at the Portland MINT meeting were in agreement that the Steering Committee should continue to explore these issues, but were not in agreement that this is something MINT should undertake. Beyond practical considerations outlined below, was the primary consideration of the consistency of a major certification effort with the overall mission of MINT. Thus far, MINT has engaged in ongoing and evolving processes for promoting quality practice. MINT has assiduously avoided efforts to police the practice of MI. Furthermore, MI has avoided emphasis on having completed a particular process of training. For example, those who have been through a TNT are nevertheless instructed not to represent themselves as certified trainers.

There was general agreement that the process of providing certification is a complex, costly, personnel-intensive business, that has implications regarding professional liability for those not certified and for the organization providing the certification. Dr. Scott Henggeler has organized a business to train and certify practitioners (and trainers) in multi-systemic family therapy, an approach with much more limited dissemination thus far than MI. The business employs twelve full-time PhDs and is directed by an experienced business manager.

Taking on certification involves far more than the process of issuing certificates. There are complex processes of marketing, quality control (reliability and validity) of certification processes, and procedures for receiving and responding to (and potentially legally defending against) complaints. There are business licenses, liability insurance, bylaws, a board of directors, service contracts, human resources management — all of the complexities of operating a legal business entity.

Furthermore, certification is not optimally a one-time event. Initial training has a half-life. There have been rapid developments in new knowledge regarding MI practice and training, and someone trained as an MI practitioner or trainer ten or even five years ago is likely to be ill informed without systematic processes for keeping up to date. This suggests expiration dates and procedures for re-certification. Neither does certification or even licensure ensure competence in practice. It demonstrates only that at one time the person demonstrated an ability to meet standards of practice.

Unresolved is the issue of whether MINT should itself become a provider of certification. There is concern that this could be such a consuming task that it could overshadow or displace the current valuable functions of MINT. There was clear agreement that MINT could and should develop clear standards for practice and training, a step toward certification that is entirely consistent with MINT's mission. Short of becoming a certifying body itself, MINT could consider recognizing one or more

separate (not-for-profit?) businesses or institutions as approved providers of certification. This would allow MINT continued involvement in the development and evolution of practice standards, being a single authoritative source for regulation and oversight of certification (MINT), and yet keeping MINT itself out of the complex business of providing these services.

Summary

This summary was an attempt at reflective listening. The group nodded heads in agreement that it reflected their thoughts in general.

1. There is a great desire within MINT to assure quality. In fact, discussion of quality improvement (continuously done), was quite favorable.
2. There are many concerns of a practical nature (and otherwise) regarding MINT pursuing certification (implications for the organization in terms of workload and liability, etc.).
3. Maybe, we should be explicit about standards for training and trainers first (which may in and of itself achieve some of the goals of certification, and if not, might be a first step in pursuing development of a certification process). For example, on the MINT website, the TNT curriculum is posted. Qualifications for leading training could be posted there as well. Questions for trainers developed by Carolina Yahne and Denise Ernst addressing these issues are a beginning. A description of types of trainings and expected outcomes would be very useful. This seems like something MINT should proceed with.
4. An evaluation form, also posted on the website, could be developed and collected by trainers (completed by their trainees) as a first pass at collecting information that could serve as a quality measure (who should review or summarize it is unclear).
5. The MINT SC should consider the organizational issues and implications, as they consider what steps to take next re: certification or quality improvement, or contracting out.

Communication Styles and Culture Change

Stephen Rollnick & Gary S. Rose

This paper, illustrated with video clips of prison life, was presented at the MINT Forum in the spirit of sharing wild ideas with a group of supportive and discerning colleagues. It addressed just one aspect of culture change: *the content of the message we give to people in the culture we wish to see changed.* The conclusion was that rather than suggest that they take on board motivational interviewing, we present them with a broad model of communication (called the Three Styles Model), of which motivational interviewing is merely one part.

One of the wild ideas that prompted this paper was a bit self-indulgent: to explore our own emotional response to training people in motivational interviewing over many years. We had the feeling that too many recipients felt inadequate or reluctant to take on board the shift in style required in motivational interviewing. Our friend Tom Barth from Norway had offered one explanation that was undoubtedly true: the style is difficult to learn.

Another possibility, much more disturbing, was that our approach to training violated some of the principles of the method itself: We had a strong view about why and how practitioners should change, and we had often ignored how they really felt about their everyday practice. This led me to develop the context-bound approach to learning some years ago. Yet the feeling persisted, most markedly when we teamed up with MINTie friend Carl Ake Fabring from Sweden to consider how to change a whole culture, in prisons. There was a huge gap between the delicate and skillful meanderings of a motivational interviewing session and the often abrasive routine conversations that took place in prisons. How to bridge this gap was the problem. Hence the references to culture change in the title of the talk. We can't apologise for the meandering route that this paper took, because it was like walk through a jungle. That's exactly what our friend Jeff Allison said when he set up the first MINT Forum meeting: "Let's make this a place to share wild ideas, you never know what might emerge...." So the meandering began thus:

Was it really the case that motivational interviewing could be presented as a viable solution to changing a culture, like that in prisons? The conclusion we reached was that this could only be done by providing a new conceptual framework for crossing the bridge from therapy to everyday corridor conversations carried out by people like prison officers. Hard as we might try to implement change in an organisation, to monitor and evaluate the diffusion of an innovation like motivational interviewing, if we don't take on board the everyday practice of people like prison officers, the change won't happen, and practitioners will continue to resist efforts to have them change their practice. To achieve this we need a model of everyday practice that makes sense to us and them. One that takes into account both what they do and motivational interviewing. Whether the Three Styles Model achieves this was the fright-

ening aim of the paper: what did MINT Forum colleagues think about this?

The Case of Laura: A Concrete Example

Laura works in a prison. She is intelligent, thoughtful and could become a leader among her peers. She has "attitude", expressed in statements like this: "I am not a psychologist, it's our job to see that things work around here". Or she could also say, in a more complex account of prison life, "When I first came here, they warned me to keep my fist tightly clenched, and then only open it slowly. If you did it the other way around, the prisoners would only take advantage of you. You learn about that over time, but that's another story…." Her world at work with prisoners is demanding, not just because of the numerous roles she has to play, but because she has to communicate with people who are full of expressions of distress, frustration, outrage, fear and resignation. Talking sense with prisoners is not an easy matter. She has had no training in communication.

Dysfunctional Messages to Laura

In this paper, we suggested that in our practice as trainers we had unwittingly conveyed messages to people like Laura that she was bound to resist:

1. "We know a better way of doing things..."
2. "Listening is better than instructing..."
3. "Just use MI"
4. "Adopt an *MI style* as much as possible..."
5. "Here's the solution, what's your problem?" (with thanks to Aneke Buiskens from Cape Town)

While many of these messages can be avoided by the discerning trainer, it was the second one that we have found most difficult to avoid. This has often emerged in training in the form of a dubious dichotomy, expressed by practitioners, and not adequately resolved by us: "I either tell people what to do ("it's efficient and maybe sometimes disrespectful") or I listen ("its respectful, but I don't have enough time"). Gary Rose, Claire Lane and I have found that the Three Styles model helps us to avoid this problem in training. It might be a better way of encouraging practitioners to become curious about the value of motivational interviewing.

A Model of Communication for Laura

The Three Styles Model was not developed after talking to prison staff, but mainly with health care practitioners who faced very similar challenges: multiple tasks and roles, many distressed and depressed patients, and no training in communication. It has already been presented in an earlier edition of this Bulletin (Rose, Rollnick, & Lane, 2004), so we won't repeat too many elements here. Its heart however is easy to describe: in everyday conversations when we are in role of helping others, we can use one of three styles, instructing, listening and guiding.

This is a list of verbs associated with each style:

Instruct ... directing, informing, leading, educating, telling and using one's expertise

Listen ... gathering information, following, eliciting, attending and empathising

Guide .... coaching, negotiating, encouraging, mobilising and motivating

In some situations it is fairly easy to discern which style is probably the best to use: if a child is about to cross a street, instruction is called for. If a child suddenly bursts into tears, most people would listen; and if a child is learning a new skill or trying to resolve a difficult problem, guiding is more appropriate. One can contemplate the consequences of a mismatch between style and problem, or of the tendency to use just one style in helping others, for example, the over-use of instruction. In other situations it is not a single style that is called for, but a mixture, depending on one's mood, the situation, the receiver, his or her mood, and so on. Examples here might include a child refusing to get into a bath, or an elderly parent who resists help despite increasing frailty.

More Functional Messages to Laura

If this very simple and undoubtedly oversimplified model of communication has any use, it should be possible to extract messages that embrace Laura's everyday practice. The following were suggested as examples:

- *Each style has its place.* Everyone uses these styles when in the role of helping others. Good communication involves using all three styles, often in the same conversation.
- *Skilfulness is flexible and strategic shifting between styles.* This is exemplified for us by the prison officer who told us in an interview: "It might not seem like you are getting anywhere with a bit of listening, but over time, if you add a bit of listening into your conversations, particularly at the beginning of them, you begin to see rewards, the prisoner changes his attitude, and you make progress...."
- *The guiding style is tricky to learn, but effective when helping people make difficult decisions or learn to change their behaviour*
- *MI is a refined form of guiding*

Conclusion

We concluded with examples of video extracts of prison conversations, where the three styles were used to solve everyday problems, taken from a communication software programme we are developing as an aid to face-to-face training of staff in large organisations. The audience laughed at some of the clips, and from the discussion that

took place, we were left with the following impression: the model had face validity, but it was merely one small starting point on the journey to improve the world of communication in organisations and services in which the more stressful life is, the more people get told what to do. With many unhappy consequences.

Acknowledgments: Our sincere thanks to Claire Lane who developed with me most of the ideas in this paper, and to MINT colleagues Tom Barth, Christine Nasholm, Michael Peltenberg and others who gave us their feedback on our writing efforts.

References

Rose, G.S., Rollnick, S., & Lane, C. (2004). What's your style? A model for helping practitioners to learn about communication and motivational interviewing. *MINUET, 11.3*, 3-5.

The Video Assessment of Simulated Encounters - Revised

David Rosengren, John Baer & Chris Dunn

This presentation was an update on an assessment system that David demonstrated in Maui in 2001. The Video Assessment of Simulated Encounters - Revised (VASE-R), a group-administered method for measuring motivational interviewing (MI) skills, consists of three videotaped vignettes of actors playing substance abusers. Each vignette is followed by six questions or prompts that ask participants to identify and generate written responses consistent with MI principles. The 18-item scale produces an overall score, as well as scores for five MI "microskills" (Reflective Listening, Responding to Resistance, Summarizing, Eliciting Change Talk, and Developing a Discrepancy) and takes about 30-35 minutes to complete. The authors developed the VASE-R as a cost-effective alternative for assessing MI skill with utility across a range of training and research contexts.

As in Maui, we invited the MINTies to learn about the (VASE-R) by first completing it. Once completed, we discussed the instrument, including data about the reliability and validity of the instrument. MINTies expressed interest in how the instrument was developed and about the scoring. About 40 of the MINTies requested copies of the instrument and the accompanying scoring manual. Other interested parties can obtain copies by contacting either John Baer (jsbaer@u.washington.edu) or David Rosengren (dbr@u.washington.edu). There may be a nominal fee for reproduction and mailing costs.

A Meta-Analysis of Research on Motivational Interviewing Treatment Effectiveness (MARMITE)

Bill Miller

This session discussed results of a meta-analysis of 72 MI outcome studies. This review will be published in Volume 1 of the *Annual Review of Clinical Psychology*. The review was coordinated by Jennifer Hettema, as part of her psychology dissertation at the University of New Mexico, and is co-authored by Julie Steele and Bill Miller. The PowerPoint file has been posted on the MI website. Here are a few highlights:

- The methodological quality of MI studies is generally good, although compared with other outcome trials the follow-ups are more likely to be shorter (less than 12 months) and less likely to collect complete data for 70% or more of participants.
- It is difficult to tell from most reports exactly what constituted MI in the tested intervention. Of 12 possible defining components of MI, the average article mentioned only 3-4.
- The average dose of MI tested in clinical trials is 2 sessions, or about 2 hours.
- The training of practitioners is rarely described (18% of studies). When described, it typically consisted of 10 hours of training, with no ongoing supervision or quality assurance monitoring.
- Despite all this, the effects of MI appear relatively quickly after intervention in most studies, across a broad range of providers, settings, and target problems. This suggests that we are studying something that is fairly robust.
- At the same time, there is large variability in the effect size of MI across providers, settings, and studies. A topic of clear importance in future research is to identify factors that predict variance in the effectiveness of MI.
- The average effect size for MI is around .6 at short-term follow-up, and tends to diminish over the year after intervention. This shrinkage in effect is common, of course, for most interventions in clinical trials.
- An exception is studies in which MI is added at the beginning of treatment. In these studies a standard treatment is compared with or without MI. Here the effect size endures or increases over one year, hovering around .6.
- Few attributes of providers or studies predicted MI effect size. However, larger effects were reported in studies that

did not use a manual to standardize delivery of MI.

- Larger effects were also observed in studies where the population included a high percentage of (or exclusively) ethnic minorities.
- Effect size varied widely depending on the particular outcome measure used.
- By target problems, the largest initial effect sizes were reported in studies of HIV risk reduction, drug and alcohol abuse, and public health interventions. These effects decreased over the course of follow-up. Reported effects on smoking were very small.
- For two targets, however, effect size showed a "sleeper" effect, increasing during a year of follow-up. These included treatment adherence and diet/exercise adherence.

Facilitating Groups with MI

Mary Marden Velasquez, Stephanie Ballasiotes, & Chris Wagner

Mary introduced the session by saying that its purpose was to discuss and demonstrate how to train participants to do MI in groups. She noted that there is a lack of information on this topic in the literature, so we are all learning as we go.

Mary is in her second year of a National Institute on Drug Abuse grant using MI in groups with cocaine abusers. No data yet, but her clinical experience has been very positive.

Mary discussed her manual (Velasquez, Maurer, Crouch & DiClemente, 2001). It is based on the stages of change, and can be used in many different ways. She has found it helpful when doing trainings to copy portions of the manual as handouts for practice sessions. She typically uses the session on "Stages of Change." She tries to ensure that trainees are proficient in MI skills before introducing group practice. She noted that sometimes trainees may feel discouraged initially, because it is very difficult to attend to MI and group process. Mary's approach to group training is described in more detail in the handouts that follow.

Mary was asked how a group leader can establish group rules in an MI spirit. She suggests telling group members that this is likely to be a very different group experience from those they have had in the past. She then describes MI much as you would in individual therapy. She also suggests asking clients to listen to each other with respect and to try to offer support rather than confrontation. Another participant added that if you are running an open group, you can have clients who have been there a while review group rules. Others commented that they use the term "guidelines" rather than rules, and ask for comments and additions from the clients.

Stephanie demonstrated, via role play, a group from her research project that evaluates dietary interventions. MI was brought in halfway through the study because women were dropping out and they wanted to increase retention. The goal of the dietary intervention was to decrease fat intake of postmenopausal women. Nutritionists facilitated the groups, and it was difficult for some of them to move away from their traditional role as teacher/instructor. Group sessions were topic-driven with integration of MI. Stephanie set up the role play and demonstrated a group on heart disease with a lively group of participants.

Chris discussed and then demonstrated teaching an MI approach to addiction treatment groups. He sets up the role play similar to Mary, but his only handout is a description given to trainees of the client and stage of change each is to act out during the role play. He does this to prevent trainees from "acting out" in the client role (so the participant acting as the counselor "has a chance"). Chris meets with the trainees who will be the counselors in the role play to discuss the purpose of the exercise, which is to practice using OARS in a group setting, assess stage of change, and attempt to build group cohesion. Like Mary, he does not introduce this until everyone has some MI skills.

Acknowledgement: Thanks to Charlotte Chapman for taking notes on the session.

Handout for Trainers

Training and Role Play for Group MI

Mary Marden Velasquez, Ph.D.

After reviewing the tips for using MI in a group, break trainees into groups of 8-10 and ask them to select two co-facilitators. (I do this just before a break).

Meet with all of the group facilitators and distribute the "Stages of Change" session from manual.* Ask each pair of facilitators to review the session during the break and decide which one of them will lead each section. Suggest that one facilitator take a more prominent role in conducting the exercises and the other focus on the process (MI spirit, open questions, reflections, summaries, etc.). They then use the break time to read through the session and prepare for the group.

Depending on the trainees, I have group members either talk about a personal behavior such as eating a healthier diet or exercising, or I distribute case vignettes that they can use to role-play including the stage of change.) Each group member gets a copy of the "Where Am I?" handout from the manual.

As detailed in the manual, this session includes: an introduction to the "motivational approach" to be used in the group; briefly establishing group rules (if trainees are experienced in running groups I often tell them to skip this step during the training for the sake of time); introducing clients to the stages of change (drawing a stage diagram on a board or flipchart, describing the stages, and emphasizing that a "slip" does not mean failure); and facilitating a discussion, using the handouts, on the stage of change each client believes he or she is in for the target behavior. Facilitators then summarize the group and close.

I usually give 45 minutes to 1 hour for the group. I ask the facilitators to use all of their MI skills and ask the "group members" to pay attention to the skills that are being used. I also suggest that it is OK for the group members to practice their skills with each other. I circulate, sitting in on each group, and coach as needed.

I ask clients to stay in role as much as possible for the entire group. If it is necessary to stop and discuss the process, I ask them to "time out" and "time back in." (I also do this when coaching.)

Debriefing includes asking about how MI is different in group, whether they found it harder to do, etc. On occasion, I have had an observer assigned to each group to rate use of OARS. If I have not done that, I ask all trainees to discuss specific times when the group facilitators (or members) used MI.

*Velasquez, M.M., Gaddy-Maurer, G., Crouch, C., DiClemente, C.C. (2001). *Group treatment for substance abuse: A Stages of Change therapy manual.* New York: The Guilford Press.

References

Ingersoll, K. S., Wagner, C. C., & Gharib, S. (2000). *Motivational groups for community substance abuse programs.* Richmond, VA: Mid-Atlantic Addiction Technology Transfer Center, Center for Substance Abuse Treatment (Mid-ATTC/CSAT).

Van Horn, D. H. A., & Bux, D. A. (2001). A pilot test of motivational interviewing groups for dually diagnosed inpatients. *Journal of Substance Abuse Treatment, 20*, 191-195.

Velasquez, M.M., Maurer, G., Crouch, C., and DiClemente, C. (2001) *Group treatment for substance abuse: A Stages of Change therapy manual.* New York: The Guilford Press.

Walters, S.T., Ogle, R., and Martin, J.E. (2002). Perils and possibilities of group-based motivational interviewing. In W. R. Miller & S. Rollnick, *Motivational interviewing: Preparing people for change* (2nd ed.). New York: The Guilford Press.

Handout for Trainees

Tips for Using Motivational Interviewing in Groups

Mary Marden Velasquez, Ph.D.

- The ground rules of the group should be made explicit at the beginning of each session. For example, gently remind members that hostile or dominating speech is not the style in which the group is to function. This will discourage disruptions and the possibility of one resistant person dominating the group,
- Use standard MI techniques to handle resistance: empathic reflection, asking for elaboration on statements that are consistent with the direction of the group, validating personal choice and responsibility.
- When negative comments do arise, reframe them in a friendlier, more cooperative style, affirming the objector and perhaps adding a "twist" to the comment.
- Ask quieter members or those who are more experienced for their reactions to permit an alternate viewpoint.
- Selectively emphasize the most relevant comments using a group summary reflection.
- Use "time outs" strategically. This is simply ignoring argumentative comments. Use "differential reinforcement" to attend to positive, nonargumentative, or change talk. Selective reflection allows individuals to be reinforced and heard within the context of increasingly constructive comments.
- Use a group decisional balance exercise to diffuse resistance. Ask the group members to brainstorm a list of reasons for not making a change (i.e., all the good things about their drug use). One facilitator can use the group's list to argue against change and invite the rest of the group to take up counter-arguments (i.e., why change would be a good thing.) A second facilitator can record the group's reasons, reinforcing comments and encouraging group members to argue their point even more forcefully. In this way, the natural antagonism or resistant groups is channeled into talk for change. When the debate is over, the first facilitator uses the list the group has generated to summarize the main points of the argument for change and asks specific members to elaborate on their expressed reasons. This reinforces change talk in the group's words.
- Whenever possible, use brief written exercises that will provide "personalized feedback" to members. For example, have group members take the Alcohol Use Disorders Inventory Test (AUDIT) and then walk them through the scoring. The group facilitator can describe what each range of scores means and ask group members if they would like to share their scores or their reactions. Typically, some group members share their scores and this leads to a lively discussion and change talk. Those members who are quieter and do not share still have the benefit of the personalized feedback from their own assessment. Affirm members for sharing their scores and selectively reinforce any change talk generated by the feedback.
- While reflective listening can be challenging in a group format, it is still possible. When it is possible to have two facilitators in the group, one may focus on reflecting and the other on the group process.
- Most importantly, be creative! Using MI in groups can be fun and you will most likely see results in a much shorter period of time than with traditional group treatment.

Documenting End of Life Care Wishes

An Ethical Use of MI?

Lesley Tinker

Carolina Yahne, Hiro Harai, Marci Campbell, Carol Carr, and Catherine Baca joined me for this breakout session, whose topic was using MI to promote documenting end of life care wishes. We benefited by having a small group and, based on interest, we veered away from a discussion of ethics toward a more experiential session. We organized our hour into four segments: (1) Orientation, by describing an advance directive and the *Five Wishes*; (2) Opportunity to ask questions and comment on experiences with advance directives; (3) Role play; (4) Discussion/summary.

Orientation: Describing an Advance Directive and *Five Wishes.*

An advance directive is a legal document that notes two items: (1) a proxy: person to speak or act on your behalf for medical decisions if you are unable to speak or act for yourself, and (2) what type of medical life support you would want if you were not expected to live without life support. (Note: an advance directive may also be used for non-terminal conditions such as surgery where unexpected decision-making is needed.) The challenges of an advance directive include that one cannot anticipate all possible scenarios and thus may not be able to identify wishes. Further, as one ages — or declines for any reason — one may redefine "quality of life," and thus choices about what one desires for life support. For example, when one is able to carry out daily activities to full capacity, needing the care of others may seem intolerable, yet as one declines, receiving care by others may be desirable. Additionally, even though a legal document, advance directives are not always honored.

The *Five Wishes* is a type of advance directive (i.e., the first two "wishes") and includes three additional sections (the remaining three "wishes") for exploring emotional and spiritual values. Thus, *Five Wishes* offers a tool for exploring life values with one's family, friends, and health care provider. The power of *Five Wishes*, or any advance directive, is in the talking about one's wishes with others. Such a conversation helps clarify one's views and gives others a view into one's wishes. As with MI, an advance directive is about the spirit of one's wishes, more than being able to define specific wishes. By knowing the spirit of one's wishes, family, friends, and health care providers are more able to act in concert with one's wishes. Website for *Five Wishes:* http://agingwithdignity.com/FiveWishes.html

Questions and Comments about Experiences with Advance Directives

Examples included one discussant's father, who had passed away 7 years ago and for whom the advance directive was a blessing honored by the family and medical team; aging parents for whom discussing end of life issues with their adult daughter was difficult; attempted suicide of a patient; an elderly aunt who had an advance directive (not wanting life support) and who had been living at home when a medical crisis occurred, causing pain and suffering — the family had her rushed to the hospital against her wishes with the goal of relieving the pain; not a good experience; how to help someone die at home?

Role-Play

We used elements of the *Five Wishes* with MI to promote a discussion of end of life care issues when aging parents were avoiding the topic. Participants found the role-play experience enlightening as to how the parents might be feeling, and discovered that empathic listening helped them relax and become more open to discussion.

Discussion/Summary

We discussed the possibility of using MI to explore decisional balance around the situations mentioned earlier that were not role-played: (1) elderly aunt who had wanted to die at home: we were not sure if MI would help. The salient issues were informational, particularly how to find support for having a loved one die at home when pain issues increased beyond the family's capacity; (2) suicide (as far as the client can communicate with health care workers and is not in critical emergency, when physical restraints are justified): MI has potential. Inviting the person to consider what would happen if she/he were successful in the suicide, e.g., escape from pain or illness, termination of invaluable existence, family left behind, soul after life; inviting the person to consider pros and cons of the termination of one's own life.

In general, we found it helpful to have a document that listed options to select from. The non-judgmental attitude, respect for the client's own values and the process of eliciting ambivalence in the client can help the client explore the meaning of the options of the documents. Because the *Five Wishes* includes options for advanced medical technologies, it is necessary for health care workers to have sufficient time for informing and educating clients or patients about the options before exploring thoughts and feelings. These communication objectives would be better achieved if the

health care workers were well acquainted with MI. We found that time is needed to allow for a clear presentation of the options.

Author's disclaimer: The author is a volunteer end of life care counselor. She is not a lawyer or physician or otherwise legally trained. Her motivation is to encourage people to document their end of life care wishes. Legal and medical aspects should be discussed with one's lawyer and health care provider.

Engagement Session

New and Improved

Allan Zuckoff

This breakout session updated a talk I gave at the MINT Forum in Maui, Hawaii, in 2002. Because mothers of children in treatment for psychiatric illness have high rates of depression but low rates of treatment, my colleague, Holly Swartz, MD, has devoted her research efforts to developing ways of making effective treatment more accessible to these women. One way she has done this has been by developing an abbreviated form of Interpersonal Psychotherapy (IPT; Weissman, Markowitz, & Klerman, 2000), an empirically supported therapy for depression; her reasoning was that offering a treatment that is intended to last only 8 sessions might encourage these often over-taxed and self-neglecting mothers to come for help.

While her initial findings with Brief Interpersonal Therapy (IPT-B) were promising, Holly became increasingly concerned with reaching out to those mothers who might remain reluctant to commit even to such a brief treatment experience. This eventually led her to make contact with me and discuss working together to develop an MI-based intervention as a prelude to the 8 IPT sessions. As our work got under way, Holly also became aware that Nancy Grote, Ph.D., a colleague who was working to adapt IPT-B for depressed pregnant women, was developing an engagement strategy based on principles of ethnographic interviewing (EI; Schensul, Schensul, & LeCompte, 1999). We all agreed to join forces, and from our collaborative work has grown an "Engagement Session" that can be used as a prelude to treatment for depression.

The Engagement Session grows out of the recognition that many "barriers" can stand in the way of depressed mothers seeking and committing to treatment, and that these barriers can be understood as sources of ambivalence about seeing "depression" as a real disorder to be treated, and about seeking treatment for it — making MI an apt approach. At the same time, the emphasis in EI on keeping culturally-grounded biases from influencing our understanding of those who are different from us makes it compatible with the spirit of MI and also adds a further dimension, when considering work with women from racial and socioeconomic backgrounds different from those of the therapist or researcher.

The goals of the Engagement Session, then, are to help the prospective participant to resolve her ambivalence about treatment and thereby to increase the likelihood that she will return to begin IPT-B. The session is structured to have five content-focused components that generally follow in order, but which are explicitly flexible enough that the therapist can allow the client's agenda to collaboratively guide the session. The therapist employs the core skills of MI (OARS, working with change talk and adherence talk, working with resistance, supporting self-efficacy) in conducting the session. The five components are:

- *Eliciting the Story:* Drawing out the client's understanding of her depression and its contributors, how it's interfering with her life, and its social context; then summarizing, attempting to crystallize the dilemma she feels she is facing.
- *Feedback and Psychoeducation:* Offering objective feedback about her depression (e.g., depression inventory scores) and an IPT-consistent understanding of depression as an illness or syndrome that interferes with problem-solving, and which is both highly treatable and deserving of care.
- *Treatment History and Hopes for Treatment:* Exploring previous experiences with depression and how she coped with it, including positive and negative experiences with treatment, as well as her hopes, fears, and wishes for the therapy with us.
- *Barriers:* Identifying and problem-solving practical barriers to treatment participation, and exploring and resolving ambivalence related to psychological, cultural, or other barriers to treatment engagement.
- *Eliciting Commitment:* Formulating a plan for initiating IPT-B, eliciting commitment to it, offering hope, and "leaving the door open" if she should have second thoughts or struggles with attendance.

The presentation ended with a review of pilot data, which suggest that mothers who receive the Engagement Session are both satisfied with it and consistently commit to and follow through with a course of IPT-B. It was emphasized that these data are highly preliminary and that controlled research must be done. In addition, such a brief course of treatment will clearly not be sufficient for every depressed mother, and we see commitment to continuing

treatment as a positive outcome, given how infrequently depressed mothers receive such care. At the same time, clinically we have the sense that the session often "jump-starts" treatment, helping therapist and patient get moving quickly on the work at hand — and, given the 8-session limit, we see this as an important effect, and thus believe that the intervention is worth developing and researching further.

References

Schensul, S.L., Schensul, J.J., & LeCompte, M.D. (1999). *Essential ethnographic methods: Observations, interviews, and questions.* Walnut Creek, CA: Alta Mira Press.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy.* New York: Basic Books.

Body & Soul

Marci Campbell & Carol Carr

Background

The American Cancer Society (ACS), in partnership with the National Cancer institute (NCI), conducted a pilot project of *Body & Soul* in 15 African American churches in three regions of the US. The "core" intervention components used were drawn from Ken Resnicow's *Eat for Life* study intervention (MI-based phone calls from trained church members about eating more fruits and vegetables) and Marci Campbell's *Black Churches United for Better Health* study (educational events and environmental changes within the church). An effectiveness study found a significant increase in intake of fruits and vegetables attributable to the intervention, and that trained volunteer church members were able to implement the program and conduct the MI calls. Based on these findings, NCI has decided to disseminate an adaptation of Body & Soul nationwide.

Challenges in Disseminating the MI Component

The MI training for church members making the MI-based phone calls in the Body & Soul pilot was conducted by trained MI counselors. NCI staff felt

Yellow Stickies on White Paper

A "Building on Knowledge" Exercise

Cathy Cole

Purpose: A variation on the "Next Response" Exercise: to provide participants the chance to test out their beginning grasp of MI concepts and then refine those throughout the workshop. To get participants interacting with each other. To quickly identify some of the main teaching points for training. To allow participants to try out the responses they are creating.

Structure: The beginning exercise will take about 30 minutes; the workshop leader will need to review the responses at the end of day one and prepare a summary sheet for use the next morning. The afternoon exercise for day two will also take about 30 minutes.

Materials:

- A supply of Yellow Sticky Notes (3x3 lined are easy to use)
- Headings for the concepts written on the white paper
- White paper taped on the wall sufficiently large enough for the exercise, or a surface where the stickies can be placed
- A one page handout listing all the concepts and a case example for the exercise
- Extra pens

Instructions for Day One:

- Break participants into groups of three/four (based on group size).
- Read the case example (see 'Participant Handout').
- Instruct participants to come up, using the sheet with the MI concepts, with two examples for each concept, and write the examples on a yellow sticky, using one sticky per example.
- After they have completed the stickies, they are to go to the white paper and place the stickies under the correct heading.
- After placing their own stickies, they are to review the others and move them to other headings if they think they belong elsewhere (do this silently!).
- Prior to each break time and at the end of the day, each person can add additional stickies to represent increasing knowledge.
- Participants are told to continue to silently review the other stickies and move them around if they desire, but they are **not** to discard any stickies.
- At the end of Day One, review the stickies and prepare a list of

that this could not occur on a nationwide basis due to cost and lack of capacity to deliver such training. Therefore, some type of more "auto-didactic" training program was needed to train lay church members to provide MI-based conversations (face to face or by phone) to church members requesting individual contact. The training needed to be fairly uniform throughout the churches to avoid inadequate or erroneous information being provided.

We had to determine what to call the training and the counselors. We wanted people to be clear that the training was only in communication skills based on Motivational Interviewing, and that they were being given skills to enhance how they talked with others.

Solution

The main training component was embedded in a DVD. Two print manuals were developed to accompany it: a handbook for the Peer Counselors that was integrated with the DVD training, and a coordinator's guide for the selection of peer counselors, how to deliver the training program, and how to maintain the Peer Counseling program.

The program was named Peer Counseling to keep the training clearly separate from MI training.

DVD Contents

Talk show host and guest discuss Peer Counseling communication skills: asking open questions; listening and reflecting; building motivation through discussions of values, importance and confidence; and summarizing.

Segments of a discussion between a Peer Counselor and a fellow church member are shown throughout the talk show, demonstrating the skills being discussed.

Interactive practice of these skills is built into each segment.

Bonus Materials: four other peer counseling conversations that demonstrate different issues that could arise (e.g., resistance).

Notes

These materials were developed for use by African American churches. This provides, then, a basic training tool for work in African American communities.

Since this is a nationwide roll-out of the *Body & Soul* program with limited funds for publicity, NCI would appreciate it if people working in African American communities would share information about *Body & Soul* when possible.

The DVD is in the final editing stage before duplication. It will be available free once duplication is completed. We will post information on the MINT listserv and in the *MINT Bulletin* when it becomes available, with instructions on how you can receive a copy.

Information about *Body & Soul* can be obtained by calling 1-800-422-6237.

the responses under the various concepts prior to the next day, not altering the responses. Use the responses to have a round robin interview with this client at the beginning of day two.

Instructions for Day Two

- At the beginning of Day Two, ask five participants to be the interviewers of the client (one additional volunteer); have the remaining participants be observers, noting on an observer sheet the degree to which the responses express empathy, elicit change talk or create resistance. Allow up to 45 minutes for the exercise, determining how long the interview should last based on how it is going and then debriefing with the observer feedback and doing teaching points in the debriefing.
- In the afternoon, break participants into groups with new people.
- Instruct groups to redo the stickies for the same case example, this time focusing on the MI concepts that will elicit change talk, roll with resistance, and work on a change plan.
- Groups are to try to avoid use of premature focus and blocks to listening and other barriers to listening.
- They are once again to place the stickies on the now blank-again white paper.
- They are again told to rearrange other stickies as they prefer, silently.
- Read through the new list, having participants compare the new responses to the previous ones from Day One. Use this discussion for teaching points.

Participant Handout 'Yellow Stickies'

Motivational Interviewing Case Example and Concepts

Cathy Cole

Instructions:

Read the following case example and then, as instructed, your small group will develop two statements illustrating the MI concepts listed and write each on a yellow sticky. Once you have completed the stickies, place them on the paper under the correct heading. As others are placing their stickies, review them and **silently** move the stickies to the heading you think best illustrates that concept.

Case example:

Betty Boop is a 45 y/o married mother of two teens, a daughter 14 and a son 12. Her husband is 47 and they have been married 20 years. Both are in professional positions and are financially in no real distress. Mrs. Boop receives her medical care in a clinic for women that also provides for mental health care if needed. In the last year, Mrs. Boop has increased the number of visits to her primary care practitioner (PCP) with vague complaints of fatigue, poor sleep, tension all the time, and general anxiety. She has experienced weight gain, onset of diabetes Type II, and mild hypertension.

Her PCP has encouraged her to talk to you as the mental health member of the team, and you have learned the following in your interview:

- Her elderly parents have moved into assisted living nearby and her contact with them has increased; her father molested her as a young girl from age 9-12 and she has never disclosed this. She does not think this is creating any distress.
- She has started using alcohol nightly to help her sleep, often consuming 1/2 bottle of wine or 2-3 glasses of bourbon or brandy. Generally, she drank only one glass of alcohol about 3-4 times a week.
- She has taken on additional responsibilities as a supervisor at work.
- Her husband does not like her parents and is somewhat upset that she sees them more often.
- She feels overwhelmed at times with being a mom, wife, daughter, and professional and does not ask her family to help out.
- She is minimizing the weight gain, diabetes and hypertension, saying it is not so bad.
- She thinks the fatigue, poor sleep, and tension are symptoms of menopause.
- She is not certain if there is anything she wants to do or thinks will be helpful.
- She has never been seen by anyone in mental health before.

Discuss briefly how this scenario might continue if you were the interviewers and write out two statements illustrating the following MI concepts: these are statements that might occur in your ongoing conversation with this client.

- Open ended questions
- Reflection: simple
- Reflection: complex
- Affirmation
- Summary
- Premature focus

- Blocks to listening: telling, lecturing, providing advice, reassuring, sympathizing, controlling, interpreting, minimizing
- Ways to elicit change talk: the importance ruler, pros/cons of change; open ended questions about change, looking forward, looking back, querying extremes, goals/values
- Rolling with resistance: personal choice and control, reflections, double sided reflection, shifting focus

Instructions for Day Two

Break into groups again with new people. Redo the stickies re: the same case example, this time focusing on the MI concepts that will elicit change talk, roll with resistance and work on a change plan. Write out as many as you would like. Try to avoid use of premature focus and blocks to listening and other barriers to listening. Place the stickies on the white paper. Rearrange stickies **silently**.

Summary of responses and observer sheet

Open ended questions

#	#empathy	#^ change talk	#^resistance

Examples

Simple Reflections

#	#empathy	#^ change talk	#^resistance

Examples

Complex reflections

#	#empathy	#^ change talk	#^resistance

Examples

Affirmations

#	#empathy	#^ change talk	#^resistance

Examples

Summary

#	#empathy	#^ change talk	#^resistance

Examples

Premature Focus

#	#empathy	#^ change talk	#^resistance

Examples

Blocks to Listening

#	#empathy	#^ change talk	#^resistance

Examples

Ways to Elicit Change Talk

#	#empathy	#^ change talk	#^resistance

Examples

Rolling with Resistance

#	#empathy	#^ change talk	#^resistance

Examples

Coding Experiences from the Field

Carol DeFrancesco & Denise Ernst

Prologue to Writing: Returning Home after the Maine MINT meeting

Coding, Coding, Coding, keep those tapes a rollin' MI!

It's a long flight to Portland, Oregon. I can't get that Rawhide song out of my head. Plagued with the inability to get comfortable enough to sleep or get my legs past a 90-degree angle, I reluctantly dig my laptop out from under the seat in front of me. I have to wrestle the strap of the bag from the leg of the young woman who is sitting in front of me; finally it gives way and I get a 'what are you doing' glance from her friend sitting next to her. The plane is too loud and my energy too low to explain what I was doing — deciding instead to get on with my original task: writing up a summary of our talk. Delaying the task for a few more minutes, I read Chris Dunn's Virtual Symposium piece on values (*If Giants Grumble, Will Values Tumble? MINUET 11.3*) and I think to myself "I bet he can't get that Coding song out of his head either or get his knees past 90 degrees."

Coding Session

We started our session by calling up fellow MINTie coders with a chant and a song.

Here's the Chant:

We are MITI coders
We know we're the best
If you can record it
We will do the rest
Goooooooooo Coders

Chris Dunn taught us the words of his coding song to the tune of the Rawhide theme song:

Coding, Coding, Coding, Keep them tapes a rollin', MI
Don't over understand 'em
Just take a stand and brand 'em
Trudging toward reliabilit-I

With the crowd sufficiently awake, Denise Ernst gave a brief history of the MISC and MITI coding schemes. The MISC was developed after Project Match. It contains 7 counselor global scores, three client global scores and 15 behavior counts. Terri Moyers developed the MITI by doing a factor analysis on MISCed sessions. The MITI has only two global ratings (counselor spirit and empathy) and 7 behavior count items.

One of the client global ratings called self — *exploration* —- which is measured in MISC 2.0- was also discussed, because this was measured in the coding project that is described below.

During Denise's description of the coding schemes several questions were raised regarding the process of training coders, establishing reliability and the behavior counts coded.

Then I stepped up to describe a multi-site coding project. The study sites were all part of an National Institutes of Health funded Behavior Change Consortium (BCC). Of the 13 studies funded, four tested MI and one used self-determination theory, which shares many characteristics with MI. Three sites had fruit and vegetable intake as a common outcome and two focused on smoking cessation. Ten 'changers' and 'non changers' were identified from each site and all their available tapes were coded. In all, close to 300 sessions were coded from the sites.

Research Assistants at Oregon Health & Science University did the coding. Six coders were trained on the MITI scheme under the direction of Denise Ernst, Rosemary Breger and me.

To gear up, our group of MITI coders met for 40 hours of training exercises over approximately two months. We studied the MITI manual and met frequently for practice and skill building. We began by coding tapes with transcripts that had been expertly coded at the University of New Mexico (UNM) and then moved to coding study tapes both as a group and individually. We spoke with Denise Ernst regularly to check our decisions with UNM. After our initial training on UNM tapes, we coded sample tapes from each study site.

The study site populations varied from young mothers to middle-aged fire fighters. The interactions took place in homes, fire stations, clinic offices and over the phone. To handle this diverse sampling of tapes, we trained and established reliability using tapes from one site at a time and then coded all the tapes from that site. We repeated this process for each site, allowing us to identify if a particular coder was losing consistency over time and to test if our reliability was drifting for a specific dimension. This process required an additional two weeks for each study site.

Once we graduated from our training exercises and started coding the 'real' study tapes, we found one of the biggest challenges to be background noise on audiotapes. Fire alarms, crying babies and TV noise sometimes created a cacophony in our earphones. If a tape was too difficult to hear, we would throw it out of the coding mix, a solution we resorted to infrequently.

Statistical Methods

Four Principle Component Analyses (PCA) were run on the 7 behavior counts and two counselor globals, using the session as the unit of analysis, not the subjects.

Rotated Component Matrix

	Component	
	1	2
Sum Simple Reflection tallies, all segments	.762	.352
Sum Complex Reflection tallies, all segments	.762	
Avg. Empathy Score for Session	.740	-.521
Avg. Spirit Score for Session	.730	-.523
Sum MI Adherent tallies, all segments	.698	
Sum Open Question tallies, all segments	.575	
Sum Closed Question tallies, all segments		.786
Sum MI Non-adherent tallies, all segments		.778
Sum Give Info tallies, all segments		.771

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalizatior
a. Rotation converged in 3 iterations.

Rotated Component Matrix

	Component	
	1	2
Sum Simple Reflection tallies, all segments	.817	
Sum MI Adherent tallies, all segments	.735	
Sum Open Question tallies, all segments	.599	
Sum Closed Question tallies, all segments		.813
Sum MI Non-adherent tallies, all segments		.809
Sum Give Into tallies, all segments		.788

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalizatior
a. Rotation converged in 3 iterations.

PCAs were performed with orthogonal and oblique rotation, both with and without the counselor globals (average empathy, average spirit). The results of the two rotation schemes were very similar; however, including the globals "dirtied up" the nice clean simple structure of the original variable PCAs. Both matrices are shown below. The items that 'hang' together in factor 1 are all things we might label as positive MI behavior. Factor 2 includes the behaviors we try to avoid. Have a look for yourself, but please remember the results below are preliminary and will undergo further revisions before they are submitted for publication.

Because the orthogonal and oblique rotation results were so similar, I created factor scores using only the orthogonal PCA. These factor scores accounted for about 63% of the variance in the original seven items.

The factor scores were used to predict the maximum self-expression global rating per session. Results showed that over 20% of variance in maximum self-expression scores were predictable by the model using the two factors. Interestingly, only the positive MI factor contributed uniquely to the relationship. Adding the negative MI factor did not add predictive information.

Next, the average empathy scores and average spirit scores were used to predict self-expression. The model accounted for 23% of variance in maximum self-expression. However, caution is warranted in interpreting the coefficient results because the two globals are so highly correlated (.90+). Either global (empathy or spirit) is significantly correlated with maximum self expression. For this reason, the spirit and empathy scores were combined into one summary global. When the regression model was rerun, as expected, it accounted for about the same amount of variance (R-square = 22%).

We have since added the average counselor global variable to the factors and were able to predict 33% of the variance in self-exploration.

"But I Already Do This With My Clients!"

False High Self-Confidence Estimators and What to Do About Them

Eugene Hoffman & Dee-Dee Stout

After an article in the MINUET appeared on the phenomenon of participants expressing false high self-confidence in training workshops, Dee-Dee Stout and I got to talking via e-mail about our common experiences. Beginning with renaming it, "But I Already Do This With My Clients!" to add some humor to a potentially frustrating experience, we also began to discuss how we might better engage these "reactive" participants. After several months of brainstorming, through phone calls and e-mails, we finally decided that perhaps if we approached this issue through an experiential exercise at the MINT Forum, we could pool our collected information to generate some ideas for improved engagement.

The Set-up

What we did in Maine was to give a very brief introduction and then divide our fellow MINTIES into groups. We handed each group a sheet explaining their task and went to work.

We called Group 1, *The Hypothesizers*. They were asked to brainstorm a list of the following: 1) reasons why training participants might say that they "already do this stuff everyday with clients," 2) times when this type of "reactive" statement might occur in training, and finally, 3) possible ways to respond to these participants.

We designated Group 2, *The Baseball Fans* (think "Batting Practice"). They were asked to generate a list of statements that reactive training participants might make along the lines of "But I already do this with my clients!" regarding the skills being taught, and then take turns "pitching them" to each other for other potential trainer responses.

Group 3 was named *The Gut Squad*. This group was given some trainee scenarios to role-play. They did this both by going around in a circle, each person responding to a "trainee" and also by setting up a fishbowl with various people role-playing the dyad trainer-trainee. In both scenarios, "trainers" began acting as if they were stuck during the process of the "training" as well as opening up the "trainer" role for anyone who wanted to participate.

A member of each group was asked to take notes to debrief the larger group when we all re-convened about 30 minutes later.

Results & Comments

Group 1

The Hypothesizers (many thanks to reporter Jacque Elder!) worked hard *hypothesizing* (!) why trainees might make statements indicating a lack of desire to use some of the basic motivational interviewing skills, such as OARS, in their work (again, this idea of "but I already do this with clients!" appears). The Hypothesizers discussed three basic areas: 1) the issues, 2) the timing of trainee statements, and 3) the trainer responses to these statements.

1) The Issues:

Some of the issues discussed were:

a. Some trainees want to prove to the trainer that they are competent, since they represent their

Interactive Group "Real-Play"

Steven Malcolm Berg-Smith

Purpose: To provide a large audience an initial introduction to motivational interviewing in a relatively brief interactive presentation (30-45 minutes).

Primary Goal: To catalyze interest in learning more about MI.

Secondary Goals: Exercise simultaneously allows trainer to: 1) model the spirit and basic skills/strategies/tools of MI; 2) present bite-size pieces of didactic information ("key elements") related to MI; and 3) support the audience in personally experiencing a simple motivational interview with a self-identified health behavior.

Format: INTERACTIVE!

Structure: Trainer plays the role of health professional/clinician (and stops action at key transition points during the clinical encounter to provide simple explanation of skills/strategies/tools utilized). Audience plays the role of patient/client (participants personally explore self-identified health behavior). Approximate Time Required: 30-45 minutes

Materials:

A. Chartpad, overhead, or powerpoint to display the following

1. Key principles
   - Change talk
   - Acceptance
   - Less is more
   - Righting reflex
   - Michelangelo belief
   - Autonomy and choice

2. Key Transitions during "real-play"
   - Open the encounter
   - Ask open-ended questions
   - Negotiate the agenda
   - Assess readiness to change
   - Elicit change talk
   - Explore ambivalence
   - Ask about the next step
   - Close the encounter

B. Participant handout, includes:

1. Options tool for setting the agenda. Circles contain: physical activity, healthy eating, play, safety, sleep, safe sex, weight, smoking, alcohol, stress (also includes several blank circles)
2. 0-10 ruler for assessing readiness
3. Box with line down the middle for exploring ambivalence
4. Box for identifying "what-if any-next steps"
5. Key MI references

Tips:

- Exercise requires a lot of finesse, willingness to be vulnerable, and the ability to shift in and out of different roles.
- To signal the many transitions from the "real-play" to "stop-action," I typically use a shaker (rattle) or take a hat on and off.

employers, such as the state.

b. Some trainees might not value looking more closely at a new approach or continued growth in their profession; they've "had enough" epiphanies or new ideas; they are overwhelmed with stress or anxiety.

c. Some trainees find it difficult to be open-minded or are uncomfortable or embarrassed for colleagues to see that they may not "know it all."

2) The Timing:
Some of the issues discussed were:

a. Many trainees seem to begin to make these statements at the beginning of a training or during the second day, when they realize that *demonstrating* their ability to use skills being taught is more difficult than they realized.

b. Sometimes trainees want to avoid participating when they are asked to do training exercises (see "c" of The Issues).

3) The Trainers' Responses:
Some of the potential responses discussed were:

a. Get trainees more involved, e.g., ask them to be the "resident expert" to help others with the skills.

b. Use the S. Berg-Smith technique of asking trainees to form a line, a la the *Readiness Ruler*, according to their level of motivation to learn this "new stuff."

c. As a trainer, avoid playing the role of the expert; don't fall into the "expert trap."

Group 2

The Baseball Fans (many thanks to Carolina Yahne!) pitched and batted for several innings around the circle of 12 people. The "batting" that earned the most "home runs" was simple, short, reflective, and rolled with resistance. One pitch was "What you're calling reflective listening sounds more like parroting to me." The "batter," a wise participant from Canada, responded, "Some parrots speak better than others." Well said!

Group 3

The work of the Gut Squad (facilitated and reported by Eugene Hoffman) began by asking for a volunteer therapist and client. A scenario was read depicting a

- With a really large audience, make sure you have a microphone that allows you to freely move around the audience, and at least one additional microphone for participant volunteers to speak into.
- Invite audience to save questions until the exercise is complete.

Instructions:

1. *Opening comments:* "We have about 45 minutes together, and my plan is to give you a taste-an initial introduction-to what a motivational interview might look and feel like."
2. *Objectives:* "... To be realistic about what we might accomplish, I'm hoping that each of you walk away from this presentation with 1) one new motivation-enhancing skill/strategy/tool; and 2) a desire to learn more about MI."
3. *Set the stage:* Begin by telling the audience that you're going to take them through an "interactive exercise/experience" that involves you stepping into the role of a health professional, and them stepping into the role of your client/patient. "... and my plan is to have a conversation with all of you about your lifestyle, specifically the kinds of things you're currently doing or maybe not doing to keep yourself healthy and well. As we're having this conversation I'm going to be modeling a number of different motivation-enhancing tools and strategies, and-at key transition points-stepping out of my role as the clinician and offering a brief explanation of what I've just demonstrated. To facilitate this conversation, you're going to need several counseling tools, which you'll find on your handout. Let's get started..."
4. *"Interactive real-play"*
   a. Open the encounter: Key elements to include: name, role, how you usually work, time to meet, and permission to have this conversation.
      i. "Hello, my name is Steve Berg-Smith. It's nice to meet you. As you may already know, I work primarily as a health counselor, and my job is to work together with patients in making decisions about what-if anything-they might want to modify or change in their lifestyle to maintain or improve their health and wellbeing. We have about 20 minutes to meet, and what I was hoping to do with our time is have a conversation with all of you about your health in general, specifically the kinds of things you're currently doing or maybe not doing to keep yourself healthy. How does that sound?" (Pause) "Raise your hand if this is OK with you?" "Raise your hand if this is not OK with you?" For those not wanting to participate, this is an excellent opportunity for you to model acceptance and autonomy / choice. "Thank you for your honesty. I respect that. During this time, as the rest of us are having this conversation-if you choose-I invite you to just observe or maybe do

trainee who was well experienced in criminal justice/corrections, and knew something about Rogerian theory, but who was also skeptical that reflective listening skills could be used in prison settings. As the volunteer "inmate" repeatedly expressed a desire to be out of prison, the volunteer skeptical "corrections" person was gently coached by the whole group (eliciting change-talk) to the point of the "corrections" person actually asking for more ideas regarding the use of reflective statements! I think this group felt encouraged that they could get unwilling trainees to participate through gentle, persuasive coaching!

Conclusions

I think we learned several things about reactive trainees: 1) that lack of desire to learn or practice a new model may occur because they think that it will add more work to their already overburdened workload, 2) that sometimes trainees haven't had the opportunity to experience the advantages, to both their clients and themselves, in using these new skills, 3) that reactive trainees are often ambivalent about how they will be seen by both management and their peers. We also learned (again?) how crucial it is for management to "buy into" the skills being taught, to not just to leave it up to the trainer to motivate trainees to see the value in these new skills. Then, it is probably quite important for the trainees to decide how far they want to go with the training and the skills being taught - what is the value of these skills in their own lives going to be?

We also saw how the trainers' personality (warmth, genuineness, authenticity, or "spirit"), presentation skills, and approach to both using and teaching the skills of MI may be factors impacting the reactivity of trainees. And lastly, we were reminded that we must keep in mind that there are probably time and money challenges, both for the organization and for the trainee-employee, as to who will be trained and whether that training is provided by the employer or must be gained by trainee-employees on their own.

In the end, we both agree that this was just the beginning of this conversation, and that as we continue to teach the skills of MI, we as trainers are challenged to remember that as teachers, we are constantly being taught by our students, perhaps more than we teach them. We are the ones who must remain teachable. We anxiously wait for the next conversation on this subject. Thanks to everyone who participated in this lively experiment! And thanks for teaching us more about MI and its spirit. MB

some of your own reading or writing. It's up to you."

ii. Stop Action! Step out of role. Offer brief explanation of key elements of opening the encounter; emphasize importance of supporting patient autonomy and choice.

b. Ask open-ended questions: Proceed by asking an open-ended question. Model OARS.

i. "To begin with, I have some questions to ask you to help me begin to understand the different ways you go about keeping yourself healthy. During this time I may offer some of my own thoughts and ideas, but mostly I want to hear from you. My first question is, What are all of things you are currently doing to keep yourself healthy, not only now, but for the future? Popcorn style, in just a few words, toss into the air what you're already doing."

ii. Stop Action! Step out of role. Emphasize the importance of 1) encouraging the patient/client to speak/dialogue...to talk more than the clinician; and 2) initiating a conversation with a focus on strengths and abilities...what s/he is already doing to maintain health.

c. Negotiate the agenda: Invite audience to pull out options tool. Walk through items in the bubbles. Encourage selection of a personal health behavior. Model OARS.

i. For example: "... raise your hand if you picked one of the lifestyle areas already in a circle. Raise your hand if you identified something else. Would a few of you be willing to share what you've identified on your own? I wonder if one of you would be willing to share a few things about your reasons for picking what you did?"

ii. Stop Action! Step out of role. Introduce "agenda setting tool," and its role in presenting small pieces of information (less is more), focusing the encounter, and supporting choice.

Real-play proceeds in similar manner with other transition steps!

d. Assess readiness to change using the ruler

e. Elicit change talk using the "backwards" question

f. Explore ambivalence ("advantages for keeping things the same" and "advantages for making a change")

g. Ask about the next step ("Where would you say the lifestyle area you've been exploring fits into your future?" "What-if any-next steps?" "Where do you go from here?")

h. Close the encounter (elements to include: show appreciation, offer advice/recommendation, emphasize personal choice, voice confidence, link with resources, arrange for follow-up).

5. *Debrief:* Emphasize that "what just happened" is an example of a simple motivational interview. Refer to references for those wanting to learn more. Entertain audience questions