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From The Desert

Bill Miller

Possible Selves

Within psychology there is an active stream of research on "possible selves" that could, I think, have fruitful applications in MI. The idea is traced to William James's 1890 *Principles of Psychology*, where he discussed potential selves among which people choose. Erik Erikson also identified identity formation and the envisioning of a future self as a key developmental task in adolescence. Rogers made use of Q sorts to help clients contrast real and ideal selves. Throughout the lifespan, the representation of possible selves is an emergent component of identity. The envisioning of possible selves is what we are eliciting in the "looking forward" exercises used in MI.

Where do possible selves come from? They are certainly social constructions, influenced by our culture, neighborhood, friends, family and significant others. In Carolina Yahne's "favorite teacher" exercise, people often recall a teacher who brought out their potential, who saw in them a possible self that they did not see themselves. The Leake and King (1977) study of the effects of counselor expectancies, like the Pygmalion literature more generally, illustrates the prophetic power of our vision of others' potential. Possible selves are part of the human meaning-making process, and thereby potent potential source of motivation.

Current research often uses a sentence completion task to contrast expected ("Next year I expect to be...") and feared possible selves ("Next year I want to avoid..." or "I worry about becoming..."), and one could also ask about hoped-for, desired, or ideal self. Another approach is to contrast contextual potential selves: my work-self, family-self, religious-self, etc. These possible selves can be in competition with each other (e.g., work/family) much as core values can conflict. In psychosynthesis and gestalt therapy, these different current or potential selves may enter into dialogue with each other. Engle and Arkowitz (2005) have conceptualized ambivalence within psychotherapy as, in part, a choice between possible selves.

Having people talk about their possible selves may itself catalyze change. At the May meeting of the American Psychological Society (APS), Daphna Oyserman presented results of a randomized trial of an 11-session group intervention with 8th graders, seeking to prevent dropout at this crucial point in education. Intervention groups were composed of randomly chosen children, not preexisting peer groups. In one exercise, participants each drew a marble from an urn that contained pairs of marbles of each kind. They then moved around the classroom to find the person who had the other marble of the same kind, and paired up with that child. The task was to interview the partner to find out what skills and abilities he or she had to succeed in the 8th grade and graduate into the 9th grade. Each child then introduced the partner to the group, detailing his or her skills to succeed. No interpretation or explanation of the exercise was offered (e.g., "We're doing this because..."). The activities in each session spoke for themselves. At 2 year follow-up, children in the intervention group were more likely to be attending school, doing their homework, and getting higher grades. Their classroom behavior was significantly better, and they were less depressed than the control group. They also reported greater consistency between achievement goals and their racial-ethnic identity, whereas

Editor's Choice

Strange Bedfellows

Allan Zuckoff

The joining of MI, with its emphasis on egalitarianism and autonomy (literally, *auto-nomos:* to give oneself the law), with institutions founded upon principles of hierarchy and control (the legal system, the military) might seem at first glance among the stranger examples of opposites attracting.

So, with entire systems adopting MI as a core strategy or "best practice" (cf. Bill Miller's "An Open Letter to Arizona Probation Staff" in *MINUET 11.2*), members of MINT integrally involved in the process of training, dissemination, and testing (cf. recent *MINUET* articles by Mark Farrall, Pat Lincourt, and Lars Forsberg & Carl Ake Farbring), and lively, recurring MINT listserv discussions, it occurred to **Harry Zerler** that the ethics, efficacy, effectiveness, and import of the spread of MI in these contexts merited closer and more sustained attention. The outgrowth of this inspiration is a ***Virtual Symposium*** on the topic of *MI and Mandated Interventions.* The symposium features an original essay by Harry, followed by 14 commentaries by MINT members who participated in those earlier discussions, and—in a new twist, and by Harry's request—a final commentary on the commentaries by yours truly. It will be followed by a *Live Symposium* of the same title at the upcoming MINT Forum, which in turn will be published in the next issue of *MINT Bulletin*. It is our hope that, by turning our attention to the ramifications and challenges of practicing MI in these settings, MINT can help to shape the thinking about these issues in the wider field of practice.

In This Issue

From the Desert, **Bill Miller** considers the implications of recent research on *Possible Selves* and *Gentle Persuasion* in children and adolescents for our thinking about MI. **Paul Amrhein, William R. Miller, Theresa B. Moyers, & Stephen Rollnick** provide *A Consensus Statement on Change Talk.* Fittingly, **Grant Corbett**, in ***What the Research Says ...About Change Talk,*** presents *Part III - Commitment Language,* in which he considers how "change talk" has changed, and where commitment talk fits in this new landscape. **Judith Carpenter & Jacki Hecht** provide an introduction and preliminary agenda for *MINT Forum 2005, and* **Kathy Goumas** offers a *Steering Committee Update.* **Susan Butterworth** & **Shawn Jeffries** describe their approaches to the use of MI in the area of weight change in *Obesity: Another Perspective and Practice Suggestions.* **V. Quercia, G.P. Guelfi, M. Scaglia, & V. Spiller** present the design and outcomes of *Motivational Interviewing with Illicit Drug Owners: An Effectiveness Study.* **Rosemary Breger, Carol DeFrancesco, & Diane Elliot** describe the structure and process of a collaborative project for *Training Coders to Use the Motivational Interviewing Treatment Integrity Coding System.* Then, ***Integration Station*** arrives with **Carolina Yahne & Kathleen Jackson** and their account of *Passionate Peacemaking: Mediation and Motivational Interviewing.* In ***Adventures in Practice,*** **Cathy Cole** offers ideas for using MI and *Staying Fresh with Long-Term Clients.* Harry Zerler challenges some of our most basic MI assumptions in the ***Theoretical Exploration,*** *Appreciating Confrontation.* And in the ***Research Round-Up,*** **Stéphanie Wahab & Usha Menon** describe an ongoing study, *Project Community CARES.* And the main section ends with a voice from the (not-so-distant) past: **Douglass S. Fisher**, who shares his personal reflections on a neglected topic in *Dear MINTIES...A Former MINTIE Looks at the Precarious Intersection of Personal Issues and Professional Work.* Then, our ***Virtual Symposium***, whose table of contents and contributors can be found on page 23.

Looking Forward

The MINT Forum, to be held on September 1-3 in Amsterdam, The Netherlands, approaches rapidly at the time of publication. The agenda generates high expectations for the success of the meeting, as does the knowledge that any gathering of MINTies will inevitably include stimulation intellectual and pragmatic, prosaic and poetic. (I will *not*, however, stoop to noting that Amsterdam's famous red-light district will present the opportunity for forms of stimulation not usually associated with the MINT...) With Jacki Hecht's able assistance, the proceedings of the Forum will appear in *MINT Bulletin* 12.3 (though again, only those proceedings *officially* part of the meeting will be included).

As Kathy Goumas' communication from the Steering Committee makes clear, we can look forward to numerous changes in the administration, financing, and perhaps purview of our organization. Similarly, changes are occurring here at the *MINT Bulletin*. **Ira Friedman**, the non-MINTie who generously redesigned this publication at my request when I assumed its editorship, has quietly been producing every issue since, offering his valuable (and otherwise exorbitantly expensive) services *gratis* on the basis of our friendship. So as not to fray the bonds of friendship beyond repair, I began collaborating on the production of this issue, and will be taking over those responsibilities completely with issue 12.3. This seems like just the right time, then, to begin the search for a MINT member who would be ready, willing, and able to join forces with me in publishing the *MINT Bulletin*. If you have a talent for production and design, time to spare, and the desire to give the gift of service to your organization, I'd love to hear from you. MB

in the control group these were uncorrelated. Oyserman's research on possible selves is described on her website: http://sitemaker.umich.edu/daphna.oyserman.

Engle, D., & Arkowitz, H. (2005). *Resolving ambivalence: An integrative approach to working with resistance in psychotherapy.* New York: Guilford Press.

Gentle Persuasion: Children Do it, Too

Here is another little gem from the American Psychological Society meeting, a poster entitled "Gentle persuasion beats peer pressure for encouraging prosocial behavior." The authors, Joan M. Zook (State University of New York at Geneseo) and Marianne P. McGrath (University of Michigan at Flint), studied 56 pairs of children who were friends, aged 5 to 11. They separated each pair of friends for a short time and did a structured empathy assessment interview with each (Davis, 1983). Then one child was shown some photographs of hospitalized children, invited to think about what it would be like to be sick in the hospital and away from friends and family, and asked to try to persuade her or his friend to create friendly cards for children in hospital. They were not told how to do this. Finally the two children went into a playroom together (no adult) where there were interesting toys as well as card-making materials, and their interaction was videotaped.

One dependent measure was the amount of time spent in making greeting cards, and the investigators also coded the child's persuasive communication style. They coded responses as questions, suggestions, commands, and reasons. Reasons were in turn differentiated into prosocial ("It's nice to cheer up the kids" "The more we make, the more kids we can help") or threats ("You'd better make cards or that lady will scream at you").

The child's empathy level significantly predicted the verbalization of prosocial reasons, and was also associated with time spent on card-making. Contrary to prediction, however, the use of prosocial appeals did not predict how much time the friend spent on the prosocial task. Neither did threats or commands avail. Instead, it was the children using "gentle persuasive techniques such as suggestions and questions" who were most successful in encouraging their friend to spend time on card-making, and who spent more time on the prosocial task themselves. These gentle persuaders were also the children who had scored highest on the empathy measure.

Here are citations on this approach to empathy measurement:

Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology, 44,* 113-126.

Davis, M. H. (1994). *Empathy: A social psychological approach.* Madison, WI: Brown & Benchmark.

Davis, M. H., & Franzoi, S. L. (1991). Stability and change in adolescent self-consciousness and empathy. *Journal of Research in Personality, 25,* 70-87. MB

A Consensus Statement on Change Talk

Paul Amrhein, William R. Miller, Theresa B. Moyers, and Stephen Rollnick

The term "change talk" did not appear in the first edition of *Motivational Interviewing.* In the 1991 book, as in the original article (Miller, 1983), we used the term "self-motivational statements" to describe a broad category of client speech that favored change. We differentiated four subtypes of self-motivational statements: (1) Advantages of change, (2) Disadvantages of status quo, (3) Optimism for change, and (4) Intention to change.

In preparing the second edition, we responded to comments from trainers that the term "self-motivational statements" seemed a bit awkward, and so we coined "change talk" as a simpler alternative. Thus the second edition (Miller & Rollnick, 2002) contains "change talk" as a substitute and synonym for self-motivational statements, with the same four subcategories.

Several studies, however, failed to find the predicted relationship between change talk defined as above (and as used in MISC 1) and behavior change outcomes (Miller, Benefield, & Tonigan, 1993; Miller, Yahne, & Tonigan, 2003; Peterson, 1997). Subsequently Paul Amrhein's psycholinguistic analyses of MI sessions suggested a different structure for coding client speech in MI (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). His coding system required a specific goal proposition, in essence the target behavior change. Some examples of such behavioral goal propositions would be: to stop smoking; to cut down or quit drinking; to get my blood glucose under control; to bring down my blood pressure. In relation to a specific goal proposition, the client offers certain motivational modifiers such as:

Desire	I would like to stop smoking
Ability	I could quit smoking
Reasons	Smoking really flares up my asthma
Need	I've got to quit smoking
Commitment	I am going to quit smoking

Amrhein's data further pointed to a sequential process whereby Desire, Ability, Reasons and Need (DARN) did not themselves predict behavior change, but did predict strength of client commitment to change. The strength of committing language in turn predicted behavior change (drug abstinence). This supports the importance of differentiating commitment language from other kinds of change talk, and also supports our original (Miller & Rollnick, 1991) intuitive differentiation of MI into Phase 1 (enhancing motivation for change) and Phase 2 (strengthening commitment to change).

So how, then, should change talk be defined and coded? After a series of discussions we offer the following three recommendations.

1. Use "Change Talk" as the Generic Term

Consistent with the second edition (Miller & Rollnick, 2002), we recommend using "Change Talk" as the generic term to encompass all forms of speech that favor change. We considered but rejected a return to "self-motivational statements" as the generic term.

2. Differentiate Change Talk into Preparatory Language and Commitment Language

Within this overall category of Change Talk, we recommend differentiating Commitment Language from preparatory forms of change talk including Desire, Ability, Reasons and Need (DARN), which are non-committing antecedents of commitment.

3. Change Talk Strength Rating Scales Should Have No Zero Value

For purposes of coding strength of change talk (e.g., on a Likert scale), we concur that no numeric zero value should be used. Such rating scales can be unipolar and valenced toward a particular proposition (e.g., +1 to +5), or can be bipolar, with negative values representing strength of commitment to status quo (e.g., -5 to +5, as in MISC 2). In either case, no zero value should be used.

MINT Bulletin

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Ambivalent About Resistance

Still under discussion is how to refer to speech that favors status quo. In practice to date, we have often used "counter-change talk" and "resistance" as synonymous generic terms for this purpose. There are, however, forms of interpersonal speech that signal dissonance in the relationship and could clearly be considered resistance by prior definitions (Engle & Arkowitz, 2005; Patterson & Forgatch, 1985), yet do not constitute counter-change talk. Such behaviors include interrupting the counselor, disagreeing with or discounting the counselor, and changing the subject away from discussion of change. Terminology in this area is still "under construction." MB

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What The Research Says

About Change Talk: Part III. Commitment Language

Grant Corbett

Evoking client statements about change has been part of Motivational Interviewing (MI) from the beginning (Miller, 1983). Why? You will find answers explored in the last two columns (Corbett, 2004b/2005).

In this third and last part, we will look at how "change talk—"including the newest subtype, commitment language—has changed. We will end with practice implications of what we have discussed over the series.

"Change Talk" has Changed

The second edition of *Motivational Interviewing* named four types of "change talk" (MI2; Miller & Rollnick, 2002, p.47). These were: 1) "disadvantages of the status quo", 2) "advantages of change", 3) "optimism for change", or 4) "intention to change."

However, in that edition, we also saw "intention to change" referred to as "commitment". "Optimism for change", or self-efficacy by another name, became "confidence talk" (Miller & Rollnick, 2002; p. 111-125). These were the first of recent changes to the concept.

One year later, Bill Miller proposed that "an interviewer needs to differentiate commitment from other forms of change talk" (Miller, 2003; p. 3). So, "intention to change" became "commitment language". Perhaps, to be consistent with other MI terms, we might call this "commitment talk".

With "confidence talk" and "commitment talk" the new language for "optimism for change" and "intention to change", I concluded that "change talk" was left to describe the "disadvantages of the status quo, (and) advantages of change" (i.e., decisional balance). However, Bill writes (W. R. Miller, personal communication, June 30, 2005) that he and Drs. Rollnick, Amrhein and Moyers:

> *...are trying to come to consensus on use of these terms. At the moment it appears that Change Talk will be the generic term, with subtypes of Preparatory Talk (DARN) and Commitment Talk.*

DARN is the acronym for client language that communicates desire, ability, reasons or needs.[1]

How then do we refer to the "disadvantages of the status quo" and "advantages of change"? Perhaps they could be the two sides of "decisional-balance talk" (or "cost-benefit talk")? Then "change talk" would be the umbrella term. The subtypes: "cost-benefit talk", "confidence talk" and "commitment talk", would become the three C's of "change talk". However, is this classification useful? That depends on your answers to two questions.

First, are DARN statements equivalent to "decisional-balance talk" and "confidence talk"? I would say yes. Decisional balance refers to the expected gains and losses from a decision. Gains have been described as including affective, social and utilitarian benefits (Janis & Mann, 1977). Desire (D) is "a state of mind whereby an agent has a personal motivation to perform an action or to achieve a goal" (Perugini & Bagozzi, 2004), and anticipated emotions predict desire (Leone, Perugini & Ercolani, 2004). So desire involves the anticipation of an emotional reward, which one might expect from an interpersonal or practical gain.

Examples of the strongest desire language in MISC2 are (Miller, Moyers, Ernst & Amrhein, 2003):

- Absolutely. I want to get off drugs for good.
- I want to be clean and sober, period.

- I'm sick of smoking.

Getting "needs" (N) met would be seen, I expect, as a gain for most people. Reasons (R) are explanations often given for needs (Miller, Moyers, Ernst & Amrhein, 2003; p. 61), although reasons for an action can be independent of our needs (Searle, 2001). Examples of the strongest need language in MISC2 are (Miller, Moyers, Ernst & Amrhein, 2003):➢

- I definitely have to get off the street.
- I *can't* go on crashing like this!
- I absolutely have to lose weight.

As noted in the first column in this series (Corbett, 2004b), ability (A) to change speaks to self-efficacy (i.e., "confidence talk"). Again, strong examples from MISC2 are:

- I'm positive that I could quit.
- Sure I can lose the weight—it's just a matter of sticking to it.
- Absolutely. I can quit whenever I want.

The second question is whether you believe it is important to differentiate DARN statements, or "cost-benefit talk" from "confidence talk"? Terri Moyers says no (T. Moyers, personal communication, February 01, 2005):

> *...we do not have evidence that they differentially predict anything, AND there are not YET differential clinical responses depending on whether or not the client speaks about Desire or Ability or Reason or Need. The clinical response to change talk is the same no matter what flavor it is and the point is to move it forward to commitment language if possible since THAT (at least in one study) predicts behavior change.*

Taking a differing position, Paul Amrhein writes (P. Amrhein, personal communication, July 22, 2005):

> *I have empirical evidence...e.g., the 2003* Journal of Consulting and Clinical Psychology *paper and the 2003 ICTAB-10 conference, in which I reported that DARN talk category strength independently predicted commitment talk strength—without any evidence of multicollinearity. Also, in subsequent analyses, I have uncovered statistical support for a causal model linking DARN talk strength to behavioral outcome through commitment talk strength (as you suggest in your article). Interestingly, D and A talk—which are not intercorrelated—pass the Baron and Kenny test as mediated factors, whereas N and R do not (yet—with an N=84, more data are needed to come to final conclusion). My point is that at least D and A talk demonstrate independent influence on behavioral change through commitment using my client talk coding scheme.*

Others say that it is important for clinicians to be able to recognize these statements. We will leave the discussion here pending future "change talk" research.

Commitment Language

In their seminal study of commitment language, Amrhein and colleagues (2003) reported that the "strength" of DARN statements did not predict change. Rather it was the "strength of client commitment language, particularly toward the end of the MI session" that predicted outcomes (Amrhein, Miller, Yahne, et al., 2003, p. 872), with:

> *Commitment strength... influenced by the strength of its underlying dimensions...client desire, perceived ability or self-efficacy, need and reasons. (p. 873)* [2]

Two examples of commitment language from the MISC2 manual (Amrhein, Miller, Yahne, et al., 2003, p. 872) are:

- I *swear* I will stop this!
- Nothing is going to stop me this time!

How does "preparatory talk" influence commitment strength? One strong probability is the independent influence of desire on behavioral change through commitment language (P. Amrhein, personal communication, July 22, 2005). This is consistent with an emerging social-psychology literature that has found a strong influence of desires on intentions.

Bagozzi (1992) was the first to propose that desires provide the motivational impetus for intentions. Subsequent research supports that desire substantially mediates most of the effects of attitudes, subjective norms, perceived behavioral control, and other personal reasons for acting on intentions (Perugini & Bagozzi, 2004). So evoking desire statements that signal emotional rewards may be critical to motivating commitment language.

How important are "reasons" in influencing commitment? Reasons are the basis for attitudes and desires (Leone, Perugini & Ercolani, 1999). So how do "reasons" influence commitment? In a recent study, Holland, Verplanken and van Knippenberg (2003) found that:

> *...commitment...(was) influenced ...by having participants express their attitudes repeatedly.(p. 594)*

Their mediation analyses suggested, "...subjective commitment may be inferred from the ease of attitude retrieval" (p. 594). This means that clients may infer their commitment from how readily and often they retrieve reasons, and their strength, in response to MI questions.

One of Terri Moyers' graduate students has found that the frequency with which a client states reasons for change is predictive of outcome (T. Moyers, personal communication, July, 2005). You will recall that reasons are often given for desires (Leone, Perugini & Ercolani, 1999). Thus, best evidence suggests that evoking desires and reasons frequently may be primary to motivating commitment.

Would you be tempted to think, "Why can't we simply ask people to give us reasons for committing to a change, rather than engaging them in MI questions (see Side Bar)?" I can suggest three reasons why we should avoid this enticement. First, reactance (i.e., resistance) is likely, particularly if the question is perceived as a manipulation or persuasion attempt (Corbett, 2004a).

Second, a person may not be sure of reasons to commit. Why? Ambivalence. Frenk van Harreveld and colleagues (2004) found that people need time to come to an overall judgement because they have to go through the process of integrating *"incongruent* attributes" of the decision; that is the costs and benefits of change versus no action. Only then can they "generate or 'compute' their overall attitudinal response" (p. 442).

In an earlier column I noted that having reasons accessible in memory accounted for "55% of the variance in attitudes" (Westaby, 2002; p. 1098). Thus, it appears that having the opportunity to think and speak about the pros and cons of a decision is critical to knowing one's reasons for change. Once reasons are accessible, they account in large part for our attitudes. Thus, simply asking for reasons may be insufficient for change.

A third reason comes from marketing research. Sengupta and Fitzsimons (2000) found that think-

ing about reasons decreased the association between an attitude and behavior, *unless* reasons were analyzed *after* consumers were asked about their attitude. This makes sense if one considers a statement about what one believes as both an attitude and a commitment.

The foregoing suggests three hypotheses for future MI research to confirm. First, to be motivated, people need time to process ambivalence to make reasons for change clear. Second, that frequent evocation of desires and of reasons are separately related to intention. Third, following the expression of "commitment talk", asking a person about their reasons can lead to an increase in the frequency and strength of that language and, subsequently, to behavior change.

Practice Implications

In the May 2003 MINUET (renamed *MINT Bulletin* in 2005), Bill Miller suggested where we might get stuck in learning MI. The following is an adaptation of his list for working with "preparatory talk" and "commitment talk", based on research and practice reviewed in the three columns in this series:

1. Menschenbild. Help trainees remain open to MI by explaining the cross-disciplinary research supporting the philosophy and practice of MI. For example, show how the research by Amrhein and colleagues (2003) is helping us to understand the "causal chain" of change (Miller, 2001).

2. Communication Skills. Experienced clinicians may question the need for review and practice of empathy, and of reflecting and responding skills. Explain to them that their demonstration is not the terminal objective, but rather to be able to use them in a "directive" way to evoke a client's "preferred self", "preparatory talk" and "commitment talk".

   Examples of client statements that imply a "preferred self", which clinicians can evoke through additional questions, include:

   - I don't see myself that way.
   - How do I get them to see all the good things I do?
   - *Then* I realized what this said about me!

3. Recognizing Preparatory and Commitment Talk. Terri Moyers offers the following (T. Moyers, personal communication, February 07, 2005):

   I want clinicians to understand that they should look for change talk (really any kind of change talk) and respond to it, rather than trying to categorize it…[as] we do not have evidence that [DARN] differentially predict[s] anything, and there are not yet differential clinical responses depending on whether or not the client speaks about Desire or Ability or Reason or Need (although future research may clarify or change this). The clinical response … is the same no matter what flavor it is and the point is to move it forward to commitment language if possible since that (at least in one study) predicts behavior change.

   The MISC manual (Miller, Moyers, Ernst & Amrhein, 2003) can be useful for learning types of client language, even though in practice you will focus primarily on differentiating preparatory talk and commitment talk. I would recommend reading Paul Amrhein and colleagues' paper (2003) at least twice (I did to get all of the learnings).

4. Evoking and strengthening Preparatory and Commitment Talk. Once clinicians can recognize these two forms of client language, the next step is to be able to evoke and to reinforce that talk in the direction of change. Thus, I would recommend that trainees read (or review) the following sections or chapters from *MI2*:

   Change talk effects (p. 8-9)

   Change talk: self-motivating speech (p. 23-24)

   Change talk and resistance (p. 46-51)

   Eliciting change talk (p. 76-78)

   Methods for evoking change talk (p. 78-83)

   Responding to change talk (p. 85-97)

   Eliciting and strengthening confidence talk (p. 113-125)

   Discuss with them the more recent information in this article that may change some of what they have read. This includes evidence for the importance of evoking desires and reasons.

5. Collecting and throwing bouquets. Teach students to use OARS: (1) Open-ended questions, (2) Affirmations, (3) Reflective listening and (4) Summaries differentially, as these are the tools for working with client responses. In particular, affirming and summary statements are critical. I would recommend they read pages 65-76 in *MI2* for specifics.

   Propose that learners attend to and affirm a person's "preferred self/view", and integrate this self in summaries of "preparatory talk" and "commitment talk". Encourage them to reflect client responses to those summaries, and to affirm self-perceptions in the direction of change. For example, to the client's statement: "I don't see myself that way", one might respond, "You're surprised that others see you that way, and you want them to look at you the way you see yourself."

6. Rolling with resistance. Help trainees recognize and respond to counter-change talk using the same responding skills discussed in the pages of *MI2* that were recommended reading (above).

7. Transition to other therapeutic methods. Clients may need help in the Action phase. Perhaps a review of the research supporting how to move from commitment to Action would be a good topic for a future column?

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

Notes

[1] DARN is a configuration of "speech acts that when uttered, result in behavior change either in the speaker, listener, or both." Thid "is based on observations made by speech act theorists (e.g., [U.K. philosopher John L.] Austin, 1962; [American analytic philosopher John R.] Searle, 1969, 197[9], 1985) who have analyzed how language can change behavior when certain things are said by a person having certain intentions about the purpose of their utterances." (P. Amrhein, personal communication, July 12, 2004)

[2] This finding has parallels with Transtheoretical Model theory and research (TTM; commonly called the Stages of Change approach). TTM studies tell us that the benefits of change and self-efficacy increase as a person moves to the Preparation Stage. Once in Preparation, a person engages in a Process of Change called Self-Liberation (Commitment) to move to Action (see Prochaska, DiClemente, & Norcross, 1992, for detail on the ten "Processes of Change").

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Preparatory and commitment talk can be evoked with the following questions:

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)

MINT Forum 2005

Judith Carpenter and Jacki Hecht

The MINT Forum provides the opportunity to share and exchange ideas related to all aspects of MI training. This international meeting, to be held in Amsterdam, The Netherlands, from 1-3 September, offers participants the opportunity to keep abreast of state-of-the-art developments in MI training, as well as to be updated with the latest research within the MI field. The format of the meeting allows participants to consider numerous training options by exchanging training formats and exercises.

The agenda for this year's meeting is almost complete, with a range of opening exercises, presentations, and workshop sessions to allow participants plenty of opportunity to practice and discuss innovative ways that MI is being used. This year there are also scheduled networking opportunities built into the programme, a live symposium, and a panel discussion on the final day to draw the experiences of the Forum together.

Historically, one of the highlights of the MINT Forum has been the demonstration and sharing of training exercises. While each day will begin with an "energiser" exercise that aims to engage participants and highlight some core principle of MI, participants are also encouraged to share other types of training exercises during the breakout workshops, if appropriate. In addition, there are designated "networking" sessions immediately following lunch on Thursday and Friday that could be used to share additional training exercises, if the need and desire arises. So, if you are attending the Forum and would like to consider sharing a training exercise, please come prepared and we will find a time slot for you. If you prefer to discuss your ideas in advance, email Jacki Hecht at jhecht@lifespan.org.

As in previous years, the MINT Forum brings together trainers of all levels of experience to facilitate and participate in sessions, thereby creating an interactive, participant-driven meeting that has been a successful formula in years past.

The preliminary agenda for the Forum follows, and as last year, the proceedings will be written up for publication in the *MINT Bulletin*. MB

Amsterdam MINT Forum

1st-3rd September 2005 Preliminary Programme

Wednesday 31st August

Time	Programme
18:45 - 19:00 Foyer Koepelkerk	Arrival
19:00 - 22:00 Koepelkerk	Buffet together with TNT participants, TNT trainers, and MINT Forum participants
18:45 - 20:00 Foyer Koepelkerk	Registration MINT Forum

Thursday 1st September

Time	Programme
08.30 - 09.00 Foyer Koepelkerk	Registration, Morning tea/coffee
09.00 - 10.00	Welcome, Introductions Morning Energiser: *"People Bingo"* David Rosengren
10.00 - 11.00	Opening Address: *State of the Art & Science of MI* Bill Miller
11.00 - 11.15	COFFEE BREAK
11.15 - 12.30	Workshop 1 *Integrating the Internet with MI Training* Jacque Elder, W.C. (Dub) Wright
	Workshop 2 *Coaching & Feedback in MI* Denise Ernst
	Workshop 3 *Resistance and Coercion* Paul Delaney
12.30 - 13.30	LUNCH
13.30 - 14.30	NETWORKING
14.30 - 15.30	*The Progress of MINT* Steering Committee
15.30 - 15.45	TEA BREAK
15.45 - 17.00	Workshop 1 *Interventions to Impact the Whole System* Denise Ernst, Mary Velasquez
	Workshop 2 *Dose Training & MI* Pip Mason
	Workshop 3 *Rapid Communications: Ongoing MI Research* Jim McCambridge, Allan Zuckoff
18.00 - 20.00 Koepelkerk Quay	*Canal Boat Trip* Free tour around canals, river, and harbour

Friday 2nd September

Time	Programme
08.30 - 09.00	Morning tea/coffee
09.00 - 10.00	Welcome, Announcements Morning Energisers Majella Green Dub Wright Koepelkerk
10.00 - 11.00	*Asking, Listening and Instructing in the Service of Guiding: A Better Model for MI in Health and Social care?* Steve Rollnick
11.00 - 11.15	COFFEE BREAK
11.15 - 12.30	Workshop 1 *Making Ambivalence Complicated* Christina Nasholm, Tom Barth
	Workshop 2 *Motivational Interviewing: Training across Cultures in the Asia-Pacific Region* Suzanne Habib
	Workshop 3 *Implementation and Randomized Research in Swedish corrections 1. Everyday Con versations* (with Steve Rollnick) *2. Manualised MI* Carl Ake Farbring, Lars Forsberg
12.30 - 13.30	LUNCH
13.30 - 14.00	NETWORKING
14.00 - 15.30	MINT Bulletin Live Symposium *MI & Mandated Interventions* Harry Zerler, Allan Zuckoff, Claudia , Tom Barth, and the Symposium Panel
15.30 - 15.45	TEA BREAK
15.45 - 17.00	Workshop 1 *Positive Emotions in MI* Chris Wagner
	Workshop 2 *MI for Anxiety* Hiroaki Harai, Henny Westra
	Workshop 3 *Relapse Prevention / Learning from Relapse* Peter Prescott et al

Saturday 3rd September

Time	Programme
08.30 - 09.00	Morning tea/coffee
09.00 - 10.00	Welcome, Announcements Morning Energiser
10.00 - 11.00	*Integrating MI and CT* Peter Prescott
11.00 - 11.15	COFFEE BREAK
11.15 - 12.30	Workshop 1 *MI and Mandated Interventions* Harry Zerler, Allan Zuckoff
	Workshop 2 *Brief Intervention in General Practice: A National Project* Astri Brandell Eklund, Peter Wirbirg
	Workshop 3 *MI & Supervision* Brendan Murphy
12.30 - 13.30	LUNCH
13.30 - 15.00	PANEL DISCUSION
15.00	TEA BREAK
15.30	END OF FORUM

Steering Committee Update

Kathy Goumas
SC Chair

Well, where do I begin? Your busy MINT Steering Committee has been grappling with a number of interesting and complex ideas and opportunities to continue the development of a robust organisational structure that is 'fit' to sustain such a vibrant and dynamic group of MINTies.

Since our last update in May we have concentrated on developing a system to rotate new members on and off the SC. In going about this we wanted the SC to benefit from new and fresh voices to sustain rich and diverse perspectives found in this wonderful community. At the same time we wanted to maintain a level of consistency that would not destabilise the working momentum we have succeeded in achieving. We are delighted to inform you that we have been successful in engaging two new members who will begin their 3-year service in September: they are Christina Nasholm from Sweden and Michael Peltenburg from Switzerland. Full rotation will take place in January when Gary Rose and David Rosengren will step into the background and take the places of non-voting advisors for 1 year. I am sure you will all extend a warm welcome to Christina and Michael and a huge thank you to Gary and David for all the hard work and time they have generously given to MINT (although they still have not gotten completely off the hook yet!).

Our aim for the next rotation in a year's time is to have developed a system to open out the process for nominations from the MINT community. So send us any ideas on what you think would make for a fair and rewarding process and we will factor them into our deliberations.

We are nearing successful completion of our 2nd MINT dues collection process. This second cycle ran more smoothly than the last because you paid in a more streamlined manner—doing away with cumbersome paper cheques in different currencies and centralising all payments to one collection point (Rik in CMC) made all the difference.... thank you for helping us to test drive different methods. We will now be collecting dues on a 2-yearly basis (apart from those who join from MINT-endorsed TNT's in the intervening period), as you can appreciate this will cut down on the level of energy needed to administer this system and free the SC up to undertake other tasks

The highlight of the MINT year is almost upon us and we are all looking forward to meeting with friends in Amsterdam in September. The busy Forum planning team has put together an impressive programme and excitement is building with over 65 MINTies fully registered at the time of this writing, and more confirming their registrations on a regular basis.

The TNT has received phenomenal interest and we have 83 eager and interesting participants who will be attending the two workshops in August. As usual there was over-subscription to this event and a waiting list of approved participants has been compiled.

Your hard working SC has also been getting on with planning the 2006 and 2007 TNT's/Forum's by discussing locations and the possibility of having a regular time slot in the year, so keep looking out for news of these decisions.

CMC has done a fantastic job on behalf of the SC administrating both the TNT and Forum meeting, and I am sure you will all agree that the transition from the hard work of Delilah and DeeAnn at the University of New Mexico (past administrative hub for these events) has been relatively painless. This is a major achievement for the SC as there was *just a little anxiety* around how these events may be impacted by two significant changes - Bill and Steve not leading the training in the TNT and UNM not leading on the management of the event. Our fears have been unwarranted and we feel the interest and smooth planning are good indicators that MINT is becoming a healthy, independent and strong community in itself.

This leads me to the importance of thinking about the future of MINT. The SC will be leading a discussion at the Forum on this topic and we thought it would be useful to summarise some of the 'trends' we are noticing:

- Over the next 12-18 months we have four European TNT's (three of which are in languages other than English), an American TNT, and a South African TNT.
- North American voting representation on the SC is being reduced from four to two of the six voting places and three of the voting members have primary languages other than English. Next year we will replace two other SC members possibly by election rather than selection.
- There are now two non-English MINT-related listservs and more on the way. Also there are two primary sites (.org and .nl) and further collective MI sites in Italian, Swiss and South African (English speaking).

With such a wonderful globalisation of MINT occurring, now might be a good time to take a step back and discuss what this means to us as a community!

Finally, a quick run-down of other ongoing work (including some that's not going anywhere fast!) - the issue of certification is at a standstill, opportunities to enter MINT from TNT's not endorsed by MINT is under the discussion, and the establishment of a budget is a priority for our next year's work.

With such challenges ahead I look forward to continuing to chair the SC through to October when it will then rotate to Chris Wagner.

Look forward to seeing you in Amsterdam for the best meeting yet! MB

Obesity
Another Perspective and Practice Suggestions

Susan Butterworth & Shawn Jeffries

Another Perspective

Susan Butterworth

After practicing in the health promotion field for 20 years, obesity is a hot button for me, but not in the way that you might think. Healthcare practitioners and researchers all around me are beating the drum about the epidemic of obesity and treating it as a chronic disease. Employers and insurance carriers bandy about talk of the possibility of higher premiums for those whose BMI is too high. Nursing and medical school faculty teach their students to assess risk based on weight or appearance alone. Health coaches work diligently with clients on the primary goal of weight loss. Yet there's no rhythm in this beat for me.

There is certainly overwhelming evidence that obesity is correlated with many undesirable conditions and diseases. It can directly cause disability, hardship and emotional distress—all quality of life issues. However, most of the studies around obesity haven't controlled for confounding variables such as fitness, dietary variables, weight fluctuation and medications. In addition, there is quite a bit of evidence that dieting is usually ineffectual and psychologically damaging. There are multiple studies that have demonstrated that chronic disease management can be improved by changing lifestyle habits such as exercise and diet, without any change in BMI. And, lastly, there is also evidence that one can be fat and healthy.

A group of researchers from the CDC just published an article in JAMA that reluctantly makes the case that the ill effects of overweight and mild obesity have been overstated. (Flegal et al., 2005). The researchers did not find overweight (BMI 25 to <30) to be associated with increased mortality in any of the three NHANES surveys. *(NOTE: This body of research was largely responsible for the recommendation that BMI levels remain <25.)* In addition, underweight was associated with an increased relative risk. As a result of the article, there have been a flurry of attacks on the methodology (individuals with wasting diseases were not excluded) and conclusions of the study, and the CDC is quickly back-pedaling on the importance of the study. Julie Gerberding, chief of CDC, stated in a recent press release: "It is not OK to be overweight. People need to be fit; they need to have a healthy diet; they need to exercise." I agree that we need more tightly controlled research on the subject, but her comments disturb me greatly. Not only is her statement laden with judgment, but she makes the erroneous and biased assumption that folks who are overweight don't exercise and don't eat healthily.

Traditional approaches to treatment begin with the assumption that, of course, clients want to/should lose weight. Without regard to clinical values, it's all too easy to assume that their fatness is a risk factor. As mentioned above, it's common to assume that if a client is overweight, he/she must be unfit and surely eats too much. Our biases do affect the direction in which we take our clients. Especially among white middle to upper class women, disordered eating and skewed body image is not uncommon due to obsession with body weight and constant dieting. As health coaches, we can unknowingly contribute to these unhealthy and unfruitful practices if we buy into the myths that thinness equals happiness, success and health, and that fatness equals unhappiness, shame, failure and disease.

It's important to pause here and acknowledge that: (a) some clients come to us to lose weight and, quite clearly, weight loss would greatly improve their health; and (b) many clients come to us who want to lose weight for aesthetic reasons and aren't ready to give up their dream. In these cases, the client's agenda is clear and it would not be client-centered, effective or ethical to persuade them away from weight loss. However, I do feel it's important to elicit all the reasons that weight loss is important and help them to identify behaviors that they can actually control. In other words, weight loss may be the 'umbrella' goal, but walking, eating more plant-based foods, watching portion sizes and developing better coping skills may be the primary goals towards which I can guide their focus and energy. Other outcomes besides weight can be easily drawn out, such as better sleep, more energy, feeling better about self. So regardless of what the scale says at the end of a week, or a month, or a year, the client has a much better chance of seeing progress and improving mental and physical health.

Obesity may be a chronic condition for some, but it's not a disease in and of itself, and shouldn't be treated as one. To assume something about one's lifestyle based on appearance is faulty, biased and can cause harm. So, while acknowledging that obesity is a risk factor for some and troublesome for many, I think my colleagues who endorse, research and write about the Health At Every Size movement have something important to share with the mainstream. (HAES is a quarterly periodical co-edited by Jon Robison, PhD, MS and Wayne C. Miller, PhD that is devoted to helping health professionals understand and practice a compassionate and effective approach to resolving weight and eating-related concerns. Go to www.gurze.com for more information.)

In the next section, Shawn Jeffries will give a recap of the important work he and his staff are doing with clients who present with the condition of obesity. Shawn will suggest some ways that practitioners may prepare for working with clients around weight management issues and how MI techniques may be modified to both prevent harm to and enhance effectiveness for these clients.

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Practice Suggestions

Shawn Jeffries

One of my primary research interests over the past three to four years has been the integration of Motivational Interviewing into research settings with a focus on public health issues, such as smoking cessation, fruit and vegetable consumption, and, most recently, obesity. Our current project (known as Kansas Primary Care Weighs In, or KPCWI) is a telephone-based MI intervention for obesity in rural Kansan primary care patients. KPCWI is a small pilot clinical trial funded by the American Heart Association (75 active participants, 75 control participants) who receive 9 MI interviews over a 12-month period in addition to health education materials, food/physical activity monitoring forms, and a pedometer. Participants receive bi-weekly sessions for 3 months (totaling 6 sessions) and then receive one remaining follow-up session every three months until the 12-month study period is concluded.

The dilemma for us in designing this project has been that obesity is not a behavior, but rather a condition defined by one's BMI score (> 30). This particular study examines obese participants, so overweight participants (BMI > 25 - 29) have been excluded. In addition, the prime goal of this study is for participants to lose 10% of their body weight, as suggested by current NIH recommendations. As a way to capture the multi-component nature of treatment for obesity, we have divided our MI "scripts" into three different categories: an "introductory weight loss" script, a "physical activity" script and a "dietary behaviors" script. The introductory script focuses on the person's initial motivation and confidence to lose weight as a part of this program. The purpose of this initial script is to build rapport with the participant, and to identify major motivators and barriers the participant might be facing.

The physical activity script focuses on three categories of regular physical activity: vigorous activities, moderate activities, and walking. As many of our participants are likely to have physical mobility limitations, we are not setting structured "exercise" as a goal, but rather introducing the various categories of physical activity mentioned above. The dietary behaviors script focuses on consumption of high-fat foods, foods with empty calories, fruit and vegetable consumption, restaurant/fast food eating, calorie counting/portion sizing, sugary beverage consumption, and water intake. Clearly, our counselors will not be going into great depth with any one subject due to the large amount of content, but these are the subjects that counselors attempt to cover over the year study period.

All scripts include a discussion of the health education materials, assessment of the particular behavior of interest, and motivation and confidence. We also train counselors to go through a decisional balance discussion, and then have a section devoted to "values clarification" or intrinsic motivators. We do a global summary, and then allow the participant to set his or her own goals regarding the behaviors that were the subject of the call.

One interesting component of this study is the addition of a behavioral action plan, or BAP. The counselor begins by eliciting strategies that the participant may have already in place to increase, for example, their physical activity. If a participant's strategy is vague or the participant is at a loss as to where to begin, the benefits of the BAP are to integrate cognitive behavioral strategies when requested by the participant. We have trained our counselors to continue to express egalitarianism through this section of the intervention and integrate participant choice at every step. We have integrated many of the techniques described in Kelly Brownell's LEARN program for weight management (Brownell, 2004) as potential options for action steps to achieve the client's goals.

Another dilemma we have faced in designing this intervention is how to divide and direct the focus on each behavior (physical activity versus dietary behaviors). A literature review indicates that dietary change is the initial critical factor in losing weight, and that physical activity is more important for weight loss maintenance. Therefore, we have installed a "yolking" procedure to allow for participant choice on topic in every other session, while differentially weighting the number of calls they receive in favor of the dietary change behaviors. Thus, participants will get 5-6 calls on dietary behaviors and 2-3 calls on PA. This is of course flexible, based on participant preference, but the intended ratio is 2:1 in favor of dietary behaviors.

As Susan mentioned above, it is very important to integrate the concept of intrinsic motivation into MI. Therefore, we have a specialized section called the Values Clarification section that asks participants to identify those values in life that they find to be most important. We then try to link the behavior of interest (weight loss in general, or, more specifically, physical activity and a number of dietary behaviors) to this value. If unable to do this, we prompt participants to identify how being more physically active (for example) is related to the values they chose. In the end, if they still cannot make the connection, we ask how losing their health may be related to their ability to live out the values they find to be most important.

I hope this has been a helpful source of input on how our team has attempted to integrate MI with the complicated condition of obesity into a research-related context. I welcome input and suggestions from readers.

References

Brownell, K. (2004). *The LEARN manual for weight control.* Dallas, TX: American Health Publishing Company.

Final Note

It may seem that the philosophies we have expressed regarding working with obese clients are in some ways inconsistent with each other—and there is some truth to this perception. However, in our concrete approach to working with an obese client around the issue of weight loss, we are much more similar than it might appear. Shawn's participants are obese, rather than simply overweight, and the 10% weight loss goal is moderate and realistic. His program primarily focuses on behaviors that can be controlled and will lead to better health. Finally, he works to understand the client's values and to incorporate them into the sessions. Susan's views on the issue of obesity are, admittedly, atypical as compared with most practitioners'. Yet, as we compared notes and noted some differences in our ideas and in the strategies we use, what kept emerging in our conversation was a shared outlook: profound respect for the client's wishes, a non-judgmental stance towards obesity, and the passion to apply MI techniques. MB

Motivational Interviewing with Illicit Drug Owners
An Effectiveness Study

V. Quercia, G.P. Guelfi, M. Scaglia, & V. Spiller

Introduction

According to Italian legislation, owning small amounts of illegal substances for personal use is punished by administrative penalties (suspension of driver's licence or passport for 2 months).

The violators—mostly adolescents and young adults, average age 23, caught by the police with small amounts of illegal substances (80% with hashish or marijuana)—are summoned by the Government Territorial Offices (UTG) for an interview with a social worker, who decides whether to refer them to the SER.T. (*Public Addiction Treatment Units*) for treatment, or to apply the administrative penalties.

For a first violation involving substances in Schedule 2 (cannabis), the violator can simply be warned about the risks of using drugs, without applying any other penalty.

According to Italian law, the goals of the interview in the UTG are:

- to provide information
- to give support in thinking about one's situation
- to help people consider the need for change.

It's quite obvious that achieving these objectives just in one interview, under coercion and, therefore, generally with an opposing and contrasting attitude, and dominated by the perception that the UTG operator is a government "agent" assigned to control and punish, is an extremely difficult and highly unfeasible goal.

Background

A group of social workers from 8 Italian UTGs, attended a 40-hour Motivational Interviewing (MI) training course. This elicited interest in using MI techniques during the interview, and in verifying the effectiveness of such techniques during the interview with the violators summoned to the UTG. In fact, to determine if the MI could help to improve the efficiency of the interview at the Prefecture, it was decided to carry out a study based on such an objective. The purpose of the study was to compare the use of MI with the standard interview techniques.

Designing the Study

In designing this study, we assumed that the possibility of achieving such specific goals would be enhanced within *empathetic* relationships and impaired within *confrontational* relationships (Miller and Rollnick, 2003). We also theorised that in-depth MI training might have a significant influence on modifying, in an "empathetic" sense, the characteristics of the interview.

To explore this aspect we decided to evaluate the subject's perception of being *listened to, understood* and *helped* (*empathetic*), as well as the perception of being *blamed, controlled and judged* (referred to as confrontational). We refer to these six aspects of the relationship as *interactional attitudes.*

The experimental hypothesis of the study was that violators summoned to the Prefectures would have a perception of receiving more information, being more supported in thinking about their own situation, and in considering the need for change if they were interviewed using a style that was more oriented toward listening, understanding and helping (*empathetic-motivational style*) rather than one through which they would be blamed, judged and controlled (*confrontational style*).

Aim

The aim of this study was (1) to verify if what we consider a motivational interview style is actually perceived by the subjects as more efficient in order to achieve the goals of the interview, (2) to verify the differences, if any, in the interview style between the group of workers who took the motivational interviewing training course and the group of workers who did not, i.e. that the interview should have been more *motivational* in the first group, and more *confrontational* in the second or control one, and (3) to quantify the differences, if any, between the perceptions about the interview in the subset of subjects interviewed by the first group and the subset interviewed by the control group.

Methods

Training. The study was designed based on several preparation phases, the first of which was the training of social workers in the experimental group. Each meeting was held by a pair of trainers from the didactic team consisting of Gian Paolo Guelfi, Valter Spiller and Maurizio Scaglia.

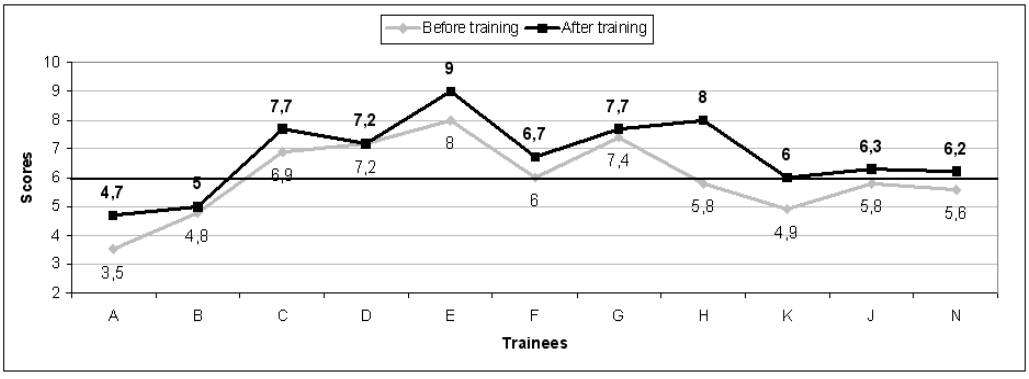
Eleven professionals, after a 40-hour Motivational Interviewing (MI) training course, underwent intensive case supervision for eight months for a total of 112 hours and was considered to be the *experimental group.* In the same agencies, the remaining social workers were considered as the *control group.*

During the first meeting, MI skills were assessed by administering a questionnaire (*Eight Situations questionnaire - Form A*) to be evaluated by the trainers. In this way, each trainee would have his/her own "initial personal skill score" on a scale of 0 to 10.

During the last meeting the trainees were again requested to fill out a new "eight situation questionnaire" (*Form B*). The outcome was a significant increase (t=4.49; p .001) in the trainees' MI skills (Fig. 1)

Design of the study. The experimental protocol included the random assignment to the experimental group or to the control group of all

Fig. 1. Evaluation of MI skills before and after training ("Eight Situation" questionnaire)



the violators summoned to the UTG of the Prefectures in the first six months of 2001. After giving informed consent, the subjects were requested to fill out a questionnaire prior to the interview, designed to explore their expectations. Afterwards, the subjects were requested to fill out another questionnaire designed to explore the outcome of the interview.

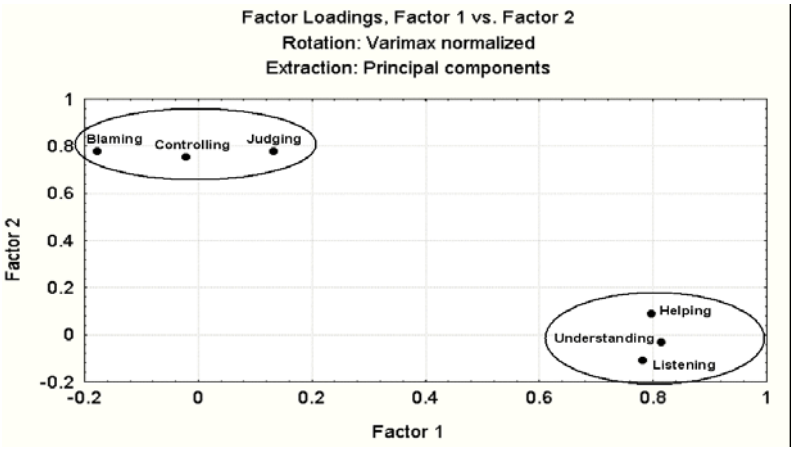
In greater detail, the purpose of the first questionnaire was to determine how much the person was expecting to be *listened to, understood, helped, judged, blamed and controlled*. The second section of the questionnaire was used to rate *the expectation of receiving information, to be helped in thinking about one's own condition*, and *to consider the need to change behaviour.*

The purpose of the second questionnaire was to evaluate the same aspects *after* completing the interview.

Results

The analysis performed on the entire sample for the *interactional attitudes* showed two different and well-defined styles. Factor analysis (Varimax normalized) shows one factor including *listening, understanding* and *helping* and another factor including *blaming, controlling* and *judging.* This confirms the clear perception of two different attitudes in conducting the interview (fig. 2). In this study we defined *empathetic* as the interactional style that makes the subjects feel more *listened*

Fig. 2 Plot of factor analysis: interactional attitude.



to, understood and *helped*. Conversely, we defined *confrontational* as the interactional style that makes the subjects feel more *blamed, controlled* and *judged*.

In order to explore which of the two styles is more consistent with the *goals* of the interview, we added them in the factorial model shown above, and found that they strongly aggregate with Factor one (empathetic style). The study of association (multiple regression) between *styles* and *goals* showed a very strong correlation between *empathetic style* and *goals* ($p<.0001$). The correlation between *confrontational* style and *goals* is either not statistically significant (Information, Change) or, though significant, weaker (Think about; $p<.05$). These results confirm that an empathetic style is consistent with achieving the goals of the interview, as defined by Italian law (fig. 3).

This point suggests that the MI training may have enhanced the interactional attitudes that are characteristic of the empathetic style and decreased the confrontational components of the social workers.

Outcome. The analysis of the outcome, considering the *goals*, shows no difference in the *expectations* between the two groups, and statistically significant differences in two out of three variables in the *outcome*: the interview in the experimental group significantly increased the perceived help in considering the subjects' condition, as well as the perception of the need to change behaviour, even within a trend in which less information was provided.

This point suggests that MI training may have increased the efficacy of the experimental group in attaining the specifics goals of the interview, as defined by Italian law.

Conclusion

In this study, the possibility of training a group of professionals to develop an empathetic-motivational type of relationship to achieve the legally-established objectives for conducting an interview in the UTG emerged in an original and satisfactory manner. It was demonstrated that a group of professionals with initial MI training can be helped to significantly improve their capabilities, especially through training that focuses on direct supervision of the practical application of skills, i.e. by role-playing real-life situations and professional cases. An important part of this process was found to be the evaluation of trainers and self-evaluation. A large part of the social workers involved in the training process significantly improved their M.I. skills, as indicated by the difference in the before and after point totals (Fig. 1).

It was also noted that an increase in work skills with regard to motivation involves a significant improvement in the quality of the relationship. This evaluation was obtained directly from the subjects summoned to the UTGs who were analysed during the study. It's interesting to note that such an improvement takes place even though the satisfaction levels indicated by subjects analysed by social workers in the control group, although significantly lower than those expressed by subjects examined by the social workers in the experimental group, still indicate an overall outcome evaluation that exceeds initial expectations.

Finally, it was observed that improvements deriving from the training of the social workers are associated to a clear increase in the feeling of the subject examined of being helped to think about his/her situation, and to be stimulated toward a change, i.e. in two out of three of the objectives established by Italian law, even without receiving a greater amount of information.

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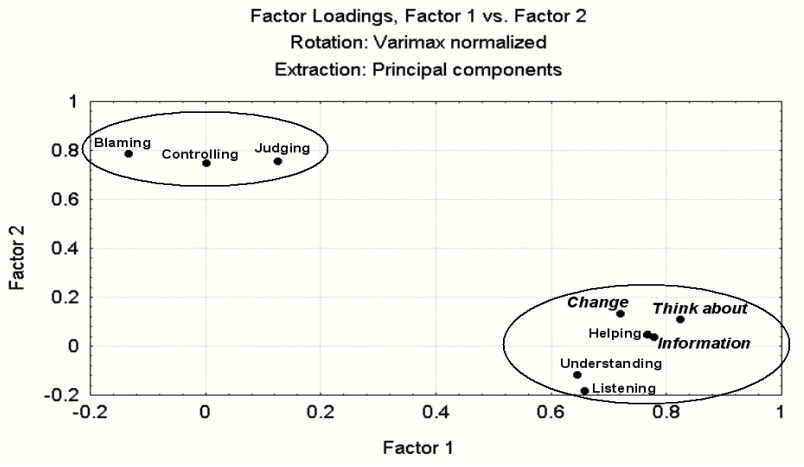
Fig. 3 Plot of factor analysis: interactional attitude.



Training Coders to Use the Motivational Interviewing Treatment Integrity Coding System

Rosemary Breger, Carol DeFrancesco, & Diane Elliot

Understanding the content and fidelity of MI delivery in research settings can help answer questions about intervention efficacy in relation to outcomes. Protocols are used to describe intervention methods, but unless we have a way of directly observing the study interactions, we don't really know what happens or what it is about the interactions that is helpful for people.

Although coding is not direct observation, in the task of accurately placing verbal utterances in a predetermined set of behaviors, we have a window to observe and assess fidelity to MI and relate that fidelity and other characteristics of the interactions to outcomes.

The purpose of this article is to describe a collaborative research project that set out to answer these questions through coding audiotaped research MI sessions. Specifically, we will describe the coding system used, how coders were trained, and how reliability was established.

BCC MI Work Group Coding Project and Funding

The Behavior Change Consortium (BCC) was comprised of 15 NIH-funded investigations, each examining new models of behavior change. Seven projects included MI in their interventions, and individuals from five of those sites and representatives from the NIH formed an MI Work Group to share experiences, interventions, and assessment methods (Hecht et al., 2005). One of these sites used a Self Determination* intervention, but was included because of its similarities to MI. The sites included the Harvard School of Public Health (Peterson et al., 2002), Emory University (Resnicow et al., 2002), University of Rochester* (Williams et al., 2002), Miriam Hospital/Brown University (Borrelli et al., 2002), and Oregon Health & Science University (Moe et al, 2002). The behaviors targeted with the MI interventions included servings of fruits and vegetables each day (Harvard, Emory, Oregon) and smoking cessation (Rochester, Brown).

The unique opportunity to share methods and findings, along with the investigators' willingness to pool their data, led to supplemental funds through the National Institute of Child Health and Human Development, National Cancer Institute, and Texas A&M Research Foundation to code and analyze a sample of intervention tapes from the five sites. The Work Group members agreed on an experimental protocol and sampling strategy, and applied that to identify tapes from 10 subjects who achieved change and tapes from 10 non-changers. The objectives included comparing MI fidelity across sites and examining the MI process across sites when 'successful' and 'not successful.' Tapes were identified using data collected over 12 months, and in addition to the change criteria, were selected to obtain a spectrum of counselors, time periods and stages of change.

MITI Coding System

There were three MI coding systems to consider. The first system, The Motivational Interviewing Skill Code (MISC), has 15 categories of counselor behavior codes, 6 counselor globals, 4 client globals, 2 interaction globals, and measures client and counselor talk time (Miller, 2000). A global score requires the coder to assign a single number from a seven-point scale to characterize the entire interaction. These scores are meant to capture the rater's global impression or overall judgment about the dimension. Global ratings are done after the first listen so that the coder can maintain a more holistic perspective of the interaction and won't get influenced by the specifics of the behavior counts. The MISC codes client utterances into 4 categories (ask, change talk, resistance and neutral). The second coding system is the revised MISC 2.0, which employs a more detailed categorization of types and strength of client change talk and rates 3 counselor globals and 1 client global (Miller, Moyers, Ernst, & Amrhein, 2003). Both the MISC and MISC 2.0 require listening and coding the interaction 2-3 times and would require a great deal of training to get coders to reliability.

The third MI coding system is the Motivational Interviewing Treatment Integrity (MITI) code (Moyers, Martin, Manuel, & Miller, 2003) which was developed as a shortened version of the MISC to measure fidelity to MI. The MITI has two components: global scores and counts of specific counselor utterances. Two global counselor dimensions, empathy (understanding of client's perspective) and MI spirit (evocation, collaboration and autonomy), are assessed. Counselor utterances are classified into one of 7 mutually exclusive categories (Table 1).

The MISC and MITI are designed to answer different questions. The MISC gathers information to help understand the mechanisms by which MI works, and captures both counselor and client behaviors as well as ratings of the interaction. The MITI captures only counselor behaviors and measures the fidelity of the interaction to motivational interviewing. It can be helpful in evaluating counselor skills and also determining the overall fidelity of a research intervention (Moyers, Martin, Manuel, & Miller, 2003).

Because the MITI had fewer codes to achieve reliability on and it would accomplish the aim of the

Table 1. MITI Behavioral Utterance Codes

Giving Information
MI Adherent
MI Non-Adherent
Open Question
Closed Question
Simple Reflection
Complex Reflection

project, which was to determine fidelity and relate fidelity to behavioral outcomes, we chose the MITI coding system. It was also an opportunity to test a new coding system. Because we also wanted to capture a client rating, we included the client Self Exploration global rating used in the MISC 2.0. Self exploration is the degree to which clients engage in discussion and discover new perspectives or insights regarding their health behaviors (Miller, Moyers, Ernst, & Amrhein, 2003).

Initial Training

Training began in November 2003 for six coders at OHSU. The coders were Research Assistants in the Division of Health Promotion and Sports Medicine at OHSU. Two of the coders were MINT trainers and had 4+ years experience with MI coding. Four of the six coders had some coding experience from a previous project using the MISC. Two coders were new to MI and coding. The latter individuals read from Motivational Interviewing (Miller & Rollnick, 2002), watched the MI training tapes from University of New Mexico, and attended a two-hour presentation to familiarize themselves with the spirit and principles of MI. Denise Ernst, at UNM, facilitated the training through emails and conference calls.

Each coder read through the MITI manual. We began training on expertly coded tapes from UNM, using the Rounder and Ponytail segments from the MI videotapes along with transcripts. We first practiced identifying how an interaction segments into utterances and volleys, and then applied such higher-level codes as questions and giving information to these utterances. We then added simple and complex reflections, followed by MI adherent and MI non-adherent utterances. Then we listened to tapes for global ratings of empathy, spirit, and self-exploration. We did coding as a group, stopping the tape at 5-minute points for discussion, and then moved to longer stopping points and then finally 20-minute stopping points. Once we felt comfortable with global ratings, we practiced coding tapes with behavioral utterances and globals in one pass.

All six coders completed the training. Coders received 40 hours of training over 13 weeks. Training meetings did not exceed 2 hours per meeting and coders were not to code for more than 4 hours each day to prevent fatigue. During group coding sessions, we generally seemed to easily reach consensus on codes and had a good grasp on the definitions. We did have some challenges differentiating between simple and complex reflections. After additional consultation with Denise Ernst and more group discussions, we felt ready to test our reliability.

Establishing Reliability

To centrally code tapes from five separate sites, we developed a protocol to train and measure reliability for each site. Activities included:

- Review MITI
- Code 2 tapes with transcript as a group (compare against expert codes if available
- Code two tapes with transcript as a group (compare against expert codes if available)
- Code one tape without transcript as a group
- Code one tape without transcript individually, debrief as group
- Review codes / exp of coding tape individually and decide if we need to do more
- Code 5 segments for reliability individually
- Meet as group to review scores and notes from reliability tapes, determine if we need more training or not
- Code study tapes for analysis

Each of the five study sites was unique in its subject population and the settings for MI (Table 2). Accordingly, each site provided additional tapes, which coders would train on, to allow the group to become familiar with any unique aspects, such as study protocol, home environments with noises in the background, phone interactions, giving information as part of protocols, and smoking vs. fruits and vegetable intake. Sometimes we had to remind ourselves how to break utterances for the specific codes. In addition, each site supplied five additional tapes, which were used to establish reliability for that site.

To measure reliability, we created a digital recording of 20-minute segments from each of 5 sessions. Each coder independently coded the 5 interactions in random order, and we created a correlation matrix for each coding dimension. The correlations were used to calculate an internal consistency reliability coefficient. In general, coders were reliable and achieved coefficients of 0.8 or greater for all dimensions at each site; there were no recurrent difficulties with either coder or category.

While we established our coders' internal consistency, we did not have an external 'gold standard' to document accuracy. So we sent a set of five reliability sessions that were coded by all six reviewers to University of New Mexico to be coded by one of their staff coders. Adding that coder into the reliability matrix did not lower the internal consistency, suggesting all coders were applying similar criteria.

Site Coding

After we established reliability for

Table 2. Attributes of Study Sites

	Brown	Emory	Harvard	Oregon	Rochester*
Outcome	Smoking	F & V	F & V	F & V	Smoking
Subjects	Parents of Asthmatic Children	African-American Adults	WIC Mothers	Firefighters	Adult Smokers
Modality	In person	Phone	In person, phone	In person, phone	In person, phone
N	20	20	38	20	20
Total Interactions	37	39	59	83	73
Average Duration (minutes)	17.4 (3-35)	20 (8-37)	31 (5-92)	33.8 (2-85)	44.4 (12-89)

each site, equal numbers of tapes were randomly assigned to each coder. To facilitate entering coding results into a database, we developed a scannable form with the coding categories and an area to record notes that would help in debriefing any questionable codes. Tapes varied in length from 2 to 92 minutes. We coded interactions in 20 minute segments and recorded both global ratings and sum of behavior counts for each segment, which will allow us to compare segments within an interaction or opening segments across tapes. To avoid drift in reliability, we coded a site's tapes over two weeks. In the unusual occasion that a problem was encountered, we used email to discuss or make a decision. Coders worked in a quiet place without distractions, avoided double tasking, and limited coding to a maximum of four hours a day. Although coders sometimes stopped to consider how to categorize an utterance or make a note, for consistency of methods among listeners coders were discouraged from replaying. In general, it took 30 minutes to code a 20-minute tape. We coded a total of 281 taped interactions, with a total of 9064 minutes, from the five sites over five months.

Next Steps

Data from this coding project is currently being analyzed. In the near future, we will be able to report fidelity of MI across research sites and be able to look at differences in relation to delivery methods. Initial findings, including a factor analysis of the codes, were reported at the MINT Forum in Portland, Maine and were summarized in *MINT Bulletin* 12.1 (DeFrancesco & Ernst, 2005).

If you are considering incorporating coding into your practice or clinical trial, or simply thinking about trying it out, we recommend obtaining high quality recordings of sessions. Digital recordings have high sound quality and are easy to back up and reproduce for coding.

The MITI was a coding tool that, with time and training support, we were able to use reliably and efficiently. We would use it again as a way to measure fidelity to the MI principles. However, if interested in looking into the workings of MI, a more detailed coding system that also captures the client's behaviors is also needed. Listening to the process of two people working together towards change and discovering new insights is always enlightening to our work as coders, trainers and counselors. To read additional reflections on this coding experience please see *MINT Bulletin* 11.3 (DeFrancesco & Breger, 2004).

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Note

* The Rochester site's intervention was based on the Self Determination model.

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Passionate Peacemaking

Mediation and Motivational Interviewing

Carolina Yahne and Kathleen Jackson

Both of the authors are trained mediators as well as motivational interviewers. We've frequently noticed similarities in the two approaches. This essay is about our observations, with the hope they will be useful to our fellow and sister MINTIES. We'll begin with two vignettes we experienced in our work.

Kathy's Example

I was co-mediating a session with disputants who called themselves "tough girls". Both women had expressed their view of the situation and they were beginning to "discuss" their different perspectives. To my ears, their discussion was becoming too angry and hostile to be appropriate for mediation. I started to suggest a break in the process so that my co-mediator and I could meet separately with the disputants to try to help diffuse the hostility. As I made this suggestion, my co-mediator verbally disagreed (modeling the normalcy of disagreeing and of us, as mediators, not being experts). We decided to ask the disputants whether they felt uncomfortable with the "volume and tone" of the discussion; they both said "We're doing great!" They were comfortable with how the conversation was going and wanted to continue the mediation. Without too much more time passing, they reached a resolution. As my co-mediator and I debriefed this mediation, we realized that my discomfort represented my background, upbringing and experience with anger being expressed in the "tough girl way." Yet, if I had imposed my way of disagreeing and problem solving, the disputants would not have owned the process or the resolution that they reached.

Carolina's Example

I was faced with an angry research participant who had volunteered for another study at CASAA. He arrived at lunchtime furious that he had not been paid his $5 for completing a questionnaire. I did my best to reflect: "You are angry because you kept your part of the agreement, and it feels like the CASAA staff has failed to keep our part. Let me make some phone calls right now to see if we can sort this out". His angry shouting was intimidating, especially because he was huge and all the other staff had left over the noon hour. Yet when his point was reflected back to him, he calmed down fairly quickly. He said he had wanted to buy lunch. He was hungry. My brown bag lunch was sitting on my desk. I offered to share it with him. When I pulled out the contents of the sack and he saw what I had packed, he said "I don't want no raisins!" But he said it laughing in a friendly way at my pitiful meal. His anger was diminishing and we were soon able to get him his payment for the study. I felt that MI had helped me get past feeling intimidated and had created the collaborative tone that diffused the situation.

Discussion

Angry behavior from patients and disputants challenges us to use our best skills. Both mediation and MI approaches can serve to de-escalate anger. Project MATCH results indicated that MI was especially helpful with angry drinkers. Those outpatients with high levels of anger who received Motivational Enhancement Therapy reported drinking less at follow-up than those who received Cognitive Behavior Therapy. Disputing parties have reported that they feel less angry following a mediation session. As readers of this MINT Bulletin, you have probably noted how your own reflecting and "rolling with resistance" during a MI session can calm participants.

The definitions of MI and mediation overlap in important ways. MI is defined as a client-centered, yet directive method for evoking intrinsic motivation to change by exploring and resolving ambivalence. The MI approach is collaborative and respects the autonomy of the client. Mediation facilitates the disputing parties' discussion of the conflict. The parties retain autonomous decision-making power about how they resolve their dispute. The discussion is focused on non-adversarial problem-solving to evoke their collaboration. Thus, the common threads in the definitions are exploration, collaboration, autonomy, and respect.

We've noted direct parallels between "OARS" skills and mediation skills. Both employ open questions. What MI'ers call affirming, mediators call acknowledging. Reflecting is named clarifying, and both methods summarize. The deep listening employed by both methods helps to melt anger as participants feel heard and understood.

We see MI and mediation as complementary forms of passionate peacemaking that facilitate expression of affect with the goal of seeking meaning. When the deeper meaning is clarified, anger, "resistance", and other forms of negativity diminish. A motto in mediation is "Go for the interests (values), not the positions". Similarly in MI, we seek the meaning, not just the words. That is why complex reflections (paraphrases and summaries) are more effective at deepening the dialogue than simple reflections (repeats and rephrases). MI and mediation are passionate because we don't attempt to squelch anger or other affect; rather, participants are given an arena in which to clarify such feelings. The MI and mediation approaches are ways of waging peace, because they involve negotiation seasoned with diplomacy and respect. MB

Staying Fresh with Long Term Clients

Cathy Cole, LCSW

I am often asked how Motivational Interviewing fits in psychotherapy with potential long term clients. I'll offer an answer in response to two prompts, one said to me and the other said by me to me. This was said to me by a colleague: 'I think I explore ambivalence too long'. This is what I said to me: 'How did I paint myself into this corner?'

Both of us are mental health clinicians working with clients who have long standing histories of difficulty managing problematic behaviors that stem from trauma. Often management of distress takes the form of just digging in to cope as best as possible with little desire of finding a new way. We have many treatments available that we know help. Therein lies a dilemma. Anxiety about the future for clients if they don't tackle what we think is best is what seems to cloud my view the quickest, getting me right off track in using MI.

How does the difficulty in using MI come into play? When I asked my colleague what she meant, her response was that maybe she just ends up trying too hard/ too long and not hearing that the client really is not interested in, ready for, or capable of doing more. She ends up pressing, the client ends up retreating / defending, and she gets discouraged, begins to wonder if she is really a good clinician. Now how can that happen when she is just trying to explore ambivalence? It makes perfect sense when we go back to the most important part of making a change: the necessity of discrepancy between how it is now and what the client desires to be different. Try as we might with all those great methods we have, sometimes what WE think should happen is nowhere close to what the CLIENT wants. Reluctance for change is frequently embedded in fear of what change would mean or belief in the ability to make change.

So what should a clinician do in this situation? Of course, we want our clients to lead safer, fuller lives. In my thinking, this is where thoughtful, caring feedback comes into play, coupled with a way to 'roll with resistance' (it is resistance we have likely created in pressing our agenda). It might sound like this: 'I'm hearing you, that you don't want to push beyond where you are now. This does concern me, of course, since I want you to not be so in the grip of your past. However, it is more important to me that I respect that only you know yourself best and that I can trust you to tell me if and when you want to tackle this in another way.'

Now, with what I said to myself, 'How did I paint myself into this corner?' A very similar client scenario, except this client is in a form of treatment that she considers to be what she needs. I have reservations for a variety of reasons but, in fact, as a member of her treatment team, I have supported as best I can the decision of the other clinician offering this treatment. As I was not too enthusiastically awaiting her appointment this week, I looked at myself in the corner, decided maybe the paint had dried enough for me to try to come out of the corner, and began to figure out just how to get out. But, how did I get there? As I reflected on this, I realized I had entered into my own decision about what was best for her, based on my worries about her overall mental health picture, and had proceeded to push that agenda (it happens to be best of us, correct?). I decided just to drop back and ask this open ended question: 'How can I best help you in your life, to support how you are trying to take care of yourself with this other additional treatment?'

And what happened? She told me. What she needed was not what I would have come up with, but it felt like the most important thing to her. Together we talked about her plan for trying to obtain what she needed. I have no idea if she can be successful with what she wants, but I do know that we both were more relaxed with each other, and were able to have a meaningful session. I am out of the corner for now. I need to remember it is my anxiety that always gets me there. MB

Theoretical Explorations

Appreciating Confrontation

Harry Zerler

What are your associations with the term "Confrontation"? Do you think of inquisitions or witch trials? Current worldwide geopolitical conflicts? The fabled residential drug treatment center Synanon? Or can you perhaps recall a time and place much closer to home:

Do any of us not carry some visceral memories of a parent or teacher demanding that we accept responsibility for some accused act of wrong-doing that we heatedly denied, with heart pounding, face flushed, tears brimming? Take a moment to summon the echoes of one such event in your life: did *they* unflinchingly use the power of *their* authority to probe your conscience, reject your veracity, judge you, and then milk you for guilt? See yourself in that moment; then, allow yourself to feel it. Did you feel cornered, shamed, and frightened by the inescapable advent of unseeing justice? *Is the mere memory enough to nudge the pit of your stomach, or to shorten your breath?* It is quite common to spend a good part of one's formative years aversively learning to avoid that sort of confrontation, which many associate with their most vivid experiences of guilt, shame, or sometimes, of innocence wronged, often leaving lasting emotional wounds.

Can we regard anything so painfully unwelcome in our lives as a legitimate clinical tool? For the past 45 years psychotherapists, lay practitioners and others have sometimes embraced or more often condemned confrontation, though very few have had direct experience using it in a clinical setting, and fewer still were adequately prepared to use such a powerful process constructively. For many of us it is simply a presumed disaster, a primitive intervention we would never want personally to be involved with as actor or subject, a violation of intimacy as discomforting and invasive as a body cavity search. Urgency for change, ambivalence, and relationship converge in clinical confrontation to a very sharp edge, a switchblade in the vicious hand of an assailant; a razor in the steady hand of a barber; a scalpel in the life-saving hand of a surgeon.

"Confrontation is a complicated concept," remarked Bill Miller at the

2004 MINT Forum, "that etymological meaning of 'bringing people face to face,' that's what we're doing in MI."[1] Bill was discussing a surprising finding of a recent study, in which MI therapist 'confront' responses[2] appeared to have an unexpected positive impact on client change talk, rather than the expected effect to increase resistance. The observation of that positive response, particularly when embedded in an MI style, is actually very consistent with a deeper understanding and appreciation of clinical confrontation.

What most think of as clinical confrontation is generally considered to originate in the development in the late 1950's of the first American-style therapeutic community, Synanon.[3] Since then, confrontation has commonly been misunderstood to be the operative core of encounter group therapy, an "attack" on "denial" in the context of "tearing the subject down to build them up again." There are several critical misconceptions in such characterizations.

First, confrontation, as practiced as a "tool of the environment" in the first decades of the therapeutic community (TC) movement at Synanon, Daytop Village, Phoenix House, and others, was a process demanding a high level of complex self-awareness and genuine respect and concern for others. The use of confrontation to attack or indict was specifically prohibited; and confrontation itself was a process that was encouraged at all times and places in the TC, not only in encounter groups. It is important to appreciate that the meaning and value of the intervention is dramatically different when taken in the context of an ongoing 24/7 examination and adjustment of behavior and emotion among a community of change-seekers over days, weeks and months, rather than seen within the brief context of a single encounter. There was also no therapist-client context, because in the traditional TC "Confrontation is valid" as a tool shared among all staff and peers alike. If one initiated confrontation of another, the posture assumed-a mirror facing a mirror-revealed, in cascading, nested reflections, as much about the initiator as about the subject of confrontation. So to confront another without both *constructive* intent, and demonstrated caring and authenticity "having your own back yard clean") was to publicly mis-use the tool. The only way to master the optimal use of confrontation was by *doing it*, to give confrontation *and* to receive confrontation, and to learn from one's own experience of doing it badly and doing it better.

A prominent reason for the misunderstanding of confrontation is that the TC prepares and instructs its members in the use of this important tool in an experiential manner that is embedded in a strictly oral tradition marked by colorful colloquial language and TC jargon. The liberal use of profanity and expletives, interpreted within the community as markers of authenticity and emotional honesty, are misinterpreted by outsiders as markers of hostility and aggression. An academic or scientific perspective is dysfunctional in a TC community, where most members have little formal education but lots of "street smarts"; and the ethos of the TC specifically avoids psychodynamics ("getting clinical" or "coming from the head") rather than focusing on concrete behavior and identifying feelings ("getting in touch with the belly.") Until quite recently very few clinicians or academics had ever actually spent enough time within or a part of a therapeutic community to improve the understanding of what I will term "traditional TC confrontation."

In a fascinating historical sidelight, Dr. Alexander Bassin, then a researcher, professor and psychotherapist (together with professor of sociology and prominent criminologist Dr. Herbert Bloch, and psychiatrist Dr. Daniel Casriel) in the spring of 1962 embarked on a journey under the auspices of the National Institute on Mental Health (NIMH) to explore whether there was promise in the nascent TC at Synanon of an alternative to either indefinitely maintaining addicts on narcotics or keeping them incarcerated, as "every person with a serious interest in drug abuse [was] firmly convinced that heroin addiction was a hopeless, terminal disorder.[4] Bassin, also at that time executive secretary of the Society for Client-Centered Therapy, describes stopping on their way to Synanon in California, for a meeting in Wisconsin, with "America's best-known psychotherapist, Dr. Carl Rogers, father of client-centered counseling."

> *At his home, seated before a picture window overlooking Lake Mendoza, we asked Dr. Rogers the question uppermost in our mind: 'We are going to visit Synanon and we would like to know if a treatment procedure that seems to depend on people shouting the vilest oaths at each other, criticizing, making judgments, moralizing could possibly be of any benefit. It seems so much unlike the gentle, sweet unconditional acceptance that you insist is the basis for personality change. How do you explain their claim that they have managed to keep heroin addicts clean for a year or more when nobody else can do anything at all with these people?'*
>
> *Rogers thought for a full minute and then replied that perhaps beneath the veneer of cursing, shouting, moralizing and judging was a supply of pure undiluted love and concern that none of the residents had ever experienced before.*

It is necessary to note, with regret, that today traditional TC confrontation is all but extinct. I believe that is largely due to the broad misunderstanding and frequent misuse of confrontation, encounter group therapy, and other TC tools exported to and misapplied in other more limited settings lacking the rich therapeutic checks and balances of the well-regulated traditional TC; and also because of the gradual lapse of traditional practice within the TC's themselves. In the early 1980's, as anecdotal (and often ill-informed) accounts of "barbaric behavior modification" at TC's converged with a swelling demand for more and tougher treatment of drug abusers, there occurred a relatively swift and fateful shift. The self-help, resident-driven, deliberately unprofessional TC's were given the opportunity to become "respectable" licensed healthcare providers, and to vastly increase their treatment capacities, facilities and revenues with public funding, provided that they abandoned many of their traditional processes in favor of "multi-disciplinary" treatment incorporating and elevating professional medical, psychotherapeutic and psychiatric roles in their programs; at the same time, social workers and psychotherapists in many other levels of care and treatment settings adopted academic or book-learned "tough," "confrontational" tactics in individual and group encounters, with none of the finesse or self-regulating protections found in the traditional TC environments. In essence, the traditional TC's largely abandoned their traditions and changed their core identity, and other practitioners heedlessly adopted powerful and sensitive TC tools that were never intended to be applied in such fashion. There has been a great deal of pointed rhetoric arising from these changes, and very little objective investigation or clarification. So today we are faced with a puzzle and a dilemma: is clinical confrontation a misguided counter-productive intervention for promoting self-actualized behavior change, or can it be a sensitively employed, constructive and powerful catalyst in an appropriate clinical setting and therapist-client relationship? Can it actually be compatible with MI? Is it

possible to have *vis a vis* without *mano a mano*?

In exploring these questions it makes sense to cast off the baggage of TC's, witch hunts, interrogations and punishments and allow ourselves *tabula rasa*. To start with a constructive definition, confrontation is a dialogue intended to help the participants align their intentions relative to an objective behavior change, with the specific short-term outcome of alleviating inauthenticity that prevents a candid exploration of ambivalence. From an MI perspective, it is clearly a tool that will be most helpful in working with persons and goals robustly situated in the action or maintenance stages of change, would require much greater sensitivity to apply effectively in the contemplation stage, and would not be appropriate at all in situations of pre-contemplation. Defined in this way, one may readily appreciate that the use of confrontation as a pre-contemplation battering ram at the gates of "denial" is as inappropriate and inconsistent with MI spirit and practice as many other therapist gaffes.

If we proceed on the understanding that confrontation, like other constructive elements in MI dialogue, should be carefully timed, and should be initiated only with permission or invitation, we may then consider qualitative aspects of confrontation that could enrich the process or enhance the outcome compared to a "no confrontation" approach. Here are some proposed qualities of *congruence* and *contrast*:

Qualities of Congruence with MI	Qualities of Incongruence with MI
Reflection	Mutuality
Caring	Accountability
Trust	Not Value Neutral
Honesty / Authenticity	Self-disclosure / Confession
Promoting Change	Promoting Change *Now*
Empathy	*Ventilation*

To incorporate confrontation with MI appears reasonable in terms of the points of congruence; the points of contrast could conflict with or enhance the course of care, and present great challenges to the skill and sensitivity of the therapist. Why take on these risks? Therapists and clients who have experienced confrontation as a positive tool report that it is uniquely helpful in promoting honesty, candor, and accurate understanding in place of dissimulation, evasion and rationalization; in helping to deal with the discomfort of embracing personal responsibility, and in promoting the ventilation of powerful emotions that can inhibit readiness for change. Optimally applied, confrontation empowers actors and subjects alike with an unshielded but safe access to the raw core energy of self-actualization, and can supercharge or greatly accelerate the process of change, perhaps something akin to *Quantum Change*. In this way hope, profound respect, esteem, possibilities, faith in the person, freedom to change, all are valuable elements of both MI and confrontation.

If we remain uncomfortable with the idea of confrontation and MI working together, it may be in part because of lasting negative associations with the word itself. Some have re-framed and re-labeled the approach as "care-frontation;" a MINT colleague reported positive responses to "leveling with the client." Bill Miller has often remarked on the almost incomprehensible harms committed by presumably well-intentioned persons misusing confrontation. Yet, considered relative to the emerging theory of MI, skillful confrontation embodies many crucial qualities of the therapeutic relationship and facilitates self-acceptance, self-efficacy, and perhaps self-esteem. Perhaps the aspect of confrontation that Rogers perceived as a source of "pure undiluted love and concern" is relevant to Bill's observation:

> *The paradox that Rogers highlighted is that when one feels unacceptable in one's present discrepant state, one cannot change. When one feels accepted or acceptable, then it becomes possible to change. Against the reflexes of the heart, the motivational interviewer does not insist or even believe that a client must change. I also agree with Rogers that this is a reciprocal process—not that the client accepts the therapist (although I think it happens, and that Monty Roberts is onto something here)—but that one's ability to extend such acceptance to others is related to and enhanced (or limited) by the extent to which one experiences that same forgiving acceptance of self.*[5]

Skillful and timely confrontation may be an expression of what Rogers suggested was "a source of pure undiluted love and concern," of agape, "a kind of selfless, other-directed, encompassing but nonpossessive love, likened to God's love. Its sole interest is in the well-being and growth of the other."[6] MI-compatible constructive confrontation may prove to be a valuable way to promote reciprocal, forgiving acceptance and to advance the possibility of change. MB

Notes

[1] From the MINT Forum presentation, "Towards a Theory of MI," Portland, ME, October, 2004, as recorded by Anthony Mascola and transcribed by this writer.

[2] As Bill Miller made clear, the study labeled all MI-inconsistent therapist responses as "confront" responses. It is unlikely that any of these were the kinds of interactions we think of as aggressive confrontation; nonetheless, it is reasonable to inquire further as to the potential compatibility of MI and confrontation.

[3] The practice of candid examination of behavior and conduct among members of specific groups, particularly communities of faith, is well-documented as far back as the Dead Sea Scrolls. One historian of the TC traces a direct line backwards from Synanon to A.A. to the Oxford Group, the YMCA and to earlier 19th century reformist churches and evangelical communities, and further back to Zwingli and Luther. See Frederick B. Glaser, MD, FRCP, *The Origins of the Drug-Free Therapeutic Community: A Retrospective History* (University of Toronto, reprinted by Daytop Village, New York, NY).

[4] Alexander Bassin, Ph.D., *The Mircale of the TC: From Birth to Post-Partum Insanity to Full Recovery.* Address delivered on August 21, 1977, before the Second World Conference of Therapeutic Communities, McGill University, Montral, Canada; reprinted by Daytop Village, New York, NY. In this paper and in other archival material collected at Daytop Village, there are many references tothe early influence on progenitor TC's *other than Synanon*, of some of America's most prominent humanistic therapists, among them Carl Rogers and O. Hobart Mowrer, who enthusiastically endorsed what I term the "traditional TC" modality of the era. For the few professionals who were actually familiar with them, TC's were hailed as virtually the only places in society where drug addicts were seen as human beings with intrisinc capacity for positive character and behavior change. It is unfortunate that Synanon (which was and remained the expression of the dictatorial and anti-professional idiosyncrasies of its founder, Charles Dederich) through its notoriety became emblematic of all TC's, despite the fact that Daytop Village, Phoenix House, and hundreds of others modeled on them around the world have evolved on significantly different lines from the original Synanon model.

[5] Miller, W.R. (1999). Towards a theory of motivational interviewing. *MINUET, 6.3,* 4.

[6] *Ibid.*

Project Community CARES

Stéphanie Wahab and Usha Menon

While morbidity and mortality from colorectal cancer (CRC) can be easily reduced through the regular use of screening tests, screening rates remain significantly low. We have assembled a team of researchers and consultants from the University of Illinois-Chicago College of Nursing (U.M.) and the University of Utah College of Social Work (S.W.) to compare the effectiveness of two interventions, Tailored Health Communication (THC) and Motivational Interviewing (MI), in increasing CRC screening behavior.

Primary Aim

This five year study, titled "Increasing CRC Screening in Primary Care Settings," is funded by the National Institute for Nursing Research (RO1 R01 NR08425). The study is conducted under the aegis of Project Community CARES (Cancer Awareness, Resources, Education, and Support), which is the overall cancer control program being developed by Dr. Menon. The primary aim of this study is to compare CRC screening test uptake among three groups randomly allocated to control or intervention conditions. The three study groups are (1) standard care, (2) tailored health communication, and (3) motivational interviewing. The two methods (THC and MI) will be compared to usual care and to each other.

Sample

Approximately 804 participants will be recruited from primary care clinics in Chicago, IL. To be eligible for participation on the study, participants need to be 50 years of age or older, CRC free, and be considered average risk for CRC.

The Interventions

THC and MI interventionists will contact study participants within one month of the baseline interview. THC counselors will be guided by printed tailored messages for each participant (drawn from the baseline interview). MI counselors will only receive information on the participants' risk for CRC (collected at baseline). Both THC and MI interventionists will deliver a one-time intervention by telephone.

Study participants will be surveyed by telephone about CRC-related beliefs preintervention (Time 1), as well as at 1 month postintervention (Time 2), and at 6 months and 12 months postintervention (Times 3 and 4, respectively).

Tailored Health Messaging

According to Kreuter, Farrel, Olevitch, & Brennan (2000), tailored interventions are defined as any combination of personalized information or change strategies intended to reach a given individual. The personalized information or change messages are derived from an individual assessment, and they are grounded in characteristics that are unique to that individual, as well as relate to the outcome of interest. Tailoring has been compared to non-tailored communications; for instance, tailored letters have been compared to generic letters. While certain studies demonstrate that tailoring, by itself, has succeeded in promoting behavior change, tailored cancer communication has not been compared to other forms of cancer communication. In this study of Project Community CARES, the intervention will be tailored to baseline stage of readiness for CRC screening and CRC-related beliefs associated with each stage. Perceived benefits and perceived susceptibility will be emphasized for those in precontemplation, and perceived barriers and benefits for those in contemplation. Additionally, self-efficacy specific to the screening test will be addressed for those with low self-efficacy in any stage.

The one-time, telephone-based MI intervention will include the following components: establish rapport, ask permission to discuss colorectal cancer prevention (CCP), invite participants to discuss what they know about CCP, assess motivation, readiness and confidence to get screened, explore ambivalence, roll with resistance, elicit and enhance change talk, and support self-efficacy and commitment.

Analysis

Data analysis will include bivariate analysis among beliefs, demographics, and screening test uptake. Logistic regression models will be used to identify significant belief and demographic predictors of stage of CRC screening test adoption as well as screening test uptake by study group. Process evaluations of the interventions will be conducted periodically, including exploratory analysis of audiotaped interventions. Path (mediation) analysis will be performed to further explore the underlying mechanisms through which THC and MI may differentially impact screening behavior.

Summary

The innovative comparison of two interventions that have not been compared to date within the same study, as well as the fact that we are adapting successful interventions to CRC screening, are both strengths of the study. Together with a strong conceptual framework and the expertise of the research team, we believe that the proposed study can make a significant contribution to cancer control research. MB

Dear MINTIES...

A Former MINTIE Looks at the Precarious Intersection of Personal Issues and Professional Work

Douglass S. Fisher

In the fall of 2003, I decided it was time to leave the field of HIV prevention in which I had worked for 13 years. The latter part of that time was spent testing an MI-based intervention. At the time I mentioned to our dear editor that my exit was due in part to a growing sense of the difficulty of working with an affected population of which I am a part: HIV positive persons. I had worked in the field about as long as I have lived with this diagnosis, and found it increasingly difficult dealing with my own issues around health at the same time as trying to help others with theirs'. Allan thought some reflections on this issue might be of interest.

With the passage of time, I find I can say a few things, although not what I thought I might say 19 months ago.

I have thought about this often and do not want to presume that my experience is so unique. In fact, I think I am late in coming to my awareness of the difficulty of doing one's own work while trying to work with others around similar issues. It would be grand if this never became a problem, but I fear it did for me.

In the summer of 2001, I began a course of therapy which I never imagined would still be going on 4 years later. With an increasing awareness of the passage of time, I pursued this aggressive path of insight therapy twice a week because I was determined not to enter my later years burdened with so much lack of resolution and self awareness. At the onset of this work, while tackling my own issues of physical and psychological health, I imagined I could keep my concerns and those of my clients separate. After all, I had been doing therapy in various settings for years and was an at least moderately skilled professional. As is the case with a personal therapy that works, the more I learned about my own issues, the more I realized how difficult it was to see those of my clients in a clear and objective fashion. This is old news to all of us. But it is striking to me how easy it was to delude myself about my ability to take my own issues into account while working with others. It is humbling to admit how blind I was in so many subtle ways.

A funny thing happened along the way. I found that the more I learned about myself, the less interested I was in being a therapist for others. I came to wonder, and still do, if my interest in doing therapy was driven, at least in part, by my own desire to be more whole. Not ready to tackle my own issues, I took on those of others, as if in a holding pattern until various forces made looking at myself unavoidable.

Unavoidable. That was the point at which I began the therapy. Two and a half years later I realized that to take my therapeutic work to a more complete and deeper level, I had to remove myself from that very active intersection of my work and that of my clients. I will never use the words "Physician, heal thyself" lightly again. My departure from working with HIV positive men made a more focused look at dynamics of my own issues much easier. Although "easier" isn't quite the right word. Nor was it quite the "crucible" that some ascribe to seeking deeper self understanding and congruence. I'm not a fan of pain, so my path has been perhaps a bit longer and more drawn out than others'. I suspect some might have been able to keep working in a setting where personal and client issues meet. Not I. The departure made it possible to focus and not have to spend significant amounts of energy managing complex dynamics.

Some tell me that I have jumped from the frying pan into the fire. From HIV prevention I moved to a study where I talk with persons who have a projected lifespan of 6 months or less. We are testing the effectiveness of massage and guided meditation as they relate to improving the quality of life for persons who are at the end of life. After doing baseline interviews, I interview folks weekly until they die or opt out of the study for other reasons. It is a "being-with" that is intense and almost always moving. I've had friends ask, "How can you be close to so much death?" That is difficult indeed. But while I see dying and death, I more often see people trying to live fully and richly until they leave this earthly plane. These meetings are often inspirational, sometimes disturbing because of the realization of unrealized dreams and hopes, but always a combination of energizing and depleting in ways with which many of us are familiar when working with persons who are willing to look so directly at their lives.

So, now, when my physical and psychological issues are more resolved than ever before, I am freed up to look at issues of mortality. Sigh! But with reference to supposedly not doing MI any more, I find I use MI skills more than ever before. I have often said my favorite kind of work is elicitation research—--client-based based work that has as its goal a basic wanting-to-know versus seeking to move toward some therapeutic goal. From the first interview 11 months ago I became aware of the importance of listening, and listening well. Reflecting back using simple and more complex, deeper reflections, and summaries, etc., seems like the most respectful thing to do with people who are sharing parts of their story towards the end of their life. What greater service can one provide under the circumstances than to use methods that may help them to hone their words and meaning? But there is often a precarious aspect to the work, since good listening often helps someone realize how deeply they are feeling about things. While I am no longer an interventionist, per se, the years of working with others learning how to be good facilitators of the human experience has served me well.

And now, as I do some minor editing on this reflective piece, I find myself getting chills and bit teary remembering the incredible warmth, enthusiasm, and creative thinking I always encountered when working with other MINTIES. I remember it all fondly and hope our paths cross again. Until then, my best to all of you. Doug

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Virtual Symposium

Motivational Interviewing and Mandated Interventions

Harry Zerler
Goodpath L.L.C. and Hunterdon Medical Center
Flemington, New Jersey, USA

What Is Freedom, Anyway?
Tom Barth
allasso.no, Bergen, Norway

Coerciveness of Preventive Medicine in the General Practice Setting
Anders Beich
Research Unit of General Practice, Centre for Health and Society, University of Copenhagen, Copenhagen K, Denmark

Physical Training in the Armed Forces
Jeff Breckon
Faculllty of Health and Wellbeing, Sheffield Hallam University, Sheffield, UK

Tempest in a Teapot?
Michael D. Clark
Center for Strength-Based Strategies, Mason, Michigan, USA

Treatment Under Orders
Brenda Coldwell
Department of Clinical Psychology (MOD), Duchess of Kent's Barracks, Catterick Garrison, North Yorkshire, UK

Probation, Cognitive Skills, and MI
Steve Emslie
Pima County Adult Probation, Tucson, Arizona, USA

Hobson's Therapist: The Paradox of Mandated Opportunities for Change
Mark Farrall
Ignition Creative Learning, Cardiff, Wales, UK

MI in Custodial Settings
Lars Forsberg
Department of Clinical Neuroscience, Section of Dependency Research, Karolinska Institute, Stockholm, Sweden

MI and Coercive Environments: Freedom within Limits
Tad Gorske
Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, USA

Treating the Mandated Client with Motivational Interviewing
Patricia Lincourt
Northeast Psychological Associates, Albany, New York, USA

One Perspective from the "Fixed Goal" Contingent
Jeanne Obert
Matrix Institute on Addictions, UCLA Integrated Substance Abuse Programs, Los Angeles, CA, USA

Swimming Upstream
Joel Porter
Pacific Centre for Motivation & Change, Ltd, Hamilton, New Zealand

Anecdotal Evidence from the Developing Field within the Criminal Justice Interventions Setting in England
Lyn Williams
Stratas Consultancy, Birmingham, England, UK

Focus on the Seed not the Forest
Wilburn C. (Dub) Wright
The Wright Path, Houston, Texas, USA

Autonomy, Control, and the Greater Good
Allan Zuckoff
Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania,

Virtual Symposium

Motivational Interviewing and Mandated Interventions

Harry Zerler

I. *Aperitivo:* A Worthy Puzzle

In October, 2004, this publication featured a Virtual Symposium on the topic of *Values and Motivational Interviewing*.[1] In twenty-four brief essays, MINT members with diverse perspectives addressed questions and concerns related to counselor values, program values, community and cultural values, and professional ethics as they are—or should be—informing MI practice in research or clinical settings.

The Virtual Symposium was forerunner to an Actual Symposium held at the Portland MINT Forum;[2] together, these discussions and ongoing listserv threads have reflected continuing interest in application of MI in circumstances that are legally mandated or otherwise structured by program or community standards that impose requirements on counselors or therapists, and on clients or patients, that may appear to be incompatible with MI. Yet, despite seeming incompatibilities, such applications of MI may appear also to positively influence outcomes in ways that are consistent with MI.

Some common examples are:

- MI conducted in prisons or other custodial settings; or in court-mandated programs including drunk-driver programs, and other kinds of "treatment" court programs such as drug treatment or domestic violence programs or family court programs;
- MI conducted in involuntary mental health or substance abuse evaluations, often provided in medical settings such as hospital emergency departments, with patients deemed "in crisis" or at risk of harming themselves, others, or property, including those who have threatened or attempted suicide;
- MI conducted in residential, inpatient or outpatient treatment services that assume fixed goals such as abstinence from all substance use;
- MI conducted in connection with provision of public assistance benefits to homeless, unemployed, or disabled applicants or recipients.

Anecdotal evidence indicates that during the past three years there has been a steadily increasing demand, and in many cases a regulatory or contractual stipulation, that "motivational interviewing" or "motivational counseling" be a required component of a wide range of human services programs. MINT practitioners have responded to these circumstances along a multivalent continuum ranging from easy acceptance to measured skepticism to principled rejection. Many have questioned the intent of such pairings of MI with mandated or coercive interventions: in many cases there appears to be an institutional desire to manipulate adherence, compliance or retention, as opposed to respecting autonomy, accepting ambivalence or offering choice. In some cases "MI" appears to be appended as a kind of fig leaf to cover naked aggression, for example, as anecdotally reported in connection with "boot camps" for criminal offenders.

Some important questions merit our discussion:

1. Is it *legitimate/ethical* to incorporate MI in such circumstances, or may the circumstances or conditions be absolutely incompatible with MI? Can you describe examples to illustrate what would be compatible and what would be incompatible?

2. Is it *effective* to incorporate MI in "compatible" circumstances? Can you describe anecdotal examples or research that indicates the effectiveness of MI in such circumstances?

3. Considering how limited (i.e. hard-to-come-by) the practice of MI in "optimal" conditions of autonomy and volition is likely to be in the near term for many clients or patients, is it *important* to make integration of MI with other dissimilar programs or interventions a priority for further study and exploration? How much "integration" is *necessary and sufficient* (or perhaps *not-enough* or *too-much*) to preserve the "integrity" of MI as an element within the larger system?

4. Can the proactive integration of MI with other dissimilar programs or interventions not only help patients/clients, but also promote desirable *institutional* and *programmatic* change towards improved respect for autonomy and volition, improved choice, and bet?

II. Recipes from the Field

In my own experience as a clinician and trainer in community-based programs, I have deliberately and enthusiastically embraced every sound opportunity, in my judgment, to explore the effectiveness and value of MI in combination with "less-free" circumstances. In America there is vanishingly little in the way of providing health care or other human services that is not being heavily influenced by the agendas of players other than simply the therapist and the client. In the balance of social and therapeutic relationships, in the balance of who gets what kind of care and how much, in the balance of decisions about readiness for change, there are often quite a few thumbs on the scales. So my approach has been to try mixes, blends, colloidal suspensions, Trojan horses and other compounds in search of optimal caregiving.

Some of these produced unusual hybrids, like my introduction of MI into the "entry unit" of long-term drug-free residential treatment at the venerable therapeutic community (TC), Phoenix House.[3] Could MI be compatible with a program famous for structure, encounter group therapy and confrontation of "negative behavior"? I found that the answer was Yes, on many levels, as the hybrid influenced everyone in the environment: residents, counselors and program administrators alike. I introduced a customized "TC Power Workbook" approach that could be personalized by each new resident, but could also be processed with

others as a group activity. The workbook was geared to fifth grade reading levels, had text illustrated with cartoons, and offered basic concepts, with self-rating exercises, on Stages of Change, Importance and Confidence, and some exercises specifically geared to help residents recognize ambivalence, and process their mixed feelings about being in a highly structured, very demanding program, often mandated by the criminal justice system.

A second opportunity arose when Phoenix House was invited to collaborate in the establishment of an advanced "treatment court" model in Brooklyn, New York,[4] that was designed to provide comprehensive on-site services to low-level criminal offenders in a unified court, hearing criminal, housing, and domestic violence or family cases, which formerly were processed in disparate courts. The model drew on analyses of offender data indicating that many defendants were typically involved in multiple offenses across these domains, and that fragmentation of court and social services was apparently often confounding effective interventions. The new treatment court wanted a "treatment readiness program" that would consist of three consecutive mandatory sessions, as a group process, required of every defendant as a preliminary adjunct to the development of an adjudicated social service plan—which, if successfully completed, could result in the satisfaction of legal obligations without incarceration. Defendants were always given the option of taking their chances with the "traditional" justice system, and many pre-contemplators chose to go to jail as more conducive to their goals or values. An existing "treatment readiness group" model, which consisted of scripted lectures on the hazards of alcohol or other drug use, and the probable consequences of non-compliance, struck me as disingenuous at best. Clearly the participants had all achieved substantial familiarity with hazards and consequences, and they often had a canny, if maladaptive, sense of how to endure or survive the latest intrusion of "the system" or "the man" into their lives.

I jettisoned the old "psychoeducation" in favor of group process[5] on decisional balance, free-wheeling conversations on stages of change, and revealing explorations of *Importance and Confidence.* To the astonishment of judges, police, prosecutors and defense attorneys, probation officers, social workers, and most markedly of the participants, this led to double digit increases in retention and completion during the initial phase of participation. Some defendants completed their three mandated sessions and asked if they could come back again, or bring a friend!

Are we walking on water yet? Not so fast: these things I've described were done with minimal funding, therefore with no integrated research component to establish baselines and to measure impact; and, there was a lack of broad, top-level buy-in to support comprehensive training of providers across disciplines. So, in a spirit of accommodation, we worked with whatever we could get in the way of time, money and participation, hoping that all of these would gradually increase. Still worse, when I moved on, these programs foundered, a foreseeable consequence of administrators electing only the "half-day in-service training in MI" rather than supporting a substantial long-term integration of new ideas, resources and skills.

Like Candide, adversity served only to quicken my progress. Empathetically following the call of a born-again MINTie and *schlimazel* (Yiddish for *luckless person*), my next opportunity came as a psychotherapist and state-certified mental-health screener in the busy Emergency Department of a community-based hospital in the deep suburbs of western New Jersey. There my practice has been immediately solemnified by the regular attendance of death on the premises. Quick, accidental, inadvertent death is easier; the slow, seductive creeping death of severe chronic mental illness and co-occurring substance disorders, with so many florid variations, is much more difficult and frightening to me, as it blossoms into all the various forms of active or passive suicidality, and sometimes erupts in fatal fruition. In crisis work with suicidal patients, more than ever before, I find that the *spirit* of MI, and the agency of MI *relationship* as an "active ingredient" to catalyze change, show remarkable power. Even embedded in the considerable statutory apparatus of required "mental health screening", an MI encounter, even as a brief isolated experience for patients who have come from, or are going to, much less open systems of care, appears to be critically affirming of hope, of life and of the possibility of change. A great deal of this work is bound by restrictions of every kind, including the overriding obligation to "maintain safety" which, in satisfying the expectation of the community, is presumed to be *co-terminus* with "the patient's best interest" even when that leads to psychological, chemical or physical restraint, or to the ultimate violation of autonomy, involuntary commitment for psychiatric hospitalization. As one patient said to me as I made him "safe" via commitment, "If I wasn't dead yet, I am now."

III. Symposium as Feast

Our MINT community enjoys a wondrous appetite for puzzles and paradigms that add flavor, zest, and mystery to the expanding movable feast that is Motivational Interviewing in the wild. Now we invite you to bring or take at this feast what feeds your skill, your enthusiasm, your curiosity, your accomplishment, or your grace. Our virtual symposiasts have provided a rich bounty to nourish the discussion, and we hope you will join us, via the listserv, or at our live Symposium in Amsterdam, in this publication, or in your own path of discovery. *Namaste.*

Notes

1 *MINUET, 11.3.*

2 Transcript of the actual symposium appears in the *MINT Bulletin, 12.1.*

3 Phoenix House is one of the oldest and largest drug treatment programs in the USA, founded in 1967. For more information visit www.phoenixhouse.org

4 For more information visit www.courtinnovation.org

5 With inspiration from: Velasquez, Maurer, Crouch, & DiClemente (2001). *Group treatment for substance abuse: A stages-of-change therapy manual.* New York: Guilford Press.

What Is Freedom, Anyway?

Tom Barth

What is freedom anyway? Freedom of choice.

The "need-dimension" of change talk is about feeling forced to change because of external or internal forces. In many (most?) cases when we offer Motivational Interviewing for treatment, the client is forced by his/her condition, or family, or community, or conscience, or even insight. Now if the client absolutely refuses to succumb to this force (which can be the case when a person feels their personal integrity is threatened), then (s)he should be free to move away from treatment. The treatment person may think of this as 'resistance', but in accordance with MI-spirit we accept it (MITI codes in parentheses):

"So in this case it feels more important for you to preserve your dignity than to follow all the expert advice..." (complex reflection)

"You are the right person to make that decision, and it deserves support..." (MI-adherent)

"and if you ever wish to explore this again, you are welcome back here." (information)

Now if we chose a different approach—

"Well, that's absolutely for you to decide... and since that is settled, would it be alright for you if we just sit for a while and have a friendly chat and a cup of coffee?" (MI-adherent)

"What are the good things for you about having made this decision" (open question)

—then we are still practising MI, but I would argue in an unethical way. Because the "What are the good things?" question is a strategic question designed to move a person in precontemplation a little bit in the direction of change, since it leads to exploring ambivalence. And we had just signalled that treatment had terminated.

A third variation:

"In the end, you're the only one who can make this decision." (MI-adherent)

"Now you know, my job here is to motivate clients for change..." (information)

"... so would it be alright for you if we spent some more time exploring your decision, and your reasons for making it?" (MI-adherent)

"What are the good things for you about having made this decision?" (open question)

Is this ethical? I would argue "yes" or "no" depending on the circumstances:

> Does this person feel free to decline my invitation to explore further? Or does (s)he feel compelled to accept because of a power difference in the relationship, or expected sanctions from the environment, or even a personal trait of politeness? The less freedom, the more should the ethical question trouble us.
>
> Is there also a part of this person that wishes change? The kind of pre-conscious ambivalence we often feel in clients who are in precontemplation? Our ethical consideration could be based on our humanistic value, that there is something within the person always striving for freedom and well-being, and what we are doing is to reach out for that something. But how do we know?
>
> And does this person have the *ability* to change? Or is the 'resistance', or even 'denial' an effort to survive in a situation where (s)he feels helpless? There are obvious ethical dilemmas that arise if we increase 'importance' with clients who have very low 'confidence'.

Ethics are about dilemmas, and there are no simple truths. We can become good at recognising the dilemmas, good at recognising their complexity and conscious that we need to work our way through the complexity. And different practitioners may arrive at different conclusions.

It is the process of "Ethical Reflection" that is the sign of the professional. Most professions have "Ethical guidelines" that help us, and certainly what we call "The spirit of MI" is a guide.

In ordinary voluntary treatment settings, where the intent of our work is clearly stated on the outside of our building or office (*Drug treatment centre*), the dilemmas are easier to resolve. Especially if we have an "informed consent policy" explaining which methods will be used and what clients can expect.

On the other hand, there are settings where it is not absolutely clear that the professional is using a "method" to influence the person's thinking or feeling—or where there are obvious limitations to the clients' freedom of choice.

In those settings professionals need to work harder on our ethical considerations, and base our practise on them. Not that we will always know what is right or wrong—but it is our absolute responsibility to give these questions proper consideration. And we must be able to explain our considerations if we are challenged.

One more point about professional ethics, is that they are about *consequences* and not i*ntentions*. It doesn't help to say "I didn't mean it like that". So if we tell somebody that they were free to accept or dismiss our offer of treatment, and the client says "that's not the way it felt for me"—then as a professional I need to realise that I arrived at the wrong conclusion.

Looking at the three examples in the beginning of this piece, the first one is safer. And in my experience as "effective" as the more "sneaky" MI of the third example. And especially in coerced treatment it is my experience that the genuine respect in the first version can reach across the gulf created by the coercion.

So, is it, or isn't it, ethical to use

MI in enforced drug treatment, or in the criminal justice system? Wrong question!

Some good questions are:

Have I taken into consideration the ethical implications of the clients' limited freedom?

Have I made it clear to my client that I am using a method, and that (s)he is free to refuse that the method be applied?

And am I willing to accept that the client may reach a different conclusion than I have – in which case the client is right, and I will have to adjust my practise?

Coerciveness of Preventive Medicine in the General Practice Setting

Anders Beich

A bus driver, male, age 46, once came to see me because he had his blood pressure measured in a campaign at the local pharmacy and they told him to get it checked once again at his doctor. He doesn't come to the surgery very often, and he doesn't take any medication. His father died in his late 50's of a heart attack, and his 10 years older brother had by-pass surgery last year. He has had six years´ schooling, was divorced three years ago, has no children and his future in the bus company which he served for 18 years is uncertain, due to cutbacks after the opening of a new driverless subway.

Even without knowing anything about the 'big four' of health promotion (smoking, drinking, exercise, diet) or even his blood pressure I would have given him high priority and practised preventive medicine with him in a client-centred way, starting off with exploring his own concerns. His blood pressure later on turned out to be better than mine (and the WHO standards according to which more than half of the population have hypertension), and he had no serious BMI violations. He told me that he was a couch potato and a committed smoker; he loved fried streaky pork and hated "compost" (vegetables) as he said; he drank alcohol maybe twice a year. He knew a lot about healthy living.

This was more than two years ago. I still see him now and then to talk about this and that, check his cholesterol level (although it is normal when it is done properly). He has actually started walking regularly with a group of neighbourhood walkers. He has been visiting friends he had not seen since the divorce. He is thinking about what kind of work he could discharge if he got fired; he has learned how to operate a PC in these two years, and mentioned further education on and off.

According to the guidelines on prevention of cardiovascular disease I should have first focused on and computed this man's risk for heart disease / heart attack, apoplexy and fatal event by only including age, gender, height, weight, BP, cholesterol, heart disease or diabetes (yes/no), and familial predisposition. Then I should have told him about his risk and shown him that his risk would change for the better if he stopped smoking, cast off the sofa, changed his diet to "compost" and started drinking two glasses of red wine every day (expensive French if he could afford it). I could have added that this new lifestyle could reduce his risk of getting other serious diseases, too. I should then have scheduled an appointment for 20 minutes of motivational interviewing with him with the purpose of altering his health behaviours (no smoking, healthy diet, regular exercise, moderate drinking).

According to the guidelines, I should keep updated records of all my patients' drinking, smoking, sofa and eating habits. And I should commit to the regulation of lifestyle, tell every smoker every time he comes to see me that it is bad for him to smoke, tell every drinker (or abstainer) to moderate, prescribe physical activity, and recommend more "compost". My own organizations tell me to do that in a recent paper (it was issued without consulting any researchers or rank-and-filers); our government, the bureaucracy, and career scientists within the public health or implementation sciences tell me to do it. Even the pharmaceutical companies tell me to do it (they know that it's probably not leading to any significant changes, and that drugs will be the next choice for a lot of patients). When I ask them all about the rationale they say, "Prevention is better than cure;" then they point at steep epidemiological risk curves and that is about it.

The dilemmas I face: I know that the predictive validity of these risk and benefit of change assessments is low (close to the one of a crystal ball). I find the use of epidemiology in its present form to be unscientific, venal and yet seductive. And even if this bus driver would and could go through with some of the changes described here, I couldn't promise him anything except that he would be contributing to the public health of the nation, so that maybe next year we would get a better placing in the European championship. If he would come to see me again (I doubt it in his case) he would be depending on my calculations for guidance, and if he couldn't go through with the changes he would have to apologize to me in some undignified way.

Even if this man would ask me, Should I give up smoking, should I eat more vegetables, should I start at the local fitness-centre? etcetera, I wouldn't know what to say to him. I don't know him that well, and I see lots of other risks and potential killers in his life that might be at least as important to face: loneliness, unemployment, marginalization among them, and now medicalization and health behaviour stigmatization. If I had followed the guidelines I would be contributing to these risk factors, and he might even stop coming to see me. Maybe a little more security regarding these basic needs would give him more peace in his psychological household, enough to consider health as a "goal of life" and thereby become fully accepted in a mod-

ern society. I don't know and I don't know whether I made a difference or not. Knowing that I did not contribute to further marginalization is enough for me.

The pressure exerted on all health professionals in Denmark, but especially the GPs, to care for the public health of the nation and the political needs of the governing party while trying to do their best for the personal health needs of the individual patient sitting in front of them, is probably the biggest conflict of interests a health worker has, yet it remains largely undeclared and unrecognised. The Danish health care system is practically fully financed by taxes, there aren't really any alternatives, and the GP is the gatekeeper. The growing coerciveness is obvious: tell me about your lifestyle and I'll tell you what to change about it. And if you don't tell us or don't change we will restrict your access to health care in the future. Drinkers and smokers (people who have paid more than 50% income tax for a whole life) are being told to abstain before they can get an operation with reference to a higher risk of complications. Recently a prospective representative registration of consultations and preventive activities in general practice in Denmark was made up: less than 17% of the adult patients admitted smoking (at least 30% was expected). The missing smokers must have smelled a rat or they had given up going to see their doctor—not really an advance for preventive medicine. The only comfort is, that less than 20% of the doctors who were asked to participate said yes (the preventivists?), so maybe the remaining 80% are still able to have reasonable consultations with their unhealthy patients.

So where does that leave me in regard to Harry's questions?

1) I find non-directive MI and the basic listening skills that come with it very helpful in my preventive work as a doctor. The circumstances, the growing yet occult coerciveness of the setting has made me more and more careful, and you could say that I'm even using MI to make unhealthy people feel OK about the way they balance their life and to make myself available in the future as a confidant who aims at being non-manipulative: a health consultant they can trust.

2) Listening is effective in establishing rapport; I don't really care whether MI is better than something else in making people stop this or do that in general.

3) Integration of MI, or you could say MI's absorption in healthistic programs within the health care system, is highly topical in the Danish health care system. Preventive hospitals spread like wildfire in spite of the fact that the hospitals can't even treat their patients fast enough or well enough as it is. MI is almost always mentioned as a promising agent for healthier patients. MI has a potential for serving a tyranny of health.

4) I also believe that MI has the potential for serving integration and democracy in prevention – but it would demand that all relevant stakeholders (including lay people) be involved in defining, coordinating, and evaluating the strategies and philosophy of preventive medicine. I'm afraid that we would have to abandon the epidemiologically defined outcome for a while, because the risks and even clinically insignificant and uncertain risk reductions seem to overshadow the otherwise widely accepted basic principles of clinical practice: respect for autonomy, nonmaleficence, beneficence and justice.

Conflict of interests:

I have done pragmatic studies within the area of systematic prevention in general practice (unhealthy drinking). The results in everyday practice seem to differ from the ones obtained under greenhouse conditions in efficacy trials and some of them are hard to publish; some published results have set off a spiteful debate.

I gave up binge drinking years ago. After years of abstinence a good colleague of mine advised me to smoke a little again, he thought it would do me good, so I am back to occasional smoking (haven't been able to find a substitute for the excellence of surrendering to the pleasure of smoking good Virginia tobacco). I do plenty of exercise (2 hours of hard rowing, 2 hours of running, 5 hours of cycling per week), I eat plenty of "compost" and a lot of meat, and my BMI is 25-26.

Physical Training in the Armed Forces

Jeff Breckon

In July 2002 I and a fellow MINTie, Lynne Johnston, were invited to visit the British RAF physical training school at RAF Cosford in order to carry out a research study of their application of MI. While the clients in this setting are not mandated in the same sense as, say, a court-ordered rehabilitation or prison population (Lincourt, Kuettel & Bombardier, 2002; Ginsburg, Mann, Rotgers, & Weekes, 2002), they do reflect a similar set of characteristics. This is due mainly to the nature of the environment: that employees are expected to maintain a certain level of physical fitness in order to remain prepared for their current or potential role in active service.

MI Context Overview

MI training is embedded into the training of physical training instructors (PTI's) at RAF Cosford. At this time in excess of 220 had been trained in MI in a programme developed with Steve Rollnick. However, we found that the setting does not offer an opportunity for delivery of 'traditional' MI and is restricted only to an opportunity for brief negotiation and behaviour change. Each year all RAF employees are required to undergo a physical fitness appraisal. Those failing to pass the minimum standard are not sanctioned for doing so, but have a 9 week period to turn it around. It is at the beginning of this 9 week period that MI is used by PTI's. However, we found this to be more as a 'delivery style', whilst instructing clients of fitness training

techniques and safe use of equipment. This session lasts around 20 minutes, during which time clients are given a personal fitness plan and shown safe exercise techniques.

This context restricts MI to being an adjunct to the main intervention of physical fitness training, although has proved effective as a favoured communication and instructional style. It is less clear, though, what real opportunities exist for client-centeredness as this programme is defined by the employer and delivered by a fellow member of the RAF personnel.

Challenging Communication Dynamics

By virtue of the rank of the personnel delivering the MI intervention there is an interesting dynamic which occurs between lower-ranking PTI's and, for example, flight officers. The power shift occurs whereby individuals have 'failed' to meet the fitness requirements of their employers and as a result are required to adhere to a set of instructions and to adjust their lifestyle accordingly. This will almost certainly create incongruent values or motives for change between the client and the PTI (representing those of the organisation). The question may well be, how does mandated or autonomy-reduced MI affect core values and beliefs or vice versa? While the individual had originally been attracted to the employer and the setting, over time the discrepancy between their values and those of the organisation has widened, leaving a dissonance between the two. The role of the PTI is therefore to re-align the two through a form of mandated exercise therapy. This has obvious negative connotations and fascinating discussion points regarding the questions that Harry Zerler has posed.

1. *The legitimacy or ethical application of MI.* In this setting, the two-way interaction between the client and PTI can traditionally be very much expert-driven, leading to resentment, defensiveness, and increased tension due to the demand for the client to change. MI has offered a more effective communication style which reduces many of the negative/defensive responses. It is effective as a method for reducing the disparity of values and goals between the employee and organisation.

2. *The effectiveness of MI in a 'compatible' circumstance.* What is fundamental for consideration are the sanctions that result from this lack of change. The physical training aspects of this are effortful, an addition to existing tasks, and a requirement rather than a desire. The effectiveness of physical activity promotion generally has been equivocal (Hillsdon et al., 2002) and there is no reason to suggest that this setting should be any different. The use of MI by PTI's here is compatible but only in an information exchange context.

3. *Preserving the integrity of MI (through integration).* The design of the programme in this setting has been extensive, as too has been the mentoring and sheer number of PTI's trained in MI. It is therefore reasonable to suggest that MI is embedded thoroughly into the culture. However, the overt expression of its practice is less convincing and the 'integrity' of MI appears a little lost. Research was attempted here but due to the spread of the PTI staff in over 60 stations around the world a randomized controlled trial would demand high funding and/or innovation of research design.

4. *Institutional and programmatic change.* The whole culture of this branch of the armed forces has been affected by MI and its spirit has been embraced at all levels. However, while it is integrated wholly into training of PTI's, the effectiveness is more difficult to measure as a true control would not be available. There still appears though less volition or choice from the perspective of the individual receiving the MI, since whichever intervention or style is used, the outcome of improved fitness HAS to be the same.

Summary

Harry Zerler offered some common examples of mandated settings for MI, and one in particular is coherent with the facets of the use of MI with the armed forces. This common element comes from settings where a service assumes fixed goals and where Harry has cited the aim to be abstinence from substance use; the abstinence in the armed forces PTI context is often abstinence from lethargy or poor diet.

Interesting comparisons of the structure and content of this setting exist with those of exercise prescription generally, which has the similar aims and objectives but with a different level of external pressure or influence. Important then to appreciate the common benefits of MI, but also to place more emphasis on the 'why' the client may want to change. Use of decisional balance would elicit work-based/externally motivated 'need' for change rather than 'desire' to change for self/internal motives, which challenges the "DARN-C" findings of Amrhein et al. (2003)—perhaps an inevitable and erroneous outcome in mandated settings. Overall, adjunct measures are required here such as Stages of Change, in order to develop an organic intervention that is 'stage-matched' in order to reflect a little more on the client- rather than relying on MI as a more humane way of coercing the individual to carry out physical training that is part of their job instead of something they want to do or feel a common value towards.

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Tempest in a Teapot?

Michael D. Clark

If there was a consensus from the previous Virtual Symposium, it seemed to detail that coercion and counselor influence occurs in all helping efforts. Therefore, the issue becomes not the presence or absence of coercion (absolute) but rather the issue of *degree* (scale). When prompted by Harry Zerler's question, "Is it legitimate /ethical to incorporate MI in such circumstances (mandated interventions)?" I find myself answering a question with a question: "Why would work with involuntary clients be any different?" One might parry, "Because mandated interventions are problematic due to the tremendous power welded by probation staff." When there is dissonance between an officer and defendant's aspirations, ethical complexities are increased, as probation agents can ask that onerous sanctions be levied in response to misbehavior. My response involves a critical look at the power attributed to probation agents and how that power is used. I have argued elsewhere (Clark, 2001, June) and repeat my contention that a therapeutic relationship in probation work can be established through (1) perspective and role-taking by the officer and (2) skillful negotiations with the probationer.

Perspective and Role-taking

Who welds this problematic power that raises the ethical tempest? A helpful MI perspective answers, "Not the officer!" The locus of power is centered in the judicial bench rather than to any individual officer. To bring this power home to roost with the officer is incorrect. It also proves to limit and stifle the very relationship that becomes the conveyor of change. Take for example a passage found in chapter twelve, "Ethical Considerations," of the MI text (Miller & Rollnick, 2002):

> *…consider a counselor who works with offenders on parole and probation and who has the power at* any time *to revoke that status and order incarceration. (emphasis added) (p. 166)*

Accurately stated, no officer is truly vested with the power to jail an offender, apply new consequences, or increase consequences by personal decision or whim. This is not a case of "splitting hairs" with a play on words. An agent *must* petition the court. The court then substantiates the alleged violations of probation in a formal hearing and *it is the court that determines guilt or innocence and imposes additional sanctions where appropriate.*

No rocks thrown, no intent to disparage, only to point out how pervasive this misperception has become across our culture. The statement that the probation officer "…has the power at any time to revoke that status and order incarceration…" demonstrates something akin to an unfounded "urban legend" that gains credibility though endless retelling. Confound becomes fact. This mistaken attribution of power is not only limiting for the MI-inclined officer, but an incorrect understanding the jurisprudence process.

I do not gloss over personal abuses of power, or even systemic bias that prompts disrespectful treatment of offenders. Officers can (and do) illegitimately grasp at this power base ("I'll lock you up!"). However, abuses of power are not specific to probation agents and can occur within any helping endeavor. Abuses may well crop up with greater frequency in the criminal justice field, yet I would assert that this becomes an *ex post facto* argument for the *greater expansion, rather than preclusion,* of MI within my field.

Misperceptions are understandable and easy to overlook when proffered outside the criminal justice field, but far more troublesome when furthered by criminologists *within* the field. Consider this short treatise from criminal justice academician Robert Mills (1980):

> *The distinguishing feature of corrections that differentiates it from other helping professions is the large amount of socially sanctioned authority, both actual and delegated, carried by the corrections official…The officer must learn to become comfortable with his authority, and to use it with restraint in the service of the officer and client's objectives.*
>
> *The reaction of some inexperienced officers is to banish the "big stick," and go hide it in the judge's chambers or in the warden's office. Such officers seem to believe that social casework and counseling can proceed in corrections in the same basis as in an outpatient clinic, that their "good guy in the white hat" image is somehow tarnished by the possession of so much power over their clients. Officers who conduct investigations and counseling while denying their own authority are usually perceived as being weak, and are subject to easy manipulation by their clients. (*p. 46)

With all due respect, my suggestion is that officers do exactly what Mills cautions against! Motivational Interviewing, as utilized within the field of probation, is refractory to personally assuming the "big stick." This becomes not a "weakness" as purported by Mills, but rather a strength. When using MI with mandated clients, I am mindful of the distinction of "power versus force" (Hawkins, 2002): greater *power* to increase readiness to change and improve outcomes can be harnessed with the use of MI, by establishing fit with a probationer ("Are we together on this?"), than with use of adversarial *force* from the "me vs.

you" nexus of dominance. I believe the ability to create and maintain a therapeutic relationship—essential to the spirit of MI—can only be realized by placing the "big stick" with others.

Skillful Negotiation

Miller and Rollnick (2002; pp. 173-174) detailed a wonderful example of this negotiation with probationers. It begins with an honest explanation of the duality of an officer's roles: certainly to supervise and report compliance to probation orders but also to act as a helper and lend assistance. Should compliance become an issue, the officer negotiates: "How do *we* (you, significant others and myself) keep *them* (the judge, the court, agency policy) off your back?"

In training, I find that staff new to MI have a hard time negotiating these dual roles. Concrete thinking of either/or tends to dominate. "I *either* supervise and seek compliance (applying sanctions for failure to comply) *or* I practice MI and try to motivate and establish a therapeutic alliance." It's not "tea or water," it's the "good-enough" blend that creates the brew. Helping staff to adopt a both/and conception is central to our MINT teapot.

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Treatment Under Orders

Brenda Coldwell

Having worked for eleven years in a National Health Service Alcohol Treatment Unit, a service that incorporated the spirit of MI into all treatment programmes, I left in 1999 to take up a post as an addictions specialist working with military personnel in the Royal Navy, the British Army and the Royal Airforce. Working in a civilian Clinical Psychology Service, based alongside a mixed military and civilian Mental Health Service, my remit is to provide national and international consultancy, training and clinical interventions in the area of addictions, most particularly alcohol misuse. I see no conflict of interests in delivering a clinical service to military personnel as my broad remit is, as it was in the NHS, simply to attempt to help people experiencing problems as a result of substance misuse.

While referrals are made to clinical services by service personnel's General Practitioner or Medical Officer, in much the same way as in the health service, it became apparent that many clients had been referred *'under orders'* following some breach of discipline when intoxicated, exhibiting poor performance, or presenting with repeated physical complaints. Clients have little choice but to attend—non-attendance being a chargeable offence. It might be considered that MI would be inappropriate or ineffective in such circumstances. However, this does not seem to be the case. The MI approach, using reflective listening skills and adult-to-adult negotiation, contrasts markedly with the direct and sometimes confrontative communications that are often used in military services. Indeed, the MI approach has facilitated some level of intervention even in those most resistant.

It has been my experience that these, usually young and usually male, clients are fairly easy to engage in the treatment service simply because being listened to (with regard to problems) in a respectful way is a fairly novel event for them. When attending with the expectation of being shouted at and told what to do, and how and when to do it, affirmation, reflective listening, and an array of goal choices can prove to be a very effective way of diffusing resentment and hostility. Many wished to continue drinking in the same pattern but without the negative consequences. In many cases the opportunity to articulate this *'shifted'* the person into the contemplative stage of change. If at this stage clients are clear that they wish for no further contact this wish is respected. Information about safe drinking can be given and the door left open for further contact should the person experience difficulties in the future. MI has thus given an opportunity to start the process of change, shifted the person a step around the cycle of change and given good information and the message that there are people *'out there'* who will treat you with respect and who, should the need arise, are worth consulting in the future. Having said this, it has been rare for me to meet a client who actually does not want a second appointment and who does not leave the assessment/initial intervention without some degree of commitment to change. Thus *'compulsory attendance',* at least for assessment, has given the opportunity for meaningful intervention.

Engaging a client in the change process gives the opportunity to write back to referrers giving a description of the methods of working with people experiencing problems as a result of excessive drinking. This at least offers other clinicians an alternative model. At best it has lead to invitations being made to talk about motivational interviewing and the spirit of MI.

Similarly, as clients succeed in modifying their drinking behaviour, progress reports describing methods of assessing their levels of importance of change, their confidence in being able to change, as well as recording their ability to articulate the benefits of change and client generated strategies of relapse prevention, are additional means of spreading good practice and defin-

ing "problem drinkers" as worthy of help. It also gives the opportunity of demonstrating "the spirit" of MI as an overlay to clinical practice.

In contrast with the majority of clients seen in a civilian service, where approximately 60% (in-patients) opted for a goal of total abstinence (Windsor Clinical Alcohol Treatment Unit, Liverpool, Data Base, 2003, compiled by Prof. P. G. Booth), most of the military personnel seen in my current practice opt for a goal of controlled drinking. Given the relative youth of this client group, and short duration of the problem with, as yet, limited consequences, this is unsurprising. However, the very mention of a goal choice, so far removed from the previous *'advice'* or experience of *'three month drinking bans'*, serves to diminish resistance. Similarly, when in training sessions the possibility of a return to non-problematic drinking is raised, the message goes out to the wider organization that an all-or-nothing approach may not be the only option.

The fact that these young men have accessed therapeutic services early in their problematic drinking careers has given them the opportunity to make an early start along the cycle of change. Previously my client group had the average age of forty-five, with a heavy drinking history of approximately twenty years. These people often experienced many physical, social and psychological difficulties as a result and had lost home, work and families. Successful clients would often remark *'If only I had come earlier,'* and as a therapist I was often saddened to think of the chaos and unhappiness people endured before seeking help.

Whilst I acknowledge that compulsory attendance is not acceptable in civilian services and would indeed be an infringement of civil(ian) liberties, the Military Services takes "duty of care" seriously as an occupational concern, which leads to the early recognition and opportunity for intervention. Perhaps the serious concern for the welfare of young problem drinkers could be the lesson taken from the military rather than the compulsory aspect of attending treatment.

Treatment under orders,' or at least clients being ordered to attend a first assessment / treatment appointment, has given me the opportunity to work with people at a stage in their lives where excessive drinking has just begun to have serious consequences. At this early stage, still having health and strength, exposure to motivational interviewing seems to help many of these young men to change or to start the process of change. For example, a young man who began drinking heavily to cope with the loss of *'music'* due to his increasing deafness was 'sent' to an appointment following several episodes of drunken brawling. Arriving at the interview angry, upset and confused, he responded to open questioning by expressing his feelings about his situation and his fears for the future. With little prompting he was able to articulate that his drinking had been a futile problem-solving strategy and that he had, within the session, decided to stop drinking. The opportunity to be heard, to hear himself articulate his loss and mistakes, served as the pivotal point for behaviour change. To his credit he went on to make many changes in his lifestyle, took up new activities, and remains abstinent at six months since assessment.

Similarly, with older clients, who have longer histories of excessive drinking and more symptoms of dependency, the contrast between *'normal'* communications necessary in the military and motivational interviewing serves to make the latter a powerful change agent.

Thus I argue that the very context in which military personnel operate make MI the most appropriate and effective approach when offering interventions for alcohol problems within a clinical treatment service. I hope that by good communications to referrers, supervision of colleagues and teaching in a variety of settings, I will be able to promulgate what I consider to be best practice.

Note: The views expressed in this essay are exclusively the views of the author and not those of the Ministry of Defence. The client described in the 'mini-case history' has read and given his approval for the publication of this article.

Probation, Cognitive Skills and MI

Steve Emslie

I am in charge of a program that teaches cognitive skills to people who are on probation. One of my responsibilities is to screen probationers to determine if they are suitable to attend cognitive skills classes I teach, and I have found that MI is perfect for this screening interview.

I don't have much time to conduct these interviews, so I primarily listen and make a few observations and reflections, while the probationer does the real work. Most probationers are used to being intimidated and coerced, and to playing very little part in making their own decisions. They are shocked when I listen to them instead of telling them what to do, and they often open up and tell me their story. Just talking about themselves and what they want in life is very cathartic for some probationers; I have had hard core "gang bangers" start crying in my office. Many times during an interview I have seen probationers make a statement, have a quizzical look come across their face, and then say, "I can't believe I just said that" or "I've never thought of that before." They also say things like, "No one has asked my opinion on that before," and ask why their PO's can't treat them like I do. Many have expressed that they would like to speak with me again.

I am also in charge of training staff and personnel in MI. Probation can be a hard-core business, and POs can very easily revert back to their old ways of negative com-

ments, coercion, and intimidation, even if doing MI is easier (less stressful). How much integration of MI is necessary in POs' caseload management? At this point, just helping POs to understand and practice the basics would be wonderful. If I can get across the spirit of MI and have them understand the process of OARS then I feel I have made some progress.

Is it legitimate to incorporate MI into helping people make it on probation and reduce recidivism? Absolutely! Some people have said that MI is manipulation. I say that if it is used correctly, MI is subtle. Manipulation is getting to do something that they really don't want to do; being subtle means helping people get what they want to have a productive, positive life. Probationers make choices after they weigh the plusses and minuses of a certain behavior or decision; therefore, MI is compatible with everything that I do and with any programs in the criminal justice system. The proactive integration of MI is simply a way of being with and for people on their journey in life. I can't think of anything that couldn't use the principles of MI. To me, preserving the integrity of MI means understanding the underlying spirit, and yes, at a minimum that spirit has to be maintained.

Hobson's Therapist: The Paradox of Mandated Opportunities for Change

Mark Farrall

Harry raises many crucial questions; far more than can be done justice to within the virtual symposium limit of 1,000 words. But I hope people will bear with me while I follow the simple structure of addressing his points one by one, with some case examples of my own thrown in, focusing mainly on the criminal justice sector which I know best and where some of these issues may seem to be at their most stark.

1) Legitimacy & Ethicality

To quote Harry: "Many have questioned the intent of .... [pairing MI] with *mandated* or *coercive* interventions..." (emphasis added).. I believe there is a crucial distinction to be made between these two themes of mandated and coerced: they are not synonymous, though obviously share some meanings. I also wish to distinguish between the general, philosophical, humanistic or person-centred stance of M.I. and the specific techniques or skills used in it.

Thus, from this humanist standpoint, it is not only entirely *legitimate* and *ethical* to treat court-mandated offenders/individuals with respect, understanding and compassion, but an absolute philosophical necessity. This immediately means adopting a stance which, while it can include punishment, focuses on rehabilitation and change rather than retribution—so that, for example, I believe the death penalty can never be justified.

On this fundamental level, the basics of how we treat people, I see no issue of incompatibility between M.I. and its use with those mandated to a particular penalty or treatment. I believe the person-centred stance of M.I. is capable only of contributing positively to the humanising of practice in the crucial everyday interactions which construct our sense of self, and as an antidote to the de-humanising and brutalising effect inherent in current corrections or criminal justice systems.

With court mandated interventions such as "...drunk-driver programs.... drug treatment or domestic violence programs..." it is clearly possible to be non-coercive, respecting the individual's autonomy and right to choose, *through the way in which the intervention is delivered*. If the intervention or treatment truly respects a person's right *not* to change and to *not* take on what is being offered/explored as much as it does positive choices for change, it still, in my opinion, remains legitimate and consonant with the spirit of M.I. Harry's example of his work with Phoenix House illustrates this, as does anecdotal evidence from interventions where people *are* 'made to attend', provided the delivery remains genuine & empathic.

If the intervention refuses to accept an individual's existential right to make choices over their behaviour, and *insists* 'you must change', then it is a *coercive* process and this will be reflected in the delivery, which in my view cannot ever be consonant with person-centred practice. If used, the skills of M.I. will be used in 'bad faith' and be attempting a covert persuasion: thus, their usage is illegitimate and unethical. In Harry's words, this is the face of "...institutional desire to manipulate adherence, compliance or retention..."

2) Effectiveness

In the field of work with domestic violence and abuse perpetrators I know of many examples illustrating the effectiveness of M.I.-based techniques. I say 'M.I.-based' rather than simply 'M.I.' because

a) practitioners are, in general, not trained and skilled enough to be 'doing M.I.' to an appreciable level

b) The setting (group work) is not suitable to the familiar, one to one, hour long model

This effectiveness again splits into 'spirit' and techniques. I redesigned a pre-existing, minimalist model of probation domestic violence group work to integrate the core values and skills of M.I. The spirit was operationalised with court-mandated men from the very beginning, in one to one motivational and assessment sessions which, as with Harry's Phoenix House example, allowed individuals to choose "...to go to jail as more conducive to their goals or values." This is crucial: allowing choice means the men were given a mandated *opportunity* which was not coercive, as they could refuse it.

For men choosing to continue, there followed a two-day induction bloc wherein their fears of being

'confronted with their behaviour' were directly addressed and a respectful, collaborative, exploratory process was established. Throughout, alongside a core component of action methods, the skills of M.I. built on the spirit to challenge, explore, and develop 'critical dialogue', a combination carried through to the core 28-week programme. Staff reviews state that this combination of 'action and M.I.' produced engaged, interested, motivated men, and statistical data for the period the programme was in operation shows attrition (drop out) rates of close to zero.

3) Integration of MI with other interventions

Harry asks if exploration of this question should be a priority? My answer must be 'yes', since I consider M.I. to be a foundational element in any structured facilitation of behaviour change. The question of what is 'necessary and sufficient' integration has an answer in work I was involved in Australia and Estonia. In the former, colleagues and I developed and delivered training in *'Motivational Interactions'* for prison and probation staff to maximise the motivational potential of whatever day to day interactions they had with offenders (Farrall, 2004). While we did not teach staff classical 'Motivational *Interviewing'* per se, we did teach enough of the skills and the core philosophy that the training has now become, according to a knowledgeable source, 'the centrepiece of offender management in [the state of] Victoria'.

We believe this was only possible because of a 'root and branch' approach from senior management: a core team of staff were trained as trainers by us and who would in turn train other colleagues. Staff advancement was tied into taking the practitioner training and supervision structures were established. We believe that this degree of integration, tied to a specific application, is necessary for long-lasting success to occur.

By contrast, work in Estonia where we trained 12 psychologists and social workers did not 'take': despite the aim being to move from an explicitly Soviet-style 'work camp' system to one more rehabilitative and motivational, the work was not integrated on the levels of systems, philosophy, scale and management. Consequently, the initiative was vulnerable to ennui, burnout and lack of support. It is our understanding that very little M.I. practice now continues, despite initial staff enthusiasm, and thus the 'integrity' of M.I as a part of the larger system has not been preserved.

4) Harry's Final Question

I will quote Harry's final question in full: "Can the proactive integration of M.I. with other dissimilar programs or interventions not only help patients/clients, but also promote desirable *institutional* and *programmatic* change towards improved respect for autonomy and volition, improved choice, and better outcomes?"

I believe that my description of our Australian experience provides a clear and resounding affirmative answer: the humanistic spirit found in Motivational Interviewing and its derivatives offers what I believe is a clear platform for effective practice within institutions which at present *do not* have these values at their core. The M.I. skills set offers clear and practicable research based tools which, when applied, offer staff the most chance of generating/receiving a positive and rewarding reciprocal experience, which in itself can alter their attitudes and philosophy toward 'difficult' client groups such as offenders, or patients in forensic settings.

In conclusion I can do no better than to strengthen Harry's proposition that "… despite seeming incompatibilities, [mandated] applications of MI may appear also to positively influence outcomes in ways that are quite consistent with M.I.", by saying that my beliefs and experiences in the field have absolutely demonstrated to me that this is the case: Indeed that "…the *spirit* of MI, and the agency of MI *relationship* as an "active ingredient" to catalyze change…" *do show* "…remarkable power" even in seemingly incompatible fields.

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MI in Custodial Settings

Lars Forsberg

Some thoughts stimulated by Harry Zerler.

Twenty years ago I worked in a prison where I first conducted MI. (At least I think that was what I did.) My purpose was to facilitate discussion of drug use with prisoners. MI was offered to the prisoner and conducted as part of an assessment of the prisoner's drug use. I was inspired by the Drinker's Check Up but had a somewhat wider focus, to cover not only alcohol, but all drugs in the assessment. What I remember of these sessions is my surprise that clients often reacted with interest to the feedback of the assessment results and were interested in discussing drug use constructively. We did not so easily get caught in any of the traps (i.e., the question–answer trap, etc.) as I would have expected.

It also became clearer for me where my responsibility as a counselor ended, and where the client's responsibility started. With MI, the responsibility was carved out more clearly than had been the case for me earlier, which was a great relief. The diffuse responsibility for changing the prisoners' lifestyle away from drugs and criminality I felt previously was much heavier to bear.

I don't have any memories of getting into problematic situations due to the conduct of MI in this prison setting. My own values, as well as those of the rest of the staff, were clearly supportive of prisoners living a drug-free lifestyle and following Swedish law. The consequences of

prisoners showing criminal behaviors or criminal attributes were clear and easily anticipated. The consequences were also explicit, often written down and discussed. Even prisoners could initiate a discussion about a certain consequence. The consequences were also limited – the staff did not maltreat prisoners physically, degrade them, or kill them.

Thinking of an extreme custodial situation, where the staff do maltreat prisoners physically, or degrade or kill them, and where prisoners have great difficulties predicting when this is going to happen (places like Abu Ghraib or Guantanamo): could it be possible to work there as an MI counselor?

I believe that for a prisoner in Abu Ghraib, meeting an MI-counselor who builds rapport, listens, co-operates, under-scores equality, etc., when discussing a problem behavior, must be a positive experience. Furthermore, I believe that it would also be confusing and difficult for the prisoner to trust the MI counselor, because the MI behaviors are in conflict with much else that the Abu Ghraib staff is doing. Thus, I do not find it likely that the Abu Ghraib prisoner will dare to engage in MI sessions and take all the unpredictable risks that are connected to doing so. However, if he does have the courage to do so, I don't think this MI session will do any harm to him. MI might be as beneficial for him as for anybody.

An Abu Ghraib MI counselor, on the other hand, will have a very strong internal conflict to struggle with. I have difficulties understanding how MI values and behaviors could be carried out while at the same time being loyal to the values and behaviors in the Abu Ghraib. Thus, when the MI counselor doing MI violates Abu Ghraib code and behavior patterns, he/she would probably be in trouble, and it might even be dangerous.

Imposed requirements on counselors and clients certainly are worth studying. We need to know more about the significance of the impact of different settings on MI, as well as more about "internal" MI variables of significance. According to the latest research findings we are in the beginning of knowing something of what components in MI count for beneficial client outcome. A few client variables have emerged-- reduced client resistance and increased intensity in client commitment to change. We have hypotheses of which counselor behaviors will facilitate these client reactions, but there is much more to be learned.

In Sweden, we are currently carrying out a study about MI in a coercive setting, but we are not studying the effects of imposed requirements, only if it is possible to conduct MI in a beneficial way in a coercive setting. Twelve prisons are involved in the study. We are comparing five semi-structured MI-sessions to five sessions of "treatment as usual", by which we are trying to establish whether MI is more beneficial for prisoners. Although the first preliminary data will not be available until the end of 2006, at the moment we know that these manual-based MI sessions can be done in Swedish prisons, that many prisoners express satisfaction with the MI sessions, and that the staff attitude is that the sessions are constructive and valuable for their clients.

MI and Coercive Environments: Freedom within Limits

Tad Gorske

Those who expect moments of change to be comfortable and free of conflict have not learned their history. Joan Wallach Scott

I find there is a parallel between mandated clients and mandated MI trainees. Individuals are told they have to do something, are given rewards and punishments for compliance/noncompliance, and are expected to behave in certain ways following the experience. Facilitators are told to teach something participants have to know, *make* them learn it, and then prove that they have learned it so the participants have no excuse but to behave in a certain way. This puts a tremendous pressure on the facilitator to *make* change happen. This is antithetical to MI, which creates conditions where *natural change is facilitated*.

This brings us to the topic of our virtual symposium. "[T]here has been a steadily increasing demand…that motivational interviewing…be a required component of a wide range of human service programs." Stated another way, "A humanistic style of interaction creating conditions that unbounds the self….is required".

A Question of Spirit

During a news program, a question was posed to the Dali Llama: "What do you think of research, is it good or bad?" The Dali Llama responded (and I paraphrase): research is good….or research is bad….all depends on…motivation of the researcher.

The topic of motivation provides some insight to the question of whether MI is ethical, legitimate, and effective in incompatible circumstances. Motivation, that is, defined as the intent of the individual administering the MI intervention. Trainees become stuck on this issue, especially when the topic of empathy is brought up. Some trainees see empathy as an attempt to manipulate clients. Certainly empathy is often used in police interrogations where the goal is to lower the resistance of convicts in order to make them admit something they don't want to admit. However, this is not MI, it is an interrogation. Many individuals in the drug counseling profession don't see that they have been trained to *make* change happen versus allowing it to happen. This is evident when I ask trainees to identify goals for a training and they say, "How do I *make* clients ….; how do you *make* clients see that…" Such questions generally mean, "How do you get clients to fall into the premature focus trap and agree with it." If this is a

helper's motivation, it is not MI. MI does not try to make change happen; it tries to create conditions where change begins to naturally occur. Here is one example:

A client, recently released from prison and mandated to a structured living environment and treatment, came into my office and began complaining about his situation, which reflected anger at his probation officer, the unfairness of house rules, the feeling of being put down and unable to get on with his life, and others. The client's arms were folded and he stared at the ground and gave the message that he was closed to alternative perspectives.

I had a number of countertransference reactions—thoughts such as, "You got yourself into this mess;" "If you want any rights, you have to earn them;" "You're not gonna get anything handed to you". Instead of allowing these thoughts to lead me into any number of traps I listened, empathized, and periodically summarized the client's complaints. As his resistance lowered I began to hear themes of feeling lost and confused, alone, and scared at not having any direction. When I reflected these themes back to the client our conversation became much deeper. Toward the end of the session I asked permission to give some information and advice, to which he agreed. My advice was based on my experience with other clients in similar situations. I've found that those who accomplished their goals essentially 1) were patient, 2) worked with their programs, 3) set short term and long term reasonable goals, and 4) remained in therapy so as to have someone to vent their frustrations with when things don't go their way. The client agreed with these suggestions and we set some initial short-term goals.

Some people might say that I was telling the client to comply and work with the system, and in all fairness I probably was. However, I was very clear that this was based on my experience and what I've seen work, and I was also completely accepting of the possibility that he might disagree totally. Had I started the session with this advice I'm fairly certain my client would have gone in the opposite direction. So far, he is doing well and is slowly seeing some rewards to his efforts.

The lesson learned from this experience is that when faced with a mandated situation, clients have the freedom to follow whatever path they choose—but that often, when they are met with understanding and empathy and given the freedom of choice, they will choose the path toward growth. Having said that, there are limits to this. An example is the article by Mullins and colleagues (2004), where MI was found to be no better than an educational control condition. This was thought to be due to the fact that a group of court mandated women were concerned about information being shared with the court and their child welfare worker, which limited their disclosures. The authors state that "…effective distancing from all coercive forces is necessary for MI to be therapeutic or efficacious" (Mullins, et al., 2004).

A Question of Distance

So, given the reality that many treatment programs have to report to governing bodies, the question remains: How do we create a distance for clients from coercive forces, in order for MI to be effective, when a physical distance is not possible? I think the notion of "freedom within limits" may provide a guideline for beginning to answer this question. The limits are the real world limits that the client and counselor face, and the freedom is the deeper, meaningful interpersonal dialogue that can be created within those limits to begin resolving important problems clients are facing. A graphical model might look like concentric circles, with the *constraints of regulation* surrounding an inner circle of *true MI work.*

Some ideas about working with this model:

1. The inner and outer circle can be smaller or larger depending on the situation. More authoritative and coercive situations will have a larger outer circle and less freedom for MI-consistent interactions, whereas smaller outer circles will have larger MI-consistent inner circles.
2. It is best to be absolutely upfront about the constraints both the client and counselor face, the counselor's role in those constraints, and the limits of confidentiality, as well as to clarify any misconceptions the client might have about how the sessions can be helpful.
3. Counselors may need to examine their own expectations about what can be accomplished in the MI session(s) given the level of constraints. Relevant questions may include: "How deeply can we explore ambivalence? How much self-disclosure can be expected on the part of the client? What kinds of changes can be reasonably expected, given the constraints?"

The question of the usefulness and role of MI in a larger systemic sense will require further experience and research to illuminate this process. Up until now, anecdotal and research evidence presents a mixed bag. I think that's because MI is truly going against the way of the wind in many different respects. The MI world is facing its own challenge of confronting ambivalence to change from a larger social sphere that is skeptical about anything that does not try to actively coerce and make change happen. I think the challenge for MI proponents is to be firm and stay the course without resorting to making others change toward the MI way. If we do that, we defeat our own purpose.

Treating the Mandated Client with Motivational Interviewing

Patricia Lincourt

As a beginning social worker I envisioned working with voluntary, cooperative, and grateful clients. My first field placement changed

that view considerably. I was working with single mothers who were referred to our agency by a child welfare agency as a result of a substantiated child abuse report. They were mandated to participate with our home visits, parenting groups and respite day care for their children (all under 4 years of age). Their other option was to surrender their children to foster care. Many of these clients were mystified about the "founded" reports, having grown up the same way they were now parenting. They were very suspicious that the "system" was targeting them because they were poor or minorities.

My enthusiasm for helping at this point (I was 24 and had not even conceived of children of my own) was absolutely boundless and I am quite sure enough to annoy the most polite of my "clients," who occasionally hid the fact that they were home by turning off the lights and trying to quiet their children with "shushes". Naïve as I was, I was not blind to the fact that I had almost nothing in my experience that could help me to understand the dilemmas many of these women faced; nothing that is, other than a willingness and ability to suspend my own judgment and empathize with them. Even with little formal supervision I had read a lot of Rogers and found that listening really seemed to help to diffuse the client's anger and often helped me to identify something we could legitimately work on even if it was not the mandating source's main goal.

This was not the last time I was faced with a group of "clients" who did not ask for my help and were less than confident that I could deliver help even if we both tried really hard. Of course this never stopped me from trying really hard. Often ten or twenty times harder than the reluctant folks I was charged with helping. I must admit in looking back many of these mostly kind people must have smiled in amusement.

The question I have often asked is: "Is it worth it to impose counseling on those who are rightly skeptical and often not interested in order to provide an option other than jail or other punitive response?" Clients I have talked with are mixed on this question, with many reporting that they probably would never have gotten help without such intervention, and others stating that mandating treatment slowed their progress to real help by keeping them angry and oppositional.

Based on my experience, I rarely question whether using MI in this context is the right thing to do. Twenty years later and with a wealth of experience both clinically and personally, I still often have little in my own life experience that can help me truly understand the situation of a severely abused recovering crack user hanging on to her 9 months of sobriety to parent her 12 month old and to avoid mistakes made with her older children. I have nothing that is, other than my ability and willingness to suspend my own judgment and empathize. To me this is what creates a therapeutic relationship from which to have a discussion about change. Once we have entered into that discussion MI has all of the tools to guide me to help the person sitting across from me find his or her own wisdom.

As long as treatment offers opportunities for people to make changes in behaviors that are unacceptable to society, we as treatment providers will see mandated clients. For me, MI has provided a base of operations in keeping separate from the mandating sources and allowing a means not only to connect with these reluctant clients but also to help me to focus the conversation from that point. Over the last twenty years I have not always been successful in engaging or moving clients in the desired direction but I've almost always been moved by them, and I am increasingly in awe of the human spirit. I see many colleagues and trainees feel angry and bitter that their help is often rejected. I believe I have MI to thank for not feeling more "burned out"—that and the fact that, since I don't do home visits anymore, I get to frame "no shows" any way I want.

One Perspective from the "Fixed Goal" Contingent

Jeanne Obert

I think this topic relates directly to my initial enthusiasm for and interest in Motivational Interviewing. I still have the three-ring binder from the first training I attended in October, 1993 in Albuquerque. In that binder Bill had included a draft of a paper later published in *Behavioral and Cognitive Therapy*. It was titled "Motivational Interviewing: III. On the ethics of Motivational Interviewing." In it he addressed the issue that was often raised when we first started teaching this technique: Are people being "manipulated" by the interventions?

At the time, we were just starting Matrix and developing a cognitive-behavioral protocol for working with drug and alcohol abusers—especially stimulant users. We were trying to go beyond the "if you're not ready for treatment, go out and continue your using until you're ready to listen to what I have to say" approach that dominated the field. We were suggesting that the therapist had some responsibility to meet potential patients where they were and to develop that "readiness" in their patients. I was so excited that Bill and Steve had been working on just that and had developed a way to better define a style that could help people actually develop that "readiness."

It seemed to me at the time that the problem wasn't with the patient, so much as with our (professionals) inability to know how to work with many of the patients who came to us. We knew from the research that how the person entered treatment wasn't important. If they stayed in treatment for most of the treatment episode, their success in treatment didn't correlate at all with whether they were "ready" when they started or with whether they were forced to come through the door. Granted, we were defining success as stopping or reducing the use of drugs and alcohol. Then the

question becomes, is it ethical to use motivational interviewing to achieve a goal that is imposed on the patient?

Perhaps this same issue is at the core of whether or not we should be applying motivational techniques with *mandated* patients. Naturally the goal of our outpatient treatment program is to assist people in dealing with their drug and/or alcohol problems. What if they don't think they have a problem or are not ready to deal with it? This is a very timely issue since we have a recognized epidemic (or maybe pandemic) of people abusing methamphetamine. An interesting quality of meth users is that they frequently do not identify the drug as the problem – they see the problems the drug has created in their lives as the problem and the drug as the solution. Should we go with patients' identified issues even when it is evident that they are impaired in their ability to evaluate the situation?

It is precisely this type of problem that has gained the most from the advent of Motivational Interviewing, in my opinion. If a patient is entering a *drug abuse treatment program* the agenda of the program and the organization is no secret. However, the individual treatment plan can not begin with an action plan designed to help the person stop using if s/he is earlier than that in his/her stage of readiness. While the mandated patient is being forced to come to the treatment program, the therapist can begin treatment with the expressed goal of helping the patient "get those people off my back" or "help me prove to people that this drug is not a problem" or "help me do whatever I need to do to keep my children."

As we all know, the traditional way that treatment programs dealt with mandated patients who were unaware that the drug was the problem was to blame the person who is in denial and either take the next person in line who *did* want treatment or berate the patient into submission. The goal of keeping mandated patients in treatment (given that we know they will do just as well as the non-mandated person IF they stay in treatment) is defeated. They are lost from treatment—and, by the way, it's their fault.

The point we are all trying to get across to those we train is that you may be able to engage and retain the person in treatment if you are willing to meet him/her where s/he is and formulate a treatment plan that deals with the things s/he sees as "the issue." What I have come to realize is that this is a much easier sell if the professionals I'm talking to are working with patients who are paying for treatment and if the *professional* is motivated to keep each person in treatment. The real work comes when you're trying to advocate for this style with people who are working in the public sector and who are overwhelmed with the size of their caseloads, the acuity of today's dependent patients and, sometimes, their own burnout. Why should these people make their job harder by working with someone early in the process of change when there might be 5 people in line behind him/her who "really want treatment?" It's a very hard sell.

It seems to me, at this point, that the problem with the mandated patient is not the situation by which the person comes through the door to treatment – we can always use more doors. The problem is that the system is not motivating the caregivers to actually give the best care to each person mandated to treatment by starting from where the client is. The more educated the caregivers become about how to do this, the more options they have. The more we can get them to feel good about slow movement from one stage of change to another, the less burned out they will be. This is what keeps me excited about doing this work. And I think I just came full circle—don't we always? The bottom line is, "You can lead a horse to water, but you can't make him drink." Is it unethical to insist that the dehydrated horse move toward the water? Is it unethical to whisper to the horse until he decides to drink? Maybe, maybe not, but he won't die of dehydration and that's a good thing.

Swimming Upstream

Joel Porter

I often say to trainees that, "Motivational interviewing is strong medicine." I know this first hand. In the fall of 1998, I attended the annual conference of the American Society of Addiction Medicine and found myself sitting in on a panel discussion. I cannot recall what the topic was, but I do recall Carlo DiClemente discussing this thing called "Motivational Interviewing". As much as I would like to admit otherwise, after ten years of working in and around the addiction field in the USA, this was the first time I had ever heard of MI. Be that as it may, I was interested in this flashy sounding "new" approach.

I returned to Germany, where I was living, and began looking on the web for any and all information on MI. Although I did not know it at the time, I was starting down a path that would radically change my thinking about addiction and treatment, and psychology in general. Two years later I was back in Atlanta, Georgia, USA, working at a well-established private addiction treatment centre. I was hired to bring some new ideas into a treatment centre firmly rooted in the disease model of addiction and the view that total abstinence was the only acceptable outcome. The treatment ethos at the time relied upon interpersonal confrontation, acceptance of ones' disease, peer pressure, recovery role modelling by staff and rule compliance to effect change. Regardless of their reasons for seeking treatment (voluntary or mandated), people were assumed to be in denial of their disease, and needed to "get with the program" in order to get better. Involuntary admission to the centre was optimal since this equated to *leverage*. Within this treatment paradigm, leverage was the crown jewel of therapeutic tools to enhance motivation for change.

Hindsight being what it is, I can see that all this was just another stone that contributed to the ever-unfolding mosaic of my life. I arrived on the scene with a head full of MI (I had just read the first edition) and ready, willing, and able to be an agent for institutional change. I was keenly aware that just my presence and mission would evoke concerns from the staff, who all "believed in" the disease theory and provided treatment accordingly. Shortly after my arrival, I crossed paths with Bill's article "Rediscovering Fire: Small Interventions, Large Effects" (Miller, 2000). After reading this amazing piece of work and exchanging mail with Bill and Terri, at my own expense I headed off to Sante Fe for an Introduction to MI workshop. To make a long story short, two things stand out in my mind: 1) That I was the only trainee in the MI workshop from a private addiction treatment centre and 2) On the third day, telling Bill and Terri that I am going to have to quit my job before too long. In true in MI fashion I was encouraged by the both of them to utilise the spirit and principles of MI with my colleagues and see where that takes me.

Well, within a year it took me to New Zealand. Back in Atlanta, I provided four hours of in-service to my colleagues and was befuddled as to why they had not seen the same light that I had. I recall comments such as: "Aren't you really just siding with their disease and co-signing their bulls***t by being nice?" "Isn't this MI really just a Machiavellian approach?" "Are you telling us we *have* to start doing this now?" "If they (the patients) knew what was best for them, they wouldn't be here." "You're actually saying that denial does not exist!" "Isn't this really about teaching people to be social drinkers?" Shortly thereafter, management abandoned their idea of re-inventing the treatment centre and settled in to the security of "If it ain't broke, don't fix it". From a business perspective the treatment centre was certainly not broke and the books needed no fixing.

So, *can the integration of MI with a dissimilar program promote desirable institution and programmatic change towards improved respect for autonomy and volition, improved choice, better outcomes?*

As a dyed in the wool optimist, I have to say, "Yes" to this question. Had I known then what I know now, I would have worked with my former colleagues in a way that was more congruent with the Spirit of MI. Had I spent more time evoking concerns, wisdom and experience from the group and less time educating with facts and outcome studies things may have gone a bit smoother for us all. I am sure to have missed several key points where I could have worked in collaboration, supporting their choice of treatment approach as opposed to preaching the wonders of MI as though I was looking for converts. At the end of the day I am sure we all wanted to the same thing: to be helpful.

It is clear that I bit off a bit more than I could chew in Atlanta. What I introduced to my former colleagues was a model of change that, from their point of view, was incongruent and in competition with their loyalty to a model and approach they *believed in*. What is crystal clear to me today is that I did not have the experience or skill as a trainer to provide the level of training required to adequately give them the opportunity to experience MI in full.

Even though an addiction treatment programme may rely on hierarchy, leverage, conformity and confrontational strategies, I believe that that training in MI can make a positive contribution that will effect change within the organization. In a training opportunity such as this, I think the key to unlocking closed systems and providing meaningful MI experience is not based on *what* information or techniques I provide, but in understanding *how* people learn MI (Miller, submitted). A positive training outcome for me is that people are interested in practicing MI and that they have a solid starting point to begin learning how to do MI from the people with whom they work. As I heard Bill say at the TNT in Greece, "Your clients teach you how to do MI". By and large, people who choose to work in the people-helping field want to be helpful. If I can offer them an approach or a way of thinking about things that they find helpful, then my guess is that they will be more inclined to practice MI in a real-life setting.

An organization does not have to systematically adopt all of MI in order to receive benefit. A sound MI training experience can provide the words and a framework to describe what many practitioners are already doing with people, as well as validate what already makes intuitive sense to them. Most professionals working in the human services world resonate with some of the basic elements that comprise the spirit, principles and microskills of MI. I think that just a little bit of MI can go along way in promoting desirable institution and programmatic change towards improved respect for autonomy and volition, improved choice and better outcomes.

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Anecdotal Evidence from the Developing Field within the Criminal Justice Interventions Setting in England

Lyn Williams

In response to my colleague Harry Zerler's paper "MI and Mandated Interventions: A Virtual Symposium," I would like to proffer the following contemplations to the question of applying MI to the development of the criminal justice intervention services in England.

Harry Zerler makes reference to the

continuing interest in the appli-

cation of MI in circumstances that may be legally mandated, or otherwise structured by program or community standards that impose requirements on counselors or therapists, and on clients or patients, that may appear to be incompatible with MI. Yet despite seeming incompatibilities, such applications of MI may appear also to positively influence outcomes in ways that are quite consistent with MI.

I would like to focus on how MI has played a part in the development of services within the criminal justice sector, and some of the current challenges facing practitioners within the field in applying MI to their work.

Reflections and Observations on Organisational Development

It has been an interesting and exciting time in the drug treatment sector in England over the last 3 years. The sector was ready for the investment and willing to take on the challenge of development, although some organisations have struggled with being able to deliver in an environment whose culture has been becoming much more accountable in terms of governance and the need to be business-focused in its operations.

There has been focused activity in creating competencies and qualifications. Motivational Interviewing skills have been a key component for competency in the development of practitioners within organisations and in particular within the drug treatment sector. Training is paramount, as there is good evidence that well-trained, supervised and optimistic staff have better outcomes with clients. In terms of human resource and organisational development, MI has a solid base for improving the culture within services to one of hopefulness and recovery.

The Drugs Intervention Programme

Another recent development in England is the Government's Drug Interventions Programme, which is

a range of services designed to target drug-using offenders at every point of the criminal justice system. By identifying drug users in the Criminal Justice System it aims to get them into treatment, off drugs and away from a life of crime. (www.homeoffice.gov.uk)

Training in MI for Arrest Referral Workers working within the Custody Suites

I would like to offer an anecdotal example of how MI has made a difference in the field. A colleague and I recently delivered two days of training in MI skills with Arrest Referral Drug Workers (ARW) within custody suites. As an opening exercise we asked practitioners to orient each other to the context that they work in and some of the challenges that they face on a day-to-day basis.

In their words, ARW's described how, on the one hand, in some work areas relationships had developed significantly and there was a real sense of support from the local police for the work that they were trying to undertake, while on the other hand other, practitioners were facing cynical police and courts personnel whilst trying to work with clients to instill some sense of hope and choice in the situation (MI spirit).

The greatest challenge for the practitioners was the introduction of the new Drug Intervention Record (DIR). This document is aimed to be a single record of a person's comprehensive assessment, which totaled 59 questions and 17 pages. The practitioners reported that this document alone could take 30 minutes or more to complete, and that by the time the client had gone through this process, there probably would be little more time than to hand over a contact card. Was this MI compatible, one asks?

My colleague and I were thinking (we reflected on this with each other after the training), How are we ever going to find a way to build in MI around the DIR form? The practitioners were from varying backgrounds and had little or no experience of working with MI. We began to deliver our training, and our experience with the trainees was one of growing enthusiasm as we got into the day. Going through practical exercises such as "Roadblocks" and "Virginia Reel" affirmed their view that there could be a different and better way of working with clients and this could be MI. There was discussion from the group that some of the confrontational communication that they witnessed on a day-to-day basis acted as a block to engaging with clients. It was quite a profound moment as participants realized skills such as OARS were in fact a way of working with clients that could help increase service users' willingness to consider their commitment to engaging in treatment services. Tools such as the "Readiness Ruler" provided an option of a visual cue to work with clients to discover how

"Ready, Willing and Able" they were to consider tackling their drug issues. The "Decisional Balance Sheet" and the "Personal Values Card Sort" were seen as tools that could facilitate a dialogue on what life could be like if clients considered stopping using substances, and where their values were at that moment in time. The fact that MI embraced personal choice made absolute sense within this setting, as clients still had choices in whether to take hold of the opportunity to make changes.

We discussed with the ARW's whether these tools could be used within their day-to-day practice, and we set the task alongside them to test out integrating the skills and tools into their work alongside the DIR form, which would be then be presented and reflected on at their training review day.

Initial Responses to the Questions from Harry Zerler

So, is it *legitimate / ethical* to incorporate MI in such circumstances? Yes it may be, as these practitioners saw a way for MI to be used to create space and an opportunity for change for people in custody. They saw their brief interventions as an opportunity for valuable

space and time for clients to contemplate if they chose to, even if their conversations were conducted through a cell window.

And is it *effective* to incorporate MI in "compatible" circumstances? We have yet to see what the practitioners come back with in terms of their feedback on the effectiveness of implementing what they learned into practice

In conclusion I am in agreement with Harry Zerler in that the "*spirit* of MI, and the agency of MI *relationship* is an "active ingredient" to catalyze change, and shows remarkable power". So does the setting matter after all, as is MI not a way of reaching out and walking alongside people?

Focus on the Seed not the Forest

Wilburn C. (Dub) Wright

I wonder if we sometime focus on the top of the forest rather than recognizing the necessity for planting the seed. Training an agency may be like trying to fertilize a forest from the air. Maybe we need to accept that many agencies have administrators, systems, and individuals that are not fertile ground for the MI seed. At the same time, we have to be ready to help the individual seed in that agency that is ready to sprout. By preparing the soil and planting seed we can greatly increase our "forest" over time when we use follow-through coaching for those in the agency who want to grow.

Some agencies are looking for an "instant fix" or something that will meet their training requirements. Many are unwilling to make sacrifices to be sure adequate training is done. However WE as trainers can make sure those individuals who do wish to learn applicable skills can have the follow-through and coaching on their own individual time and in their situations. The Internet tool allows us to expand beyond telephone, personal visits, and tapes by using e-mails, webcams, and listservs to help those who want the help.

Evidence of the Sprouted Seed

I unknowingly used some basics in MI for many years before it was "born," sometimes successfully and other times unsuccessfully. I found that the spirit of MI was most effective when it was applied on an individual basis.

As a parole office in Houston pre-MI, my supervisor would never have accepted any premise of autonomy, evocation, and collaboration. We had "rules," and, by gum, the parolees abided by them or we would go for revocation. To even try to use a concept like MI would have been met with total ridicule. Whereas today we are seeing less ridicule, I strongly suspect that underlying skepticism is still prevalent.

I was "reprimanded" several times by my supervisors for being "too easy" on my parolees and, looking back, that was because of my use of the spirit of MI. I had a man call me at home and plead with me to pick him up at his home and take him to the Houston, Harris County Jail. I had revoked his parole a week earlier and he and several others had escaped from a jail in another county. The relationship I had developed with him during his parole showed him that I accepted his autonomy and his right to choose. The collaboration toward correct choices obviously was not effective, but the atmosphere was there. It was interesting that he accepted my revocation of his parole without anger toward me.

Using MI and Losing the Contract

Children's Protective Services contracted with an agency to provide training for parents whose children had been removed from their home. Parents were mandated to take the parenting course before CPS would consider returning their children. The agency had a very structured lecture program for "teaching" parenting skills. The first class I taught I "followed the manual." By the end of the training attendance was at about 60% and about 50% passed the agency test.

The second time I taught the class I decided (without permission) to use the manual as a resource and the parents as the teachers. I wanted to evoke from them parenting ideas that worked and ideas that did not work so well. The use of humor was very important—learning how to laugh at their own ideas and the ideas of others while moving toward valid and usable solutions. Attendance remained at almost 100% throughout the training. When one parent could not attend, the other one always did. The atmosphere of collaboration recognized that the parents were actually "good" parents with ineffective parenting skills but with a desire to obtain them. In recognizing that each parent, each child, and each situation was different, I was able to help them work together as a team finding effective and acceptable discipline methods.

Was this successful? I do not know. They all took the test at the end of the training, and the classes I worked with scored significantly higher than those who did the lock-step lecture training; however I was "allowed to quit." It seems that administration was very uncomfortable that we might move from chapter two to a section covered in chapter eight and then go back and review something in chapter one. The process was more important to them than the goal, and we must accept that in some agency situations.

Ethical Effective Use Of MI?

Recently a detective took my MI training in preparation for a career change to work in the substance abuse field. He began using the MI tools within the interrogation process of suspects. He found that by letting them talk about their values, doing complex reflections that demonstrated understanding of

their views, they began talking freely and his confession rates significantly climbed. The suspects were given their total Miranda rights before the interrogation so they were aware of the potential consequences of what they said. He was so successful that the other detectives put a banner in jest over his office door labeling him "The Confessor."

I posted this on the MI Listserv, and it drew significant discussion as to the ethics of the use of MI in this situation. A question arises here: who is the client? Is society the client or is the individual being interrogated the client? Is the use of MI questionable when it places the individual being questioned at risk as far as being indicted for a crime? Should MI trainers be willing to train those whose primary goal is to solve crimes?

The Unhappy MI Marriage

A school district contracted with me to work with substance-abusing high school students. Because it is illegal to expel student for more than a week, the identified students were mandated to take this "training." A school administrator required that I use a friend of his (in recovery) as a co-trainer. This individual (let me call him Fred) has as his basis of expertise the AA program he attended. He refused to meet with me in advance, saying his life training was more useful than my "book learning."

The first session I arrived early and was outside talking with students when Fred roared up on his Harley with a sleeveless tee shirt freely exposing his preponderance of amazing tattoos. He as an instant hit with the students. They quickly exchanged bumps and grinds and "bro's" and launched into war stories. This carried over into the "training." There was no work at change and no real work on the issues, and I was quickly ostracized by him and the group. After the second meeting I contacted the individual supervising the program and explained my concern with the process. After the third meeting I explained that ethically I could not work with Fred and the gang and terminated my contract. Lesson learned!!

The Bow Takes the Hits

I think that as the bow of the ship of MI we must accept that we are going to hit the heaviest ice floes, and we need to be prepared for this as we move forward. When we hit an ice floe, we need to share and examine our methods, values, processes, and ethics and share what we learn, good and bad, with one another.

Response to Commentaries

Autonomy, Control, and the Greater Good

Allan Zuckoff

In his typically eloquent, thought-provoking, and playful Virtual Symposium essay, Harry Zerler poses four questions on the topic of use of MI in mandated interventions. Roughly paraphrased and simplified, they are:

1. Is it *ethical* to integrate MI into these settings?
2. Is it *possible* to effectively integrate MI into these settings?
3. Is it *important* to find out whether, and in what ways, MI can be integrated into these settings?
4. Is it potentially *transformative* to integrate MI into these settings?

I would like to begin my consideration of these questions, and the responses of our symposiasts, by hazarding that, for Harry, the answer to the first question was never really in doubt: surely he would never have "*deliberately and enthusiastically embraced every sound opportunity…to explore the effectiveness and value of MI in combination with 'less-free' circumstances"* had he not believed that doing so was, indeed, an ethical course of action. His efforts, as he makes clear, focused on exploring the possibilities, trying out a range of methods, and discovering the limitations of this integration.

Among the symposiasts, the clear consensus is that MI can, indeed, work in mandated settings; that it is possible—though not without challenges—to integrate MI into these settings; and that, given the potential for MI to positively impact the cultures of these settings, developing ways of doing so is an important undertaking. Several symposiasts (as well as Quercia, Guelfi, Scaglia, & Spiller in a related article) describe evidence ranging from anecdote to efficacy to effectiveness in support of these positions.

The symposiasts also seem generally in agreement that, while ethical considerations must be given their due, they are not troubled by the use of MI in a range of "less free" contexts. On the contrary, they argue on conceptual as well as evidentiary grounds that the integration of MI can only benefit both the individuals who are mandated to treatment, and the system that mandates them.

Questions about the feasibility and potential impact of integrating MI into mandated settings are empirical ones, appropriately addressed, as Harry and the symposiasts have done, through review of more or less controlled experience. The question of significance is largely rhetorical; the existence of the symposium itself would be senseless unless the answer were "yes." Where I believe I might contribute to the discussion is in raising some further questions about the positions (some of which are implicitly rather than explicitly drawn) taken by the symposiasts on the ethical ramifications of doing MI with mandated clients.

One line of reasoning holds that, as a respectful way of treating people, MI is an unambiguous boon to those mandated to treatment, who may rarely experience such treatment otherwise. Indeed, in some contexts, MI may be virtually the only source of support for autonomy that individuals receive; as such, MI potentially becomes a counter-cultural force for humane values in coercive settings.

That MI's client-centeredness is more humane than more coercive styles of communication seems inarguable; if we were simply talking about the use of skills for rolling with resistance, or for expressing understanding, it would be hard to see how anyone could object to the use of MI in mandated settings. These skills embody a spirit of gentleness, understanding, and non-confrontation that could well humanize encounters in settings where the spirit of compas-

sion and kindness might otherwise be missing. But MI is more than just client-centeredness; what of the "directive" elements of MI, or the intention not just to calm or connect with people, but to influence them to change their behavior and their choices? Does MI become simply a more humane way of achieving the outcome desired by the coercive institution? And if so, is not it not preferable, from the standpoint of human freedom, that the tiger show its teeth, so that the prey knows it is being set upon and has a chance to resist or escape?

A second line of reasoning holds that mandating people to attend treatment is not the same as coercing them into changing behavior; so long as the MI practitioner does not fall into abetting coercion of change, there is negligible harm in doing MI with those who have been externally pressured to attend. Furthermore, since mandated clients retain the freedom to defy the mandate, so long as they are willing to accept the consequences, their presence in treatment means that they have chosen to attend.

The first thing I wonder about this argument is: when we offer individuals a "choice" between participating in a counseling process intended to result in behavior change, and a punitive process intended to result in behavior change, what sort of choice are we offering them? Are we really offering them a choice—or are we, in essence, saying: you can do this the hard way, or you can do it the easy way—what's it going to be?

I also wonder: what are the implications, for the practitioner of MI, to be at least implicitly endorsing the agenda of an institutionalized authority (whether governmental, military, or even religious in nature)? Imagine, for a moment, that certain foods were determined to be so dangerous to one's health, that a governing body with the power to enforce its dictates prohibited their sale or consumption. (I suspect that Anders Beich would not find this scenario as far-fetched as others might.) How comfortable would we be, ethically speaking, supporting the use of MI with people arrested and mandated for treatment of high-fat-food abuse? How about for body abuse, if masturbation were criminalized?

A third line of reasoning holds that MI practitioners can and must be trusted to make ethical choices with regard to determining when their clients' autonomy is or is not being adequately protected. Though the ethical delicacy of offering "choices" to people who may believe that they must choose in a certain way because the person offering the choice has the power to punish is recognized, trust in the clinician's self-reflection as a way of deciding when and whether genuine choice has been offered wins out.

This argument relies on the goodwill and the wisdom of providers of mandated interventions to use the power they have in ethical ways. But is it really safe and wise to entrust clinicians with that much power? Though not part of the Virtual Symposium, the reflections offered by Doug Fisher in this issue seem relevant to this question. How sure can we be that our motives are as pure, and our perceptions of clients as objective and unbiased, as we would like to believe? What would be the implications for the ethics of mandated interventions of learning that we are not always aware of how our own biases and struggles are influencing our interactions with our clients? And might it be preferable to rely not on the choices of individual clinicians, but instead on rules that make it impossible for providers to abuse their power, by denying them power that they could abuse?

The fourth and final line of reasoning I will consider in fact underlies, I think, all of the others: that the pragmatic, bottom line is that MI helps those who receive it in coercive settings, and that the benefit it brings outweighs any harm the reduction in autonomy inherent to providing it to mandated clients causes. In this argument the clash of values implicitly in play throughout this symposium takes center stage: that between 'autonomy' (or freedom) and beneficence. For at least some symposiasts, the choice is self-evident, indeed may not even seem like a choice: if it helps, then surely it is the right thing to do. And when the harm to autonomy seems slight—and especially when one could argue that MI has the potential of restoring autonomy stolen by addiction to a drug or by other compulsive behavior—it may seem like a no-brainer.

It has been claimed that it is impossible to defend one value against another, since it is on the basis of our values that we argue for a course of action. The question of whether it is possible to ground our choice of values in something more fundamental is beyond the scope of this discussion. So instead, I will raise the question of the supremacy of beneficence by invoking two well-known situations in which it is subordinated to other values.

Informing a patient who has only days to live of this fact may not be beneficent—in fact, it might be the occasion for terrible mental suffering through the last moments of that person's life. In the past, physicians argued just this way in order to justify withholding that information. Yet today the field (at least in the USA) has reached a clear consensus that such withholding would be unethical, in the name of valuing autonomy—the right to know, and thus to have some control over one's response to, one's impending death.

Though in practice, psychoanalysts have influenced their analysands and wielded their power as analysts to do so, the analytic ideal, as articulated by its most important theorists, is to valorize autonomy as the goal as well as the method of analysis: the analyst does everything possible to avoid intruding upon the analysand's autonomy, and the outcome of a successful analysis is autonomy, that is, freedom from inner bonds to the past and ability to be in charge of one's own life.

Without question, the world as it is, is a place where many people will be mandated to receive psychological treatment. One could argue that, given this reality, it is better for the mandated to receive MI than a more authoritarian or disrespectful one intervention. And this is an argument for which I have some sympathy.

Yet I find myself unsettled by the recurring question: at what cost, not only to the mandated, but to us as MI providers, do we make ourselves a part of coercive systems? Government controls, even when put into place with the best of intentions, can end up robbing individuals of their dignity as well as their freedom. What do we sacrifice (and how precious is it?) when we join MI with the apparatus of social control? MB