

From The Desert

Bill Miller

Can Organizations be MINTy?

Individual clinicians who learn MI sometimes become more conscious of aspects of their organizational culture that are inconsistent with MI. Some of them change jobs: "I just couldn't work there any longer." Others choose to stay on and seek to change the culture.



What would constitute an MI-consistent organizational climate? A good starting point would seem to be the principles of MI spirit: collaboration, evocation, and autonomy support. An MI-consistent organizational climate should be apparent to those who work in it as well as those who are served by it.

Collaboration. One level at which an MI-consistent organizational climate would be apparent is in how its management and staff do their work. The principle of collaboration suggests a participatory rather than take-

it-or-leave-it climate. A collaborative organization is one that offers choices and takes an active interest in the needs of its members (employees, clients, customers). Employees and clients are actively engaged in making decisions that affect them. The opposite is a top-down organization in which decisions are passed down through a hierarchy without consulting members.

Evocation. Similarly, the employees and clients of an MI-consistent organization are not passive recipients (e.g., of salaries or services) but are important sources of ideas, priorities, and solutions. Members are regularly asked what they think and want. There is active interest in the collective welfare of the organization and its members. The opposite is an autocratic structure in

which policies and decisions are made behind closed doors, then merely announced and enforced by the organization.

Autonomy Support. Relatedly, an MI-consistent organization not only tolerates, but values and celebrates diversity. Individual differences in needs, styles, and preferences are honored. Members of such organizations have a sense of being respected and valued. Self-direction and self-determination are encouraged. There are active channels through which employees can enhance their skills, growth, and opportunities. The opposite is an organization where priority is given to uniformity, unanimity, and obedience.

This does not mean, of course, that MI cannot be used and important within organizations that are themselves less MI-consistent. Uniformed military and police organizations, for example, understandably rely on obedience to authority rather than self-direction. Prisons tend to be run without collaborative decision-making by inmates. Nevertheless, MI may be usefully practiced by certain personnel or programs within such organizations, and indeed its impact may be enhanced by its contrast with the larger context.

How Do Organizations Become More MI-Consistent?

How can organizational climate be changed to better support the practice of MI, and manifest a more MI-consistent spirit? Obviously one important factor is leadership buy-in. The director and

Editor's Choice

Hammering MI

Allan Zuckoff

In MINT Bulletin 13.1, fresh from attending a conference chock-full of positive views of MI, I burbled happily in this column that *MI is All Around*. Somehow, while wafting about on a cloud of good feelings, I had managed to ignore the cautionary notes sounded by Bill Miller (most recently) in the summary of his plenary talk at MINT Forum 2005 published in the very same issue. Under the heading "Some Things That Concern Me," Bill pointed out that, as MI diffuses rapidly, the risk grows that it will become a diffuse approach as fewer of those exposed to it "get it right;" indeed, he continued, "[t]here are already published descriptions of MI that depart substantially

from what we regard to be the essentials."

Well, not long ago I came across a letter to the editor, published in the *Journal of Psychiatric and Mental Health Nursing* (2004), titled "Motivational interviewing: A hammer looking for a nail?" The letter bears summarizing as an illustration of exactly the phenomenon Bill has been concerned about.

According to the author, Jane Graham, who cites *MI2* as one of her sources, MI "is largely heralded as the definitive model for effecting behavior change" in the field of substance misuse. However, she continues, alluding to Abe Maslow's well-known dictum to the effect that everything looks like a nail when all you have is a hammer, "the client and their (sic) situation may be made to fit the tool rather than the tool being adapted to suit the needs of the client." MI, she says, may not really be suitable "as a 'one-size-fits-all' treatment."

Feeling very much like Alice after she passed through the looking glass, I learned that MI was developed by Bill and Steve “following clinical studies based on their experiences of tobacco use in the United States during the 1980’s” and then “modified to enable its use with drug and alcohol users.” The model “is cognitive-behavioural in approach,” and is “underpinned by four broad principles that form the stages of the model.”

The author then offers the substance of her critique, which contains the following claims:

- ◆ Because it “is focused more on ‘doing’ than ‘being’” MI is “likely to be less empathic in its process than is claimed.”
- ◆ Bill and Steve claim that MI “is a skill that can easily be learned and put into practice,” a belief evinced by the fact that the average training course lasts only 2 days. Yet “the development of empathy is widely accepted as emanating from life experience and self-awareness.”
- ◆ Given the rapid, widespread implementation of MI, “the consistency of the standard with which it is taught and practised...” is questionable, making it “something of a lottery for the client with respect to the quality of their therapeutic care.”
- ◆ Abstinence being the government-mandated goal of substance abuse treatment, whereas controlled use is frequently the goal of clients, the real discrepancy developed in MI “may often lie between the expectations of the therapist and those of the client.”
- ◆ Similarly, rolling with resistance is “merely a cat and mouse game” in service to the achievement of the therapist’s “hidden agenda.”

- ◆ While supporting self-efficacy is “not inappropriate,” it is “simplistic” in light of many clients’ developmental deficits.
- ◆ In contrast to the “quick fix” mentality of MI, clients “need space to develop their own insight and develop wholly at their own pace.” All MI does, in contrast, is “knock away the values the client attaches to their (sic) substance misuse...and replac[es] them with little else on which to rebuild a life.”
- ◆ The evidence for MI is “based on clinical studies and practice with a limited clientele,” whereas “researched evidence still remains sparse and in its infancy.”
- ◆ Following as it does “a singular, unitary approach,” “principally access[ing] the client] through the cognitive channel,” MI “lends itself best to clients who are particularly verbal and cognisant,” “exclu[des] clients who have cognitive impairment,” and “is not suitable for many substance misusers.” Though she herself uses MI selectively, the author concludes, it cannot “replace the power of empathy itself; the honest meeting of two people, both vulnerable, in a therapeutic space.”

While it would be easy to make light of its blatant misunderstandings, I have found myself discomfited by the nagging sense that this letter represents the shadow side of the very popularity of MI that I expressed pleasure about a few months ago. It might be, in part, that the letter reflects the variability in the quality and availability of MI training that the author (and Bill) worry about. But getting so much so wrong, and so completely missing the spirit of MI in her descriptions of it, suggests something more at work.

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managers of an organization set and model norms for how members are treated. It is difficult to practice MI when the organizational climate and structure promote opposite values. Organizations can sometimes be transformed from the bottom up, but it’s usually a slow process.

A start, then, is for key opinion leaders to promote the spirit and practice of MI. If the organization’s objective is to increase the uses of MI in clinical services, for example, the key leaders may be clinical managers and supervisors. I believe it is also helpful to have a team of individuals who work together, perhaps at different organizational levels, encouraging each other. The practice of MI is more likely to be promoted by training and supporting one team of five co-workers at one agency, rather than one isolated individual at each of five agencies.

Those who are most able to influence the social climate of an organization, however, are those who select and hire new personnel. As staff turnover occurs, priority can be given to hiring employees already skilled in MI, or whose working style is at least consistent with the spirit of MI. Such change can be particularly rapid in systems with high staff turnover. Tom McLellan has estimated, for example, that the average personnel turnover in U.S. addiction treatment programs is about the same as in the fast food industry—roughly 50% per year (McLellan, 2006). That affords an opportunity for a major change in organizational climate within a relatively short period of time. That change may, in turn, reverse the pattern of high turnover. It is my experience that an MI-consistent organizational climate promotes staff retention and reduces burnout, but thus far I know of no systematic data on this point.

How MINTy is MINT?

As the MINT organization has grown, we have struggled with how best to preserve the spirit that has characterized the network from its very beginning. The kind of rapid growth that we have experienced invariably challenges an organization to adapt without losing its mission and character along the way. What, then, are the organizational values that MINT wishes to manifest? Again, the principles of MI spirit seem a sensible starting point.

First, MINT has certainly been collaborative. There has been a generous spirit in the free exchange of new ideas, materials, and training exercises in our meetings, listserv, and website. MINT promotes the sharing of resources and ideas around its central mission of promoting quality MI training and practice. In fact, resource and idea sharing was the original pur-

Might not the author be manifesting the reactance we are so familiar with in clients who feel pressured to accept someone else's views, and believe that their own values and concerns are being disregarded? In light of its still-growing popularity, can we prevent MI from becoming an enemy to be hammered?

In This Issue

From the Desert, Bill Miller ponders the question, *Can Organizations be MINTy?* Current SC chair Chris Wagner provides a *Steering Committee Update*, and this is followed by a note on the upcoming *MINT Forum 2006* by Jackie Elder on behalf of the Planning Committee. We then present an **Update** of their recent position paper by William R. Miller, Theresa B. Moyers, Paul Amrhein, and Stephen Rollnick, entitled *A Consensus Statement on Defining Change Talk*. Guy Azoulaï gives a rich account of his method for *Teaching Empathy in Motivational Interviewing* in France, and in the **International Forum**, Gian Paolo Guelfi describes an exciting step in the advance of MI training in his country in a *Note from the MI-TNT in Genova, Italy, November 2005*. Grant Corbett tells us **What the Research Says... About MI Training: Part II**, and Cathy Cole shares her **Adventures in Practice** in *Struggling with the Righting Reflex*. And the issue concludes with two new features. In **Training Tools**, we will present ready-to-use materials for MI trainers; for MINT members who prefer developing tools to writing about them, this provides an opportunity to share what you have created. Mike Clark inaugurates this feature with two training handouts, *The*

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pose in organizing MINT. This generous spirit has also extended beyond the organization. Our training materials and other resources are shared free of charge on the widely used MI website. We have sought to extend TNT and MINT participation to trainers from third-world nations and other underserved populations. MINT is there to serve the needs and concerns of trainers in promoting quality MI practice and training.

The principle of autonomy has also characterized MINT. No one is required to become or continue being a member. We have avoided any role as "MI police" to enforce uniformity within MINT, or to restrict practice and training. Differences in approaches to MI and styles of training are not merely tolerated, but valued. We provide a menu of options, but mandate nothing. The organization has operated wholly on a volunteer basis, with countless hours devoted by those who have chosen to serve the welfare of the MI community.

The evocative principle becomes more challenging as an organization grows. Certainly this implies readily available channels for members to provide ideas, opinions, and perspectives and to have a say in the organization. When a group is small this is fairly easy. As it grows, the process becomes more complex and representative. From a committee of the whole, MINT moved to management via a volunteer steering committee. The listserv continues to be an open forum for member opinion and participation. The annual MINT Forum also affords such an opportunity for those who can afford to attend.

As MINT continues to grow, we will continue to struggle with how best to adapt without losing the organization's soul. I suspect that we will be well served by asking in particular how the Network can best manifest the central attributes of MI spirit.

Lessons from the Twelve Traditions

I have often reflected on similarities between MINT and the organization (or lack thereof) of Alcoholics Anonymous, clearly one of the most successful international social organizations. In many ways, we manifest similar organizational values. In AA, these values are best expressed in what are known as the Twelve Traditions (not to be confused with the Twelve Steps). A web search will quickly point you to the official wording. Not all of the Twelve Traditions have direct parallels in MINT, but here are a few worth pondering:

1. *Our common welfare should come first . . .* It has been characteristic in MINT to put the common interests and welfare of the group above personal interest and gain. It's a simple but important tradition: our common welfare should come first.

2. *. . . Our leaders are but trusted servants; they do*

MINT Bulletin

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"I Have What You Need" Expert Trap of Installing Right Behavior and The "You Have What You Need" Spirit of MI for Evoking the Client's Own Motivation for Change. And finally, in a feature we call **Speaking Personally**, **Jake Rollnick** offers his unique perspective on the oft-debated question, *Is Motivational Interviewing a Tool or a Way of Life?*

Looking Forward

As I write this column, planning for MINT Forum 2006 Miami is progressing rapidly. I am particularly looking forward to two of the sessions. The Forum will include its first ever Poster Session, designed to give members who would like to share their work, but do not wish to take on the responsibility of leading a plenary or breakout session, a chance present a poster along with (we hope) a large number of other MINTies. Scheduled at the end of the first day, it should provide a relaxed and informal opportunity for mutual learning and pleasant discussion.

The other session I eagerly anticipate is the opening plenary of Day 2. Titled *The Evolution of MI*, this panel discussion will be an extension of a special issue of MINT Bulletin, due at the end of the year, that will celebrate the contributions of Bill Miller to our field on the occasion of his retirement from the University of New Mexico. Planning for this *Festschrift* ("celebration publication") issue is under way, and I anticipate that it will be among the most special I have been privileged to edit. Panel members for the plenary session will be drawn from contributors to the *Festschrift*. With Bill in attendance, it promises to be a highlight of the meeting. **MB**

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not govern. There is no question in my mind that this has been the case in MINT to date. In fact, the organization has had very little that could be considered governance of any kind. We have operated more like a band of nomads. A growing organization, however, will need more specific principles of operation, if not governance, and MINT leaders should continue to be regarded as trusted servants. To emphasize this, A.A. does not permit any one individual to occupy an office for more than a few years.

4. *Each group should be autonomous except in matters affecting other groups or A.A. as a whole.* We already have a few national and regional MINT groups, and certainly there has been no effort or even inclination to constrain them. The same principle of autonomy has applied to individual MINT members as well. The occasion may arise where that autonomy needs to be constrained if member or group actions affect others in MINT; thus far that has not been a significant problem, primarily because of member faithfulness to #1 above.

5. *Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.* MINT also has had a central purpose—to promote quality practice and training of MI. It is important, I think, to be clear about and remember what MINT's primary purpose is, and what it is not.

6. *An A.A. group ought never endorse, finance or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.* So far, so good. We have had nothing that is officially MINT-approved thus far except for Training for New Trainer events that lead to MINT membership. We have also asked members not to use MINT membership as a badge of qualification, and we state this caveat on our webpage. I anticipate that there will be future requests to use the MINT name to endorse specific products, proposals, facilities, credentials, publications and such. Central in our vision should be the primary purpose of MINT.

9. *A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those we serve.* We have behaved as if "MINT, as such, should never be organized." Like AA, MINT has no officers, no President, no Board of Directors. Instead MINT has operated via volunteer ad hoc committees responsible to the membership. Unlike AA, we also have had no central office or salaried staff.

10. *Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.* MINT has not taken

organizational positions on political issues, endorsed political candidates, etc. We have operated by an informal guideline that even the listserv should not be used for communications outside the mission of MINT, such as to express opinions on national political issues or figures. No one speaks for MINT.

11. *Our public relations policy is based on attraction rather than promotion . . .* I'm not sure we even have a public relations policy, but certainly MINT has operated by attraction. People join MINT because they are drawn to it, and stay because they love it. We do not market MINT, have membership drives, or seek to promote MINT's growth or influence. If anything, we have been cautious to limit growth. The annual TNT/MINT event has no marketing beyond announcement on our website and listserv.

12. . . . *Place principles before personalities.* Clearly MI now has a life of its own on a world scale that transcends any personalities, and so does MINT. Steve and I did not initiate MINT, and we have been actively resisting and stepping back from any decision-making role. MINT is now effectively self-governing. No one is MINT or MI. Rather, together we seek to understand and manifest principles.

It is intriguing to me that we have developed, through our history together, an organizational structure and traditions similar to those of A.A. I suspect we could learn more through this comparison. Perhaps our NYC MINTies could pay a visit to the A.A. Central Office in search of some organizational wisdom. **MB**

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Steering Committee Update

Chris Wagner

Five upcoming TNTs, the MINT Forum, workgroups focusing on several aspects of MINT operations, and a transition to administrative support underway—the MINT steering committee has been hard at work.

The upcoming months will be a busy time for training new trainers and bringing them into the MINT group. We have English-language TNTs in South Africa (September 13-15) and the US (November 28-30), a Scandinavian-languages training in Sweden (September 11-15) and a French-language training in France (January 23-26, 2007). As of this writing, the South African and Scandinavian TNTs are full, and the US and French TNTs are filling up. Trainers for the South African and Scandinavian events were mentioned in my previous Update. The French training will be led by Cristiana Fortini, Johanna Sommer, and Dorothee Lecallier. More on the US TNT below.

In addition to these public events, we are trying a new systems-focused TNT process with the Iowa corrections and substance abuse treatment systems. Denise Ernst, Chuck Sweetman, Jeannie Kerber, and I will be leading a small TNT of 6-8 individuals from these two systems that will be immediately followed by those new trainers conducting a 2-day clinical training with the four of us as coaches. Denise, Chuck, Jeannie, and Mary Velasquez have been working with these systems for the past few years, and this TNT is part of a new phase of system-development that will include follow-up coaching, training, and mentoring. This approach is similar to informal training of trainers that have been done in various systems by a number of MINTies, but is the first time that MINT is directly offering such an event (although a similar approach was endorsed by MINT in Sweden several years ago). In addition to piloting this approach as a new way to bring trainers into the MINT network, we are also determining if such an approach may be able to help to provide some much-needed funding of MINT infrastructure development.

Regarding the organizational development of MINT, the committee recently initiated four task groups intended to focus on different aspects of MINT functioning. An infrastructure group is taking a broad look at all aspects of the structure and functions of MINT in order to brainstorm a viable set of processes for future MINT management. A practice development group is working on summarizing current knowledge about MI training and practice, leading toward the possibility of

renewing consideration of certification options. The member relations group is developing procedures to survey MINT members on various issues and documenting the activities of various regional MI trainers and practitioners groups. And finally, a finance subcommittee is preparing a fiscal report for membership review, followed by fiscal planning for the years ahead. As these workgroups establish themselves and get moving forward, we plan to invite participation of interested MINT members.

Most visibly, the steering committee has been arranging the upcoming TNT and MINT Forum in Miami Beach. The MINT-sponsored TNT event, being held November 28-30, will again include two subgroups of 40 participants, one led by Denise Ernst and Ralf Demmel, and the other led by Cristiana Fortini and Steven Berg-Smith. The steering committee again selected pairs of trainers that balanced experience (one returning TNT trainer with one new trainer), gender, and continent (Europe and North America anyway). SC members experienced an approach-approach conflict in choosing these trainers from among nominees forwarded by previous TNT trainers and steering committee members.

The MINT Forum is being held November 30 – December 2, and promises to be a productive and exciting event. The planning group for this year's event includes Jacqueline Elder (chair), Judith Carpenter, Jacki Hecht, and Allan Zuckoff. A tentative schedule has been developed, with openings left in place to accommodate anticipated developments over the coming five months before the gathering. Unlike past years, the TNT and Forum are not being held at a con-

ference hotel, but at a free-standing conference center (the Miami Beach Convention Center). We have reserved a block of rooms at the Doubletree Surfcomber, a beachfront hotel about three blocks from the convention center. The hotel has a recreation area including a large pool and beach volleyball court, and direct access to the beach and boardwalk. A few minutes' walk down the boardwalk brings you to the heart of the Art Deco district, with many restaurants, nightclubs, art galleries, and retail stores.

These events are not all that is happening around the MINT network. The Irish Association of MI Practitioners (IAMIP) recently had what sounded like a very productive and enjoyable meeting. The Nordic group is meeting in Denmark in October, hosted by Annette Soegaard Nielsen and colleagues, and continues communicating through their own listserv. The Italian and German groups continue to work together to develop MI in their own regions/languages, and the budding South African group is posed to expand their collaborations following the upcoming TNT there.

Please email me at chrischwagner@gmail.com with information on other regional MINT or MI activities so that we can continue to share the information. I have now turned over the role of steering committee chair to Rik Bes, who will serve as SC chair through the end of 2006 while we work on our reorganization plan. However, I would still like to continue to gather information on MINT regional activities as part of the member relations workgroup.

I hope to see many of you in Miami Beach!



MINT Forum 2006

Jackie Elder on behalf of the
MINT Forum Planning Committee

This year's MINT Forum, to be held at the Miami Beach Convention Center, Miami, Florida, USA, from November 30 – December 2, is shaping up to be both informational and interactive. We will be covering issues/subjects from "MI and Cultural Diversity" to "Coding," from "MI's relationship to 12 Step/Spirituality" to "Clients' Experiences of MI," and many others; there will be sessions specific to healthcare clinicians, behavioral health clinicians, and corrections/criminal justice clinicians, to name a few. The first ever MINT Forum Poster Session will give attendees the chance to discuss each others' work in a relaxed and informal atmosphere. We are also most excited to have Bill help us kick off our dedicated "training day" on Day 3 with "A Refresher for Aging MINTies," which will describe all the developments in MI over the last 10 years. This will be followed by a swapping of training ideas by interested MINTies and presentation of specific techniques for use in future trainings.

The Planning Committee is very appreciative of all the great ideas that have come in from members, and we look forward to a great Forum. We are also working on a "night out" together, but haven't quite nailed down those details yet. Fun and fellowship are high on our list of priorities, as well as making this an educational meeting. From those of us on the Planning Committee, we look forward to seeing you in sunny Miami Beach!

Update

A Consensus Statement on Defining Change Talk

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

Editor's Note: In MINT Bulletin 12.2 we published an article by Paul Amrhein, William R. Miller, Theresa B. Moyers, and Stephen Rollnick entitled "A Consensus Statement on Change Talk." In January, 2006, the authors posted a revised version of their statement in the members-only section of the MINT website. With their permission, we reprint their revised statement here.

A Brief History of Change Talk

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), the term "self-motivational statements" was used to describe a broad category of speech acts that favored change. Four subtypes of self-motivational statements were described in *Motivational Interviewing* (Miller & Rollnick, 1991):

- Advantages of change
- Disadvantages of status quo
- Optimism for change
- Intention to change

In preparing the second edition, Miller and Rollnick responded to comments from trainers that the term

"self-motivational statements" seemed a bit awkward, and they coined "change talk" as a simpler alternative. In the second edition (Miller & Rollnick, 2002), "change talk" was used as a substitute and synonym for self-motivational statements, with the same subcategories.

This definition of change talk was also used in the first version of the Motivational Interviewing Skills Code (MISC 1.0; Moyers, Martin, Catley, Harris, & Ahluwalia, 2003). Several studies, however, failed to find the predicted relationship between change talk defined as above (and in MISC 1.0) 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 system began with 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.

Subsequent experience in coding change talk revealed one additional category not included in Amrhein's original system. Termed "taking steps," it involves statements indicating that the person has taken specific action toward a change goal. Studies indicate that taking steps is also a predictor of target behavior change, and in this regard may resemble commitment more than the antecedent DARN categories.

Specific Recommendations

1. Use "Change Talk" as the Generic Term

We recommend that for clarity in future writing and training, the term "change talk" be used to encompass all six recognized types of self-motivational statements: desire, ability, reasons, need, commitment, and taking steps.

2. Use "Preparatory Language" to Describe DARN

From Amrhein's research, desire, ability, reasons and need statements did not directly predict behavior change, but rather were antecedent to increasing strength of commitment. For this reason it is useful to have a term to summarize DARN and to differentiate these statements from commitment and taking steps. We recommend using the term "preparatory language" to refer specifically to the four DARN categories of speech.

3. Use "Sustain Talk" to Describe Status Quo Statements

Natural language also contains statements of desire, ability, reasons, need, and commitment that favor sustaining the status quo rather than changing.

We recommend using the generic term "Sustain Talk" (originally suggested by Jeff Allison) to summarize these counter-change statements.

4. Differentiate Resistance from Sustain Talk

Finally, we recommend a more limited and specific use of the term "resistance." In prior MI writings and training, "resistance" has often been equated with arguments for the status quo (i.e., sustain talk). This is somewhat problematic, in that it seems to pathologize what is a quite normal process of verbalizing the status quo side of ambivalence. There is a meaningful class of client behaviors, however, that does not constitute sustain talk, but nevertheless signals dissonance in the counseling relationship and is inversely related to behavior change (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Miller et al., 1993). Such behaviors include interrupting the counselor, disagreeing with or discounting the counselor, and changing the subject away from discussion of change. We recommend that "resistance" be used specifically for these behaviors, and differentiated from sustain talk.

5. Use No Zero Value in Coding Strength

For purposes of coding the 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

goal 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). A revised version of the MISC (2.0) included strength coding of change talk on -5 to +5 scales, with values of -5 to -1 representing sustain talk, and values of +1 to +5 representing change talk. In either unipolar or bipolar rating scales, no zero value should be used. **MB**

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Change Talk (directed toward a change proposition)			Sustain Talk (directed away from change)	Resistance
Preparatory Language	Commitment Language	Taking Steps	Desire for status quo	Interrupting
Desire			Inability to change	Disagreeing
Ability			Reasons for status quo	Discounting
Reasons			Need for status quo	etc.
Need			Commitment to status quo	

Teaching Empathy in Motivational Interviewing

Guy Azoulai

Introduction

Carl Rogers was the first therapist to emphasize the centrality of the counselling relationship to the efficacy of therapy. In work published in the 1940's and 1950's, he described three critical conditions necessary for a therapist to promote self actualization in clients: showing empathic understanding, unconditional positive regard, and congruence.

Over the years a great deal of research concerning therapy efficacy has been conducted, and it has given some startling results. Rather than better methods, what seems to emerge is the finding that what actually fosters success lies in the therapist's ability to establish a good working alliance with his or her client. Studies have repeatedly shown empathy to be a major ingredient of success in therapy, and this has remained true no matter which method, patient, problem, or stage of change was addressed. It has come to be the holy grail in the therapist's quest for efficacy.

Yet, even though it is now understood to be an undisputed part of therapeutic efficacy, I have never been taught empathy throughout all my studies as a physician or as a therapist, and have found only limited material helping to give a better understanding of what it is, how we recognize it, how we experience it, how we express it, and mostly, how we teach it.

Defining Empathy

In searching for ways to answer those questions and turn those answers into simple and pragmatic exercises for the trainees attending my seminars, I have found that empathy could not be thought of like any other social skill. It is multifaceted, and seems to require a convergence of skills. Before going into how I go about trying to get trainees to develop those skills, let's start by defining empathy.

If one wants to marvel at the array of popular definitions of empathy found in France, all one needs to do is address the question to a group of general practitioners. Here is a sample of some of the spontaneous definitions that usually arise: "feeling what the patient feels", "suffering as one with the patient", "identifying with the patient" "being able to understand the patient", "knowing exactly how the patient feels",

"being able to put oneself in the patient's shoes". Although these definitions might seem similar, some in fact do not apply to empathy at all (the first three), and some don't quite capture the full essence (the last three). This will become clear as we move into what empathy is and how to make it work for the client.

Carl Rogers defined empathy in the following way: "...being empathic is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto ... it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them..." Rogers does not limit empathy to the understanding of clients' emotions; he widens it to the scope of frame of reference, thoughts, values, judgments that underlie those emotions.

Described in this fashion, empathy can be seen as a particular interpersonal skill that requires a subset of intrapersonal skills. In order to teach empathy, I have tried to develop a pragmatic and functional definition. There seem to be two closely interwoven parts to empathy: the capacity of experiencing it, and the capacity of conveying it to the client.

Two Facets of Empathy

Experiencing Empathy

The first facet of empathy would necessarily be the ability to establish good rapport, create a climate allowing for clients' self-disclosure, and elicit spontaneous expression of key values, thoughts and emotions. Part of this would probably be

intuitive from the knowledge of the client's sensitivity and the situation he or she is going through. Then one would have to perceive and identify verbal as well as para-verbal and nonverbal signs allowing one to recognize the emotions most likely being experienced by the client. Here it would be necessary to identify and to handle anything incongruous in the different modes of expression, for instance the patient claiming that "everything is fine" with a shaky voice or a nervous stance.

The ability to imagine oneself in another's place plays the key role in the understanding of the other's feelings, desires, ideas, and actions. Yet this understanding would not be empathic by Rogerian standards if the therapist, in projecting him or herself in his or her client's place would be sharing the same thoughts and values, experiencing the same emotions, and producing the same behavior. How could the therapist be able to help the client if he or she were to experience helplessness, hopelessness and despair in a similar situation? In order to convey hope it would seem necessary for the therapist to have a different point of view based on experience and personal growth. In order to experience empathic understanding, imagining oneself in another's place would have to be, in Rogers' words, "just as if" we were there, yet harboring a different and helpful point of view.

Conveying Empathy

Experiencing empathic understanding alone without conveying it is unlikely to be helpful to the

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client. Empathic understanding has to be shared in order to be effective. This can be done by direct expression of one's understanding or by reflecting thoughts and feelings in nonjudgmental fashion. Cultural adaptations of the way we express and reflect are probably necessary. Certain expressions are likely to elicit resistance in some clients. One example I have encountered in France was with the expression "I can imagine just how bad you must have felt," that gave in return a few "No, you can't imagine" responses. Paraphrasing seems a good way to convey understanding without referring to oneself: "You must have felt pretty bad about that".

Teaching Empathy

Prerequisites

When is it appropriate to teach empathy? Before coming around to teaching empathy, I will have trainees able to do reflective listening and paraphrasing, using the methods familiar from the first edition of *Motivational Interviewing* with some variations of my own devising.

To help trainees understand what reflective listening is all about, I begin by getting them into pairs of speaker and listener and having the speaker give an account of a recent and happy event while the listener shows/he is listening by nonverbal attitudes and facial expressions alone. A first synthesis of speakers' reactions to this exercise usually sounds something like: it's not always easy to talk about something personal, even if it's happy, to someone we don't know, but eye contact, facial expressions, and body language that show respect, attention and interest facilitate speaking. A synthesis of listeners' comments typically sounds something like: listening closely to what someone is saying isn't easy; we are also listening to our own inner voices telling us what we would like to say (about ourselves, what we think and feel, what advice we'd like to give, etc.), and keeping ourselves from saying it at the same time.

Trainees themselves then usually come up with using rephrasing as one key way to keep the client on track without bringing in their own agendas. In France, rephrasing is often done in the shape of a closed question: "Are you saying that...?" However, this can lead the client to focus on "helping the listener understand" rather than "hearing what s/he has him/herself expressed". When asked, How can we get the client to focus more on what s/he is saying?, with a little help the trainees usually find that they can use a statement—"What you are saying is..."—to do the same rephrasing. I then tell them, "That is what we call a

reflection".

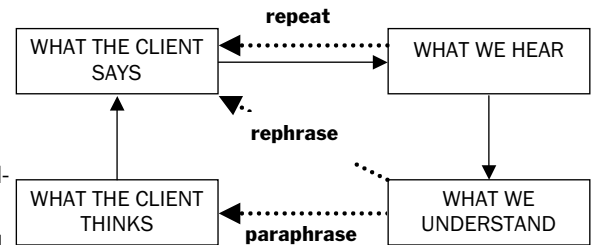
I then suggest we take a look at Thomas Gordon's "roadblocks" and see together why he suggests that these are roadblocks to communication. In the light of the preceding exercise it usually becomes easy for the trainees to spot how they all arise from our own agendas and judgments, and that using reflections keeps us out of roadblocks. Some trainees have a hard

time accepting the idea that positive judgment can be a roadblock; in these cases I help them recognize that "positive judgment" is still judgment, and trainees quickly understand that this tells clients that we could also be judging negatively. This is a good way to introduce affirmations, which I present as selective, non-judgmental reflections of clients' strengths, resources, self-enhancing behaviour, and personal achievements.

The next thing I have the trainees work on is developing their "third ear", listening to things that aren't said. To illustrate this I play a client and ask them to see if they can guess through my behavior what I am most likely to be thinking without it being far-fetched. I will then sit among them and non-verbally express that I am not interested in dialogue with them by turning back on my chair, looking behind, not answering solicitations, looking at my nails, cleaning them, etc.. The trainees easily see that I'd rather be elsewhere and that the only reason I'm staying is because I feel obliged. I then give them the following feedback: "What you've just been doing is a special way of reflecting. When we reflect the most probable underlying thoughts we can hypothesize from

what we know of the client and his/her situation, verbal communication, and nonverbal cues, we call it "paraphrasing."

To illustrate the differences between rephrasing and paraphrasing I use an adaptation of the familiar basic communication schema:



The next exercise helps develop reflective thinking and paraphrasing skills. I ask a volunteer to complete this phrase using a descriptive adjective which summarizes one of his or her characteristics: "I am a ____ kind of person." I give a few examples of adjectives and encourage the trainees to find their own: realistic, outgoing, fun-loving, cool, wild, serious, etc. The other trainees are then asked to make guesses as to what s/he means and express that in a statement: "What you are saying is that you ____." The volunteer is told to give only a yes or no answer, and the group gives feedback on the guesses: were they rephrasing or paraphrasing, questions or statements? We give it a few rounds so trainees can see that there are many ways to paraphrase and still get it right. After the exercise I ask for feedback from the volunteer on how it felt to receive the paraphrasing, whether right or wrong. The volunteer usually says that, right or wrong, trying to understand shows concern and that helps build trust; and, when it's right, there is a very gratifying feeling of really being understood, a "positive energy" that helps him/her want to say more.

I end this sequence of exercises with an introduction to empathy: "We are now going to look into

something you all have heard a lot about, empathy! As we will see, expressing empathy can be seen as a special kind of reflection that focuses on what people are feeling.”

Introducing the Concept of Empathy

I then introduce the concept of empathy by explaining its importance in the change process and giving some references:

- ♦Luborsky et al. (1975) suggest that it is only common factors that are important e.g., therapist warmth and empathy, partnership between therapist and client accounting for the fact that therapies are equally effective
- ♦Miller, Taylor & West (1980) suggest that the outcome in therapy is closely related to the degree of empathy expressed by the therapist
- ♦Crits-Christoph et al. (1991) suggest that outcome of therapy depends more on the differences in therapists rather than differences in types of therapy.
- ♦Lafferty et al. (1989) write that the crucial therapist qualities for effectiveness are: empathy, emotional understanding, directiveness, and support
- ♦Najavits & Strupp (1994) found effective therapists showed more warmth, understanding, and helping and were less likely to ignore, reject, or attack clients than ineffective therapists
- ♦Kopta et al. (1999) emphasise the importance of the therapeutic alliance, the active co-operative relationship between the client and therapist

Asking for a Definition

I will then ask the trainees to explain what they think empathy is and to feel free to do so even if it's just a wild guess—mistakes are welcome as it is not simple to define. Usually faced with a wide variety and so as not to offend anyone I acknowledge that there are quite a few definitions going around, and say that we will be focusing on the one given by Carl Rogers, and that we will see why this definition makes empathy so effective.

How People React When Faced with Emotional Distress

I will then ask trainees to consider the following situation: a child has just lost his balloon and he's crying desperately over it, making a huge fuss in public and demanding it back although it is quite apparent there would be no way of retrieving it. I ask them to imagine the different attitudes parents might have and things they would say to their child.

There usually is a wide array of responses, and in the answers that are given we can see emerging different attitudes towards the child's grief. Some don't

address the child's distress at all: "You only have yourself to blame", "I will get you another one next time", "Say goodbye, balloon". Some will address it while disqualifying or minimizing it: "Will you stop this fuss, it's only a balloon", "How can you be crying so much for a balloon when you have so many toys at home?", "If you stop crying I will get you an ice cream," "If you don't stop crying, I'll give you something to really cry about". Some will acknowledge it and adhere to it: "I know how bad you must feel, I still feel bad about the ones I lost when I was a child", "It was such a nice balloon, how sad you lost it". The less frequent answers are the ones where the feelings are acknowledged without adherence: "I know how sad you must be, you really liked that balloon". If needed, I will give a few examples myself. I have also used as example that of a grown person crying and what adults usually say, with somewhat similar results.

The Four Basic Positions in Regard to Emotional Distress

Once it is acknowledged that we take different attitudes regarding others' emotions I tell the trainees that we actually have words to define these attitudes. These words have changed meaning over time and may not be used in their original sense today. They can be found with their original definition in a dictionary from the 19th century. Their meaning stems from their etymology. They each consist of a prefix placed in front of a root word, in this case pathy, which comes from the Greek word *Pathos*, originally meaning "suffering". Empathy is one of those words, composed of the prefix *em* and the root word *pathy*.

I then ask the trainees what prefix they would use to indicate that emotions had been altogether ignored by the listener, adding that this is a very common prefix often

used to indicate that something is absent. The trainees are quick to find the word *apathy*, which originally meant not being concerned by another person's distress. One analogy that I use is that of a swimmer in distress. He sends out signals to indicate his distress. Being in apathy would be the equivalent here of seeing without understanding the distress calls and moving on. We then look for examples of things we say that may lead a person to think we weren't concerned or hadn't noticed his distress.

Next, I tell them that sometimes we do perceive a person's distress but tend to think he is over doing it and shouldn't be reacting so much. In a way we are disqualifying the importance of that distress by minimizing it. I ask what prefix usually indicates going against something, and the word *antipathy* is quick to be found. In the swimmer analogy, the witness sees and recognizes the swimmer's distress but minimizes the severity of the situation. She could very well be shouting to the swimmer, "Come on now, calm yourself and concentrate on your swimming, you are only a few yards from shore". We again look for examples of antipathy commonly used in everyday life.

We then focus on the word that would indicate the perception of distress where the listener would be feeling an equal amount of distress herself. The prefix used here usually indicates the fact of being strongly together. The term *sympathy* is quick to emerge (if not, I suggest they think of "symbiotic"). Here one can imagine what would happen to the witness who would jump in the water to help the swimmer in distress and find herself in the same predicament.

One of the most common confusions made in France is that between sympathy and empathy. This exercise will help trainees to recognize the differences between

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those two attitudes in a practical way. The prefix *em* in front of *empathy* can be found in other words such as “embrace” or “embark”, it refers to containing without being a part of. Here there is a particularity in the French language, where the same word is used for both “containing” and “understanding”. A witness seeing the swimmer in distress would very accurately send a lifesaver from a place where she had good footing.

A	PATHY	No response to other’s distress
ANTI	PATHY	Minimizing other’s distress
SYM	PATHY	Sharing other’s distress
EM	PATHY	Understanding without sharing other’s distress

Comparing the Positions’ Effectiveness

The trainees are invited to think just how helpful each of these attitudes would be to someone in distress. In order to illustrate this I use the table below, in which four criteria would be considered for each attitude: to what extent each attitude tells the client he or she has been listened to, shows understanding, is nonjudgmental and is helpful in that it can inspire hope and offer guidance. Apathy shows little or no listening, understanding or helping. To express antipathy implies acknowledging the client’s distress, while rejecting it instead of trying to understand it. The expression of sympathy shows both good listening and understanding, but offers no help. It can also be noted that antipathy and sympathy both contain elements of judgment, and are therefore in contradiction with unconditional positive regard. The table has been filled in the following manner by every single group I have used it with since I conceived it.

	LISTENING	UNDERSTANDING	JUDGING	HELPING
APATHY	NO	NO	NO	NO
ANTIPATHY	YES	NO	YES	NO
SYMPATHY	YES	YES	YES	NO
EMPATHY	YES	YES	NO	YES

Relying on Trainees’ Experience to Understand the Effectiveness of Empathy

Once the trainees have a better understanding of what empathy is, I will help them see why the expression of empathy is so important for the therapeutic alliance. I usually ask them straightforwardly, “Why do

you think it has such an impact on the relation and on outcome?”

The trainees are invited to refer to their own experiences. What do they do that helps when they feel bad? For those who need to talk about it, what qualities do they seek in those they talk to, and how does that help them? The trainees are quick to recognize that sharing a burden with someone who can lis-

ten and understand without judging can be soothing. The trainees will often say that talking to someone who knows how to listen helps them feel better right away, it can be like

a weight off their chest, it can help them get things in perspective, think more clearly and feel more confident

in dealing with the problem.

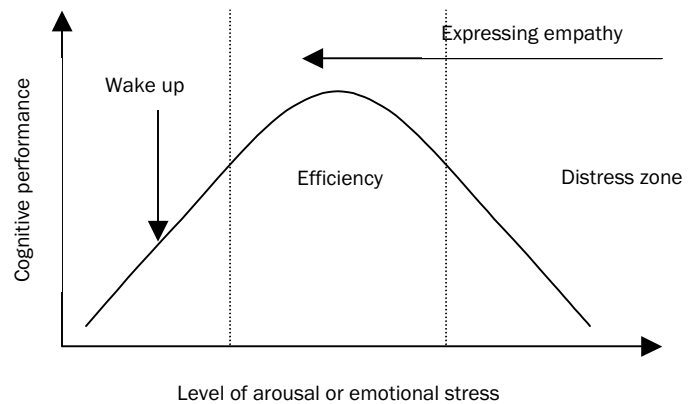
Sometimes they can also get ideas and advice and come away with a different point of view that will be more helpful in the long run.

We can then see how this applies to therapy. It is usually agreed that the expression of empathy will consolidate therapeutic alliance, show the patient he or she is being listened to and understood, and make him or her feel he or she is being

accepted as a person, and that his or her feelings are legitimate. This helps the client feel better, builds trust, and makes him or her more inclined to work with and listen to the therapist.

Using an Old Model to Promote New Understanding

One model I found to be very helpful in explaining the importance of helping to relieve the client’s distress is Yerke’s and Dodson’s (1908) law. They predict an inverted U shaped curve for many cognitive functions when people are exposed to rising levels of stress and anxiety. Insufficient and excessive arousal are both correlated with lower levels of motivation



and cognitive performance, memory, attention, concentration, thinking. According to this model, when we express empathy, by helping to reduce the client’s distress we are helping him or her to think more clearly, be more attentive and concentrated, remember better, and be more motivated.

Can the Effects of Empathy be Faked?

One of the questions trainees frequently ask is, “Considering it is the

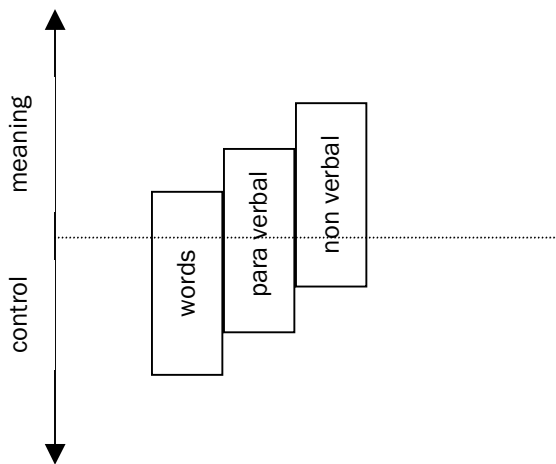
expression of empathy that is efficient, if we were to experience antipathy and be good liars, wouldn’t that work the same?” This is a good introductory question for the second part of learning empathy, which is expressing it. If none of

the trainees bring on this question I will myself ask them what they think the result of faking empathy would be on the client, and why would that be. Some of the answers I get here are that faking it isn't all that easy, that body language could give it away, and that the client would lose trust if he or she sensed the therapist wasn't sincere.

Albert Mehrabian (1971) showed that in many cases nonverbal communication gives more impact and meaning to messages than the words themselves.. In studies that have been replicated, he showed that up to 90% of the meaning could be attributed to para-verbal (tone, volume and rhythm) and non-verbal communication. Even if these statistics do not necessarily apply to all communication circumstances, they prove beyond doubt the importance of nonverbal communication. This implies that therapists should be wary of silent cues in clients, and be able to grasp their meaning beyond the words that are pronounced so as to be able to reflect any eventual lack of congruence: "I hear you saying you're OK, on the other hand I get the impression it could be better".

How to be Congruent and Express Authentic Empathy?

This also implies that therapists are themselves constantly giving silent cues to their clients—that these cues are conveying meaning to the client beyond the words that are spoken. Trying to fake empathy or lie to the client would risk losing congruence, provoking resistance and loss of trust. Even the best actors cannot constantly master nonverbal cues. I use the following diagram to show that the more we have control, the less meaning is conveyed.



There can be only one answer to maintaining congruence at all times: empathy and unconditional positive regard cannot be faked. I will suggest to the trainees that if for whatever the reason they cannot

experience empathy for a given client regardless of their training, it is only fair to think of addressing him or her to another therapist.

Learning to Express Empathy

The next sequence I propose in teaching empathy is getting the trainees to start expressing it. The following exercise is easy to do and trainees feel safe to try out their skills. I prepare a dozen statements made by the type of clients or patients the trainees in the session usually see. I ask the group to respond with empathic reflections to those statements. The group gives feedback on each reflection. Trainees are usually quick to master this exercise. Another exercise I offer after this one is getting trainees to give a non-verbal expression of an emotion and have the other trainees give empathic reflections. Expressing emotions does not come easy in French culture. This exercise gets trainees to imagine the non-verbal cues that go with the specific emotion and gives a chance to practice expressing it.

Empathic Role Play

In the last sequence of empathy training I get the trainees to practice all the skills previously acquired in role plays. In order to structure the role-playing I ask the trainees to think of a patient or client they might be having a real hard time with and to write a brief description of the client and situation on a sheet of paper. I then have the trainees fold the paper and place them in a container, from which one is picked. The role-playing can be done fish bowl-style with three therapists or just one-on-one. The trainee who wrote the summary will enact the client or patient that he or she knows. The role-playing is organized like any other, with feedback from the group on empathic reflections and emphasis on how it was done. The role-playing is organized like any other, with feedback from the group on empathic reflections and emphasis on how it was done as well as what if anything had

changed in the trainees' understanding of this client or patient.

Finishing the Sequence

We usually end the sequence with a pause before resuming training with more basic skills, mainly making summaries and affirming the patient.

Conclusion

The empathy part of the training is one of the most important sequences in length and intensity. It is fast-paced, and usually lasts 2h00 in a two day program. Evaluations show trainees to consider it a major part of the training. Most of the trainees find it very helpful in understanding the client's distress, and in being more accepting of the client. **MB**

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Note from the MI-TNT in Genova, Italy, November 2005

Gian Paolo Guelfi

The diffusion of Motivational Interviewing in Italy started with the training of three trainers in the MINT-sponsored TNT held in Santa Margherita in 1995, and a further enhancement followed the MINT-sponsored TNT in Italian that paralleled the course and the MINT Meeting, again in Santa Margherita, in 2001. The Italian organization connected to the Center for Motivation and Change (CMC Italy) was organized in 2001 as a cultural association in order to promote good quality in training, support trainers, and enhance exchange of experiences.

Four years later, almost fifteen trainers were active in the country. Overall, about 200 training courses had been done, with almost 3,000 participants involved in training. At the same time, requests for both basic training and continuing training were growing in different areas of the country. It was clear that more trainers were needed. So we decided to hold our own, MINT-approved TNT.

Instead of spreading the word and advertising throughout the country, we decided to invite personally some of the professionals who had participated in training sessions we had run. We invited almost fifty professionals, and 27 accepted to attend. The criteria of the invitation included being "able, willing, and ready" to become an MI trainer, and having the personality characteristics and motivation for that business. Of course, the last two criteria were arbitrarily decided by the trainers before the invitation was made.

The 27 participants in the course came from 12 Italian regions: Piemonte, Veneto, Friuli Venezia Giulia, Alto Adige, Liguria, Emilia Romagna, Toscana, Abruzzo, Basilicata, Calabria, Sardegna, Sicilia. Almost all Italian regions have now MI trainers. The participants were medical doctors, psychologists, nurses, workers in therapeutic communities, and social workers. Mostly they came from drug and alcohol agencies, but among the participants there were also a family doctor, the head physician of a Cardiology Prevention Unit with a nurse colleague, and several professionals working in the prevention field. The TNT trainers were Maurizio Scaglia, Valter Spiller, and me, Gian Paolo Guelfi. Naturally, the

course was held in Italian.

In our view, participants in an MI-TNT must be very familiar with MI, and have an established practice. We believed that it was important to focus on the teaching of MI, in the way described in the second edition of Motivational Interviewing, which we also deem to be a good way to enter the spirit of MI. The trainers in the TNT must not teach MI, but help trainees to develop a correct training attitude. The main component of such an attitude is that MI can be taught only "motivationally". We also thought that a course for trainers in MI had to be as active as possible, with the trainees being actively involved in the teaching.

With such premises, we (the trainers) planned the course, and defined the topics to be addressed and their sequence as follows:

How to start

What motivates people to change?

Empathy and client centeredness

Reflectiveness

Discrepancy

Confidence

The course was held in the Romanesque convent Santa Maria di Castello, in the medieval centre of Genova. The duration was three days, for 24 hours of work.

The morning of the first day was devoted to introducing participants to each other and outlining aims and objectives of the course, matching the expectancies of the participants with the general goal of the course. In the second session of the morning we discussed

the principles of teaching MI, spirit and technique, with emphasis on consistency between clinical work and training work (the leitmotif was: you cannot teach MI other than in a MI way).

The opening session ('How to start') was run by the trainers. The trainees were then invited to choose one of the remaining topics listed above to work on, and accordingly were split into small groups, organized according to both professional and territorial criteria. Each small group was charged with developing a presentation on its chosen topic according to guidelines we gave them: 10 minutes teaching, 20 minutes practicing, 30 minutes debriefing. The small groups held a first meeting in the afternoon of the first day of training, during which they started planning the presentations to be done the following days.

In the morning of the second day two sessions were held, one on "what motivates people to change" (or the factors of motivation), and one on "empathy". Each session took 1 hour and 50 minutes: one hour for the presentation by the trainees, including a debrief run by the members of the small group, and the rest for commentary and remarks on the teaching, done under the guidance of trainers.

The same happened for one session in the afternoon of the second day, on "reflectiveness". The afternoon of the second day ended with a discussion on MI in different fields.

The morning of the third day was

for teaching on “Discrepancy” and “Self-Efficacy” (or, if you prefer, Importance and Confidence). The last half day included small group work on the actual programs of application of MI in different fields: drug problems, alcohol problems, residential treatment units, prevention and rehabilitation (cardiology, pneumology), family doctors, justice system... And a final session on the future of the association, and the organization of teaching and developing MI in the country, was held in the last afternoon.

A great deal of creativity appeared in the presentations by the small groups of trainees. As an example, one of the small groups worked on Empathy. The work was divided in four phases. It started with a brainstorming session aimed at voicing as many words as possible related to the concept of empathy (warmth, acceptance ...). Then followed a short session of teaching: summary of the brainstorming, using paraphrases and reframing, focusing on “what is the utility” of empathy in a helping relationship. The third phase was defined by the trainees’ “shared experience”: a case vignette was presented, in a fish-bowl worker-client role play. The client was a woman with an alcohol problem seen in an outpatient facility after an “accidental” fall. The patient in the script was withdrawn, hostile and denying. The effort of the worker was to develop an empathetic relationship, using MI skills, to overcome the hostile, denying attitude of the patient. Finally, the participants of the training were invited to discuss the role play, and led to analyze the changes observed in the feelings of the patient as well as the behavior of the worker, and how the empathic features of the interview helped in achieving that goal.

I found it interesting that the concept of empathy was taught in an active (eliciting meanings from the participants) and practical (what is the use of empathy in a helping relationship) way. And the trainees were also allowed to observe in a role play how empathy can be evoked and how it can be recognized in the relationship.

Four months after the TNT, a joint two-day meeting of senior and new trainers was held in wonderful premises near Verona. It was a pleasant and fruitful meeting, and the main decisions made were to develop MI training in new areas and new fields (psychiatry, criminal justice), and to involve new trainers along with senior trainers in the new trainings.



Acknowledgement: Eleonora Ferraris outlined the exercise on empathy.

What the Research Says ■ ■ ■

■ ■ ■ About MI Training: Part II

Grant Corbett

Part I of this column looked at formats for motivational interviewing (MI) training (Corbett, 2006). Thus, we looked at the evidence for the duration (e.g., days or hours) and organization (e.g., workshop and individual supervision) of training to achieve “competence” in practice. Here, in Part II, we’ll begin to look at MI training objectives.

If I said that our training objectives included, “To explain and practice the principles and spirit of MI, the micro-skills, and how to evoke and reinforce change talk”, would you agree (see previous columns for research updates on the foregoing)? In the traditional adult-education sense they are. However, what would you say are the objectives of MI? I believe that training content differs from practice objectives. The latter are what we want clinicians to target if they are to be competent in MI practice.

What is the difference? Focusing only on adult-education objectives might leave practitioners with the sense that MI is a style, but they may also leave thinking that it is a set of techniques and the absence of certain behaviors (e.g., confrontation). I believe that by being clear about our objectives for change (both for the professional and the client), we are more likely to help clinicians make MI “a way of being”. What then are we targeting?

Targets for Training the Spirit of MI

Let me take you back two years

to my first column, “What the research says about MI skills” (Corbett, 2004). After reviewing cross-disciplinary studies, I concluded that two abilities were critical to exhibiting the Spirit of MI:

1. To *communicate safety* to a client through facial expressions, voice and movement.
2. To *communicate acceptance* (i.e., that a person has “social value”) while helping clients minimize any perception that they are unacceptable (i.e., a “social burden” to you or others).

When a person feels safe and accepted, the research tells us, that person’s ability to cognitively process change and to take risks is increased.

In part I of this column (Corbett, 2006), I proposed that people need to trust that change will do them more good than harm. Why? Because change entails risk. The evidence is that people are more likely to take risks when they trust, and trust can be evoked by “any tangible and honest signal by the clinician that ‘values’ the patient...” (Corbett, 2006).

MI in practice can help clients feel secure and valued, and that increases trust and a willingness to risk change. So how do we train clinicians to communicate safety and acceptance?

Implications for Training

Recall that the “spirit” underlying MI is an interpersonal style of the counsellor characterized by an absence of confrontation or per-

What the Research Says... | continued

suasion, and by acceptance of the person, communicated by empathy, respect, and support (Miller & Rollnick, 2002; p. 33).

How do we explain that clients may not feel safe if they are confronted or if attempts are made to persuade them of some position or action? Do you know any clinicians who would say that they are not empathic, respectful, and supportive of their clients? If not, how do we demonstrate acceptance so that trainees can recognize how the MI style is different from their usual approach?

I believe that we can begin by demonstrating that one's worldview can unknowingly leave clients feeling threatened and devalued. Bill Miller & Theresa Moyers (in press) say it this way:

This point is best illustrated, perhaps, by the difficulty of learning or practicing MI if one is guided by conceptually opposite assumptions. When clients are viewed primarily from a deficit perspective (e.g., being in denial; lacking insight, knowledge, and skills), it makes little sense to spend time eliciting their own wisdom. Instead, the counselor would be inclined to confront denial, explain reality, provide information, and teach skills. Within this perspective, consultation is clinician-centered: it revolves around the counselor providing what the client lacks: 'I have what you need.'

This "deficit" worldview leads to the clinician wanting to fill the client with knowledge, beliefs, and skills. The word "deficit" is not a judgment; it simply expresses the belief that a person's problems are the result of something that he or she is missing. These deficits, it is assumed, need to be filled by the clinician. The client has the problem; we have the answers.

I propose that the MI spirit presumes a "competence" worldview. When we believe that people are competent, we assume that they have self-knowledge, attitudes, and capabilities on which we draw to motivate change. In this worldview, our role is to evoke and guide this competence to help clients resolve their ambivalence.

The difference in worldviews is the difference between seeing a client as an "empty glass" or a "well" (with thanks to Carolina Yahne). The "deficit" worldview assumes that we have to fill the glass with advice and knowledge for change to occur. The "competence" worldview assumes that there is water in the well, even though it may be deep, and that we need to draw it out to evoke change.

Can people feel valued when they are perceived as deficient? Possibly, but the probability is lower than when we assume people are competent. For example,

consider the following differences between the MI and advice-giving styles. In MI we:

- ♦ Ask open-ended questions (which seek to understand what *the person* is saying, as opposed to closed-ended questions that seek answers to what we want to know, to solve the client's problem or information deficit)
- ♦ Listen without interruption (rather than interrupting to ask a question, for which we want an answer, or to provide advice)
- ♦ Affirm client attitudes and behaviors in the direction of change (as opposed to asking people to affirm our advice to them)
- ♦ Reflect the content and feelings of what people say to facilitate *their* resolving their ambivalence (rather than just listening long enough to diagnose and prescribe a solution)
- ♦ Evoke preparatory and commitment language (as opposed to advising the person to commit)
- ♦ Ask permission before offering information and advice.

Could the foregoing MI behaviors lead to a person to feel valued? I would say yes. Do we have evidence that clinical practice operating from the "deficit" worldview of advice-giving is less effective than from the "competence" worldview from which MI is practiced? I believe we have indirect evidence.

Rubak and colleagues (2005), in a systematic review and meta-analysis of 72 randomized controlled trials that compared advice-giving to MI, concluded:

...[M]otivational interviewing in a scientific setting effectively helps clients change their behaviour and it outperforms traditional advice giving in approximately 80% of the studies..." (Abstract)

The foregoing review does not address the mechanisms of action that would support that it is the worldview that is contributing to the

difference in outcome, but a UK study offers a glimpse of this.

Secker and colleagues (2005) held focus groups of staff in Health Development Agency pilot projects about their assumptions, or theories of change, for developing programs. Staff in all pilot projects assumed "that providing information will increase clients' knowledge, that increased knowledge will engender a sense of empowerment, (and) that a sense of empowerment will enable people to take action..." (p. 396).

The results did not support these "deficit" worldview assumptions: *Overall, evidence to support the projects' theory that providing information would lead to knowledge gain is not strong...Clearly, increased or reinforced knowledge does not necessarily lead to behaviour change...few people...reported behaviour changes.* (p. 397-8)

What did clients who participated in the projects indicate as their motivation for participation? Secker et al (2005) report:

...[T]he sense of being neglected...was a key motivating factor for many of the pilots' clients... [T]he projects were addressing the needs of an age group participants felt was generally neglected. (p. 397)

Feeling valued, not knowledge, was a primary motivator of program participation.

Workshop Exercise: Introducing the MI Spirit's "Competence" Worldview

I have learned from MI that discrepancy engages attention and that desire and commitment language increases the probability of behavior change. Thus, I use an introductory exercise in my workshops that begins by evoking discrepancy between the two worldviews and ends by asking participants about their desire and com-

mitment to practice from the “competence” stance that is the MI spirit.

I have the group break into dyads. Each person in the pair alternately takes the role of therapist and client. To the first in the role of clinician, I provide the following written instructions (along with a request not to show or discuss it with their partners until requested during debriefing):

“Health Professional’s Instructions (A): In your interview, be sure to achieve the following:

- ♦ Explain why the person should make necessary changes.
- ♦ Give at least three specific benefits that would result if they made these changes.
- ♦ Correct any misinformation they have.
- ♦ Provide advice on how to make one or more of these changes.
- ♦ Emphasize how important you believe it is that they make changes.
- ♦ Advise them on a place to start.”

The other person is asked to assume the role of a “typical” ambivalent client or patient in the group’s clinical environment. I give verbal instructions that there be a three-minute interview, and I ask the individual playing the health professional to follow the instructions as closely as possible.

At the end of the interview, I ask each person to privately record three scores. Each is a rating on a scale of 1-10, with 10 being a high score and 1 being a low score. I ask them to rate:

1. Their *confidence* that the “client” will change as a result of the interview just completed (e.g., 10 would indicate high confidence that the “client” would change).
2. How *safe* they believe the client felt to explore change.
3. How *accepted* by the clinician they believe the client felt.

I ask that they not share their scores with each other until debriefing.

The foregoing role-play and scoring is repeated with the client now taking the therapist role. I ask the clients to assume a role similar to the one that their partner has just played; that is, no more difficult or easy. I provide the clinician with the following second set of instructions:

“Health Professional’s Instructions (B): In your interview, do not give advice or information (or try to figure out their problem). Rather, focus on understanding their worldview and how they would resolve their concerns by:

- ♦ Asking: ‘What do you think is important?’
- ♦ Expressing empathy (‘You are feeling X (happy, worried, etc) about that.’)
- ♦ Reflecting back what they have said to confirm understanding.
- ♦ Asking them, ‘Why would you want to make changes?’
- ♦ Emphasizing autonomy, choice (‘Whatever you decide; it’s up to you.’)
- ♦ Affirming any stated intentions to change (‘That’s great, you know what you want to do.’).
- ♦ Asking: ‘How might you do that, to ensure your success?’
- ♦ Summarizing what they have said at the end of the interview.”

Again, I ask participants to record their ratings on the three factors: 1) confidence, 2) safety, and 3) acceptance. I remind the group that I have influenced the outcome of scores by the instructions provided, so that the scores do not reflect their individual capabilities.

Debriefing begins by my asking those who were the clients in the first role-play (under the “A” instructions) to read their scores out for the three factors. I record these on one side of a flip chart. The scores are totaled and averaged by someone I have asked to do this while I collect scores from the persons who were clients in the second role play (the “B” instructions). As the B scores are totaled and averaged, I ask the group what they see in the scores. B scores are generally higher (this can create discrepancy for those who realize that their style is more similar to the “A” rather than the “B” instructions).

I ask the pairs to take two minutes to share with each other the instructions they were given and their ratings.

After two or three minutes, I bring the group back to ask their experience of the exercise. I explain, then, the worldviews behind the instruc-

tions, and that the spirit of MI derives from the “competence” worldview.

I conclude the exercise by asking for group comment on which worldview they desire to practice from and why they may be committed to the “competence” worldview.

I will end this column by asking a question. If client perception of safety and acceptance are the targets of training clinicians in the MI spirit, what are the targets of the micro-skills and change talk? Perhaps we could look at what the research says in Part III of this column?

I welcome your comments and questions. You can write me at grant.corbett@behavior-change-solutions.com. **MB**

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Struggling with the Righting Reflex

Cathy Cole

As MI trainers, we teach our trainees about the Righting Reflex (RR) and provide strategies for them to avoid this natural tendency. We discuss how the RR, the natural tendency we have to “make it better” for another person, engages us in prescribing, perhaps lecturing, and almost certainly deciding what is important to another person. Personal choice and control are off the table when an interviewer gets into the RR.

Given what I consider my ability to help trainees recognize and then avoid the RR, let me reflect on my recent struggles with the Righting Reflex. My clinical work is with veterans from the branches of the military in the United States and I have almost 30 years of experience in this area. I am now meeting with recently discharged veterans returning from deployment to either Iraq or Afghanistan who have symptoms of Post Traumatic Stress Disorder (PTSD). PTSD from combat trauma manifests in avoidance, hypervigilance, and a changed belief in safety in general. After some self-reflection and discussion with a colleague, I realized that I had lapsed into prescribing treatment for PTSD and I was certainly meeting with some strong ambivalence (we often call this Resistance).

Here is one such scenario, which occurred with a recently discharged woman veteran in her early 20s who had enlisted in her state’s National Guard in order to earn benefits for college. Her expectation had been to provide assistance after natural disasters in the US. She was deployed to Iraq and drove a large supply truck, one of the most dangerous assignments. Post discharge, she was fearful of driving, certain that any debris was rigged as a bomb and that other drivers were intent on doing harm. Additionally, she was avoidant of shopping, and had to leave settings where someone of Middle Eastern origin was present, certain that the person was planning a terrorist act.

The usual treatment is to assist the client in

confronting the fears and beliefs by examining the reality of the current environment as opposed to the dangerous environment of Iraq. However, the more I did this, the more she held onto her beliefs and provided arguments against any change in her view.

Now, how did this occur? I am a practitioner of MI and a trainer! Once I realized what was happening, the answer to this question became very clear, and this realization also became my solution. I was practicing when the first soldiers were returning from Viet Nam. I clearly recall how helpless many of us felt about what to do to help, and I have seen the outcome of untreated, chronic PTSD: almost complete isolation, inability to handle emotions, and the inability to freely engage in work or socialization. I, along with many of my colleagues, feel very committed to trying to prevent this with this group of returning veterans. So, it was easy to become overly determined to help, and to prescribe treatment.

What have I done with this realization? I now provide information on the recommended treatment, based upon our clinical knowledge and experience. I also disclose the history that generates the sense of urgency that might be apparent to clients despite my best efforts to just give information. Once I’ve done this, I can explore veterans’ ambivalence surrounding

confronting the behaviors that keep the symptoms of PTSD alive and determine a starting point, if any, that the veteran can commit to. I can remain open to solutions generated by the veteran, while at the same time continuing to provide information from the clinical perspective on whether this will help or hinder recovery. While I still have to be watchful of my leanings toward prescribing, I can allow for personal choice and control and respect that the situation may or may not get better, or that the veteran may just find a solution that is not within the framework of what we would have recommended.

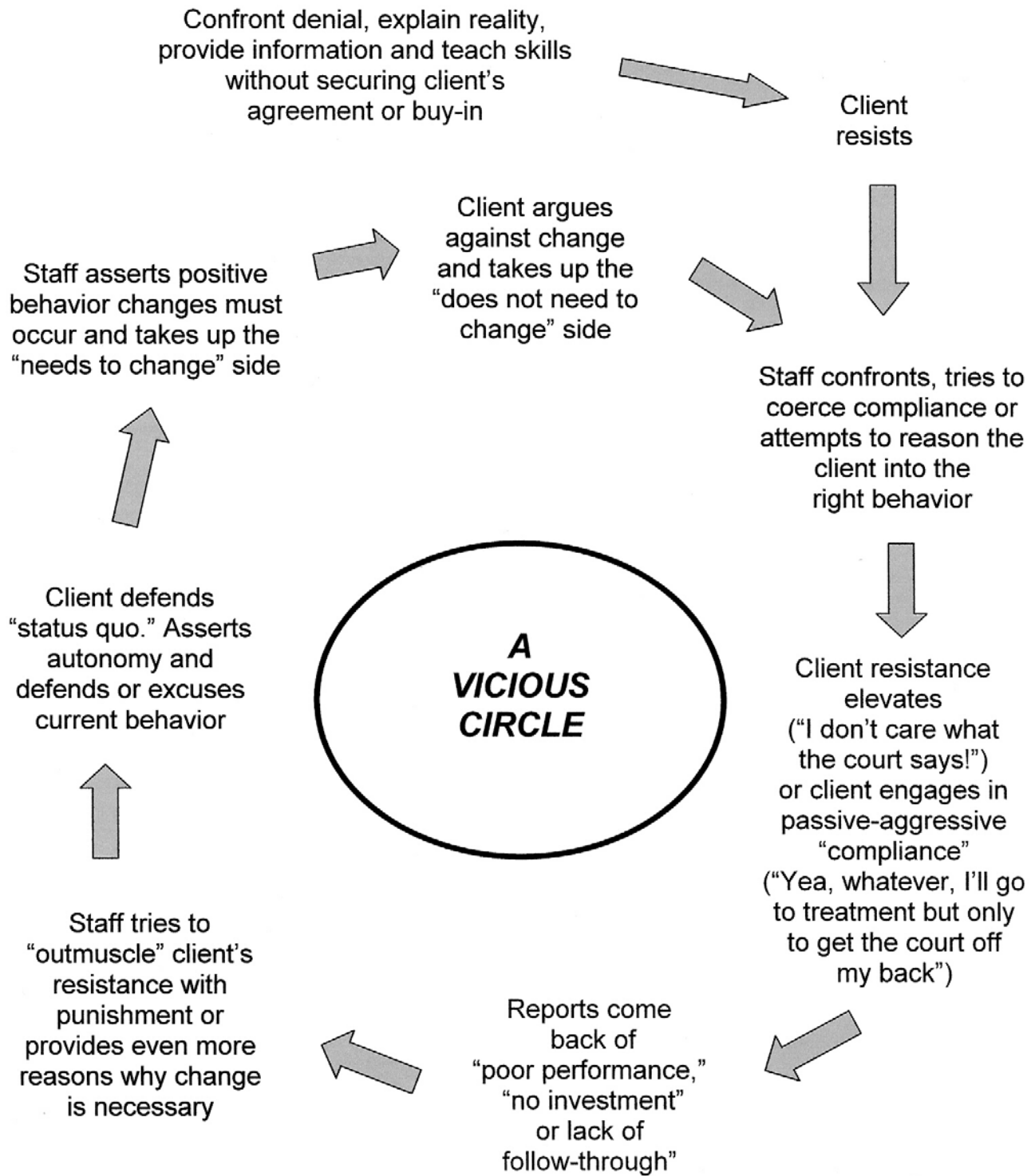
So, as a practitioner, I get to confront the reality of struggling with the RR. One more time I get the chance to remain humble by realizing I can get caught in just the same ways as my trainees. Each time I provide MI training and teach about the RR, I add my personal story as illustration. I find that this helps trainees more easily identify where they might get caught and have a clearer understanding of why they need to avoid the RR.

It is an interesting dance, but isn’t that what MI is about?

MB

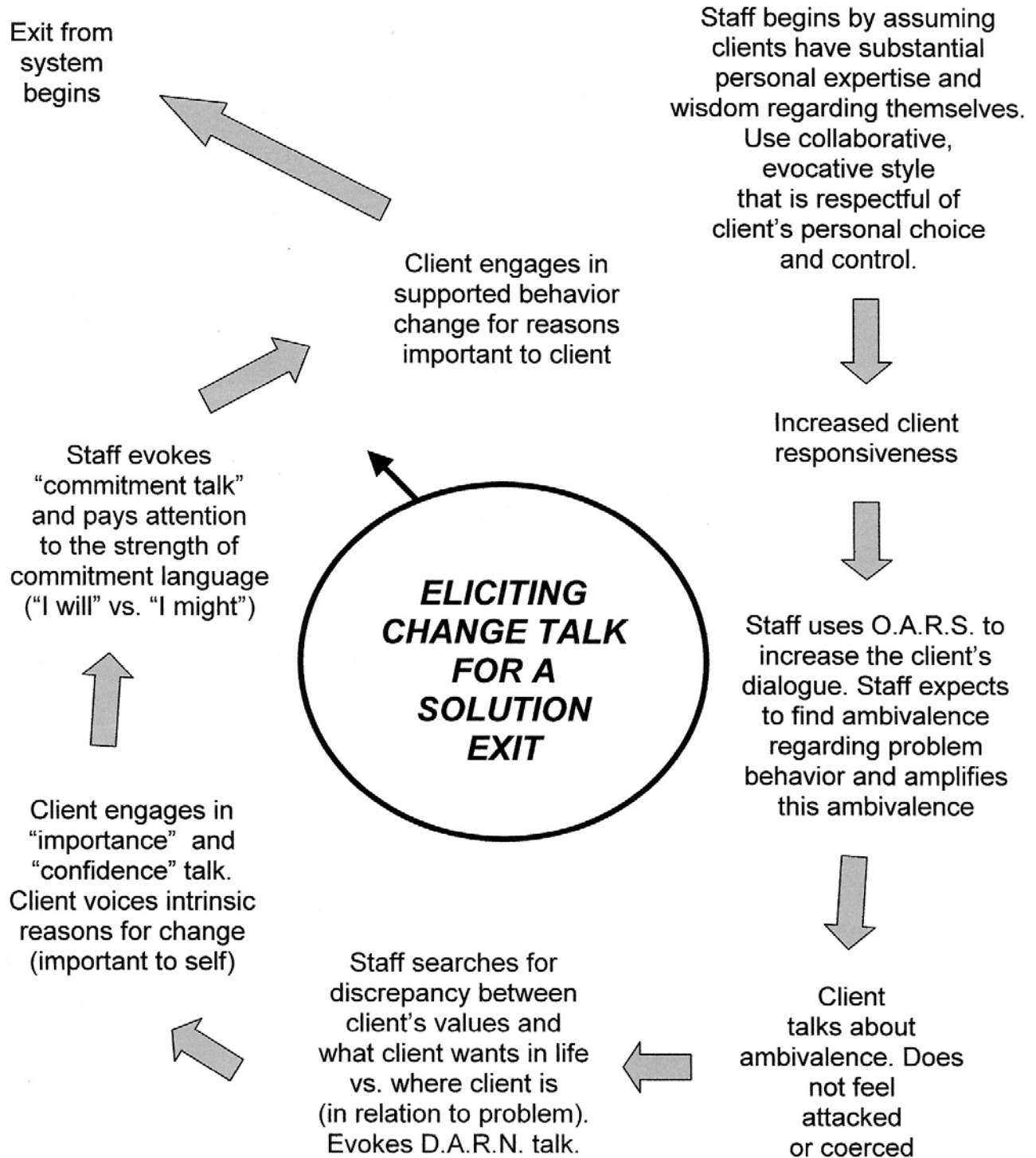
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Is Motivational Interviewing a Tool or a Way of Life?

Jake Rollnick

The question whether MI is only a professional tool, or if it can be a way of life, has been much discussed. As a tool, MI is used in the professional setting in order to promote behaviour change. We can all agree that MI is a useful way of initiating behaviour change with clients. Can it be a way of interacting with people generally? What about MI as a way of initiating behaviour change in your children?

Maybe this question should really be answered by Bill and/or Steve; after all, they are the example-setters. As professionals, they would answer it in a clinical and professional way.

Maybe, however, my perspective as a mere (and completely unprofessional) spectator to the MI world is of value. MI has a direct impact on my life, in a way that not many people experience. As Steve's eldest son, I have experienced his method of communication more than anyone else in the world. With that perspective, I would like to suggest that MI is a professional tool and not, at this stage, anything else.

Before I sat my A-Level exams I was under a lot of pressure from both school and from Rollnick himself. At one low point we were arguing a lot about certain academic problems I was facing, and all this culminated one day en route to a café to complete some (more) work. He was chastising me for waking up too late or some other hideous sin, and I screamed, "So what style are you adopting, Dad?! Direct!?, Guide!?, or Follow!?" This suggestion of a more clinical, detached and professional method of tackling the situation was met with a flurry of expletives and threats. Not a good idea, then.

What brought on such a strong reaction to the suggestion of approaching the problem using a method of communication that my father has dedicated his professional life to? I suggest that it

is simply this: emotion.

The three communication styles my father talks about are ways to change the behaviour of clients in a professional setting, an emotionally limited context. There will obviously be some emotional vibes present in the consultation, but not the sort that would be present between you and your child.

So what about my father's efforts to change my behaviour? I found that high emotion was often present in my relationship with my parents. This high emotion manifested itself in two ways: positive and negative. On the one hand you have patience, love, compassion, and cooperation, etc. (positive); on the other hand you have the style I have named 'Demanding' (negative), illustrated by dad's behavior in the car. Demanding is most obvious in tone of voice, though how it manifests can depend on the context.

Demanding can only control very resistant behaviour in the domestic setting. We are all aware that Demanding behaviour change in a client will only, at best, lead to "resistance" and at worst lead to complete breakdown of the practitioner-client relationship, with potentially catastrophic results. So why can parents use the Demanding style, when professional practitioners cannot?

There are very different emotional bonds between you and your client, and you and your child. Perhaps the bonds are more empathic with your client; you know how the client feels, you want to help. But this is a professional relationship; you'll go home at 5:30, open a can of beer, put the TV on and forget all about the day. And what about your client's bonds with you? Put simply, your clients do not really care what you think, how you think, how you act and what consequences their behaviour will have on you (as their behaviour towards you doesn't affect them) in the long-run—or if they do, they care a lot less. After all, they are there for themselves!

On the other hand, your child would have to take all of the above factors into consideration. So for parents, the Demanding style is one of great importance and one of great effect.

There is a third possible parenting dynamic: 'Calm'. This is where you are more stable, relaxed, and perhaps more clinical, enabling you to tackle whatever domestic issue there is in a style approaching MI. But this is very difficult, because all the time there will be emotional vibes sparking reactions and swinging you to either positive or negative high-emotion states.

The environment in which the practitioner operates is very clinical and professional. High emotion is not present, so both parties can continue without risk of frustration. Surely MI can be used in a professional environment because one needs that emotional distance from the client? With its potential to swing one to the Demanding style (due to frustration), I would suggest that MI is destructive in the home.

Cooperation, compromise and love are key elements in my relationship with my parents. These three elements help with behavior change within the child/parent relationship, giving the parents the opportunity to change behaviour before Demanding is necessary. Demanding is certainly not the "one" way of controlling behaviour with children, it's simply a way of controlling it when all other methods have failed—a last (but sometimes necessary) resort.

MI has never really affected me personally, though Demanding has many times. When Steve tried to apply MI to his private life (which wasn't too often), it worked for a short while—but when I saw what he was doing, I counteracted it with resistance talk until he gave up. Despite expletives and other non-professional behavior that my father emitted, laughter and love was and is often at the center of our exchanges. He's been OK...just!

