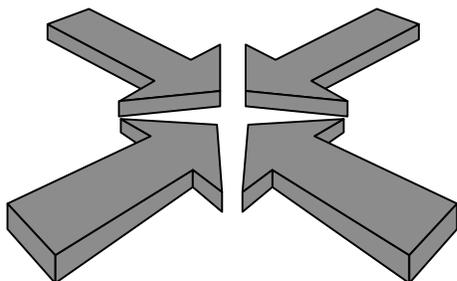


Motivational Interviewing Newsletter: Updates, Education and Training

September 1, 2000

Volume 7, Issue 3

A Publication of the Motivational Interviewing Network of Trainers



New Perspectives



From the Desert

Bill Miller

Let me begin with a request. Research and other publications on MI are emerging so quickly, and in so many fields, that I can no longer maintain a comprehensive bibliography by myself. As you are aware, our website, thanks to Chris Wagner, offers a bibliography of publications on MI, and thus far additions to that list have come mostly from my office. I am asking for this to become a collective responsibility of the MINTies. Whenever you produce or come across a publication on MI that is not already on the web site bibliography, please send the full APA-format citation to Chris, so that he can add it to the bibliography.

Here in New Mexico, lots is happening. Carolina Yahne, Terri Moyers, and I just completed the first two-day MI training in our NIDA-funded project to evaluate methods for teaching MI (dubbed EMMEE: Evaluating Methods for Motivational Enhancement Education. To keep terminology straight, perhaps we should change it to EMMIE.) In any event, we had a delightful group of health professionals for the first training, and it was such a pleasure to train with Caro and Terri. I hardly felt like I was working. We encourage you to continue to refer licensed professionals who treat substance abuse. They can apply for the study through the MI website. We will be taking applicants for another year or so, before implementing the Spanish-language training phase.

The EMMEE training came right on the heels of the annual MINT meeting in Quebec City, and the training and welcoming of a new group of MINTies. No doubt there will be other news about Quebec in this issue. Thanks to Gian Paolo Guelfi, the next MINT meeting is already scheduled for June, back at the Hotel Regina Elena in Santa Margherita Ligure, Italy. The MINTies will meet June 6-8, and the training of new trainers will be June 7-9. We no longer advertise the TNT, and we're already receiving registrations for 2001 in Italy. Gian Paolo plans a parallel Italian-language TNT. I'm thinking toward a MINT/TNT in Hawaii in 2002.

The MIDAS study (Motivational Interviewing in Drug Abuse Services) is coming down the home stretch, with final follow-ups underway. This is a randomized trial of MET (receive it or not) at entry to drug abuse treatment. A preliminary peek suggests that we got an effect with cocaine-

dependent people, but not with opiate dependent people (mostly methadone maintained). Paul Amrhein's labors with psycholinguistic coding are about to come to fruition in MIDAS, and it looks as though he has a causal chain that works to document a mediator of behavioral outcomes after MI: the positive *slope* (not the intercept) of client commitment language during an MI session. We will be presenting these results at ICTAB-9, the 9th International Conference on Treatment of Addictive Behaviors, in Cape Town during late September.

The second edition is rolling along. Steve and I have made good headway on the first 14 chapters, and we are now reviewing proposals for chapters in the edited second half. The current production schedule would have the book on shelves in late 2001.

An issue that many seem to agree is crucial at this stage of development is the quality control of MI interventions. Steve and I have intentionally avoided trying to regulate the practice and training of MI, preferring to devote our efforts to promoting quality practice rather than policing it. We have no MI certification process and no franchise on training. The more MI is disseminated, of course, the greater the variety in fidelity of practice. We have seen published research evaluating an intervention called MI, that bears little resemblance to our understanding of the method. Very few outcome studies to date (including my own) have included adequate monitoring to document that MI is being delivered properly. We know that there are therapist effects, variability in the efficacy of MI depending upon who is delivering it. As a first step in this direction, the MINT group in Quebec began to develop guidelines for quality control of MI interventions. A first draft is provided below. Please send me your comments and suggestions!

Guidelines from the International Motivational Interviewing Network of Trainers (MINT)

Motivational interviewing is a complex clinical style, the acquisition of which typically requires special training and a period of supervised practice. Because of possible drift in style, it cannot be assumed that counselors are actually delivering motivational interviewing, even if they have had initial training and supervision. For certain purposes (such as clinical research), it is therefore important to document that motivational interviewing was delivered as intended. This document provides some guidelines from experienced trainers for assuring quality control of motivational interviewing. Not all of the recommended procedures can be implemented in every setting, but the following guidelines will help to ensure and document the fidelity of delivery.

1. Selection of Counselors

When counselors can be selected to provide motivational interviewing, pre-screen for skillfulness in reflective listening (accurate empathy). This is a fundamental skill upon which the clinical style of motivational interviewing is built. Training is considerably more complicated and time-consuming when candidates must first learn reflective listening. We know of no paper-and-pencil measures that accurately predict empathic ability. A practice sample is most effective, in which the candidate is asked to rely primarily upon reflective listening during a conversation or role-played interaction.

There are no other firm guidelines thus far for selecting good candidates for training. Practitioners who have been trained in a mental health discipline often find it easier to comprehend and acquire the clinical style of motivational interviewing, but acquisition is not predicted by years of education.

2. Specification of Intervention

Describe in detail how the intervention was designed, trained, and delivered. A therapist manual is helpful in standardizing and specifying intervention procedures. It is desirable to have an explicit theoretical model for the intervention, and to test via process measures the causal chain by which the intervention is hypothesized to impact outcomes.

3. Training

Counselors who are to provide motivational interviewing should be trained by a qualified trainer with expertise in this clinical style. Although reading materials and training videotapes are useful adjuncts, we do not regard these to be sufficient preparation for practice. Initial training in the clinical style ordinarily consists of at least 15 hours of instruction and supervised practice. It is clear, however, that participation in a 15-hour workshop is not sufficient for most trainees to develop skillfulness in motivational interviewing, and follow-up supervision is therefore recommended.

4. Follow-up Supervision

Clinical skillfulness is developed through supervised practice, with feedback and coaching from a qualified supervisor with expertise in this clinical style. Such supervision should be based on direct observation of practice (e.g., via audiotape or videotape), rather than relying upon trainees' reports of what transpired in counseling sessions. There is no fixed length of supervision that is sufficient to establish skillfulness. Training should continue until the candidate reaches established criteria of proficiency.

5. Ongoing Monitoring

After initial training to criteria, continue to record all intervention sessions via audiotape or videotape, so that fidelity can be monitored. It can be helpful to use a therapist checklist or self-rating form that is completed by the counselor after each MI session, but this is not sufficient to ensure quality control. Besides internal review of session

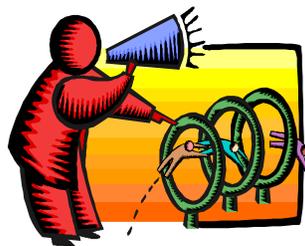
tapes, it can be useful to have a subset of tapes reviewed independently by a trainer who is not part of the project team.

6. Structured Coding

A structured coding system, such as the Motivational Interviewing Skill Code (MISC), is a useful way to standardize the monitoring of session tapes. At least a 15-minute segment should be coded, with procedures to ensure that the same phase of counseling is being monitored across counselors. Therapist and client behavior will be quite different, for example, during an open-ended MI phase as compared with an assessment feedback (MET) phase. Focus on the part of the intervention where an MI style is presumed to be most crucial. Begin coding tapes early in a project, so that feedback can be provided to remedy errors and drift. Track MI-inconsistent as well as MI-consistent counselor responses. Even a low frequency of certain MI-inconsistent responses may override positive impact of MI-consistent counseling. If not all tapes are coded, select a representative sample of 10-15% of tapes for monitoring.

7. Correcting Drift

The ratio of tapes monitored should be increased for counselors who show less adherence to (or more drift from) the intervention approach. In a clinical trial or other outcome study, there should be a procedure for "red-lining" counselors who fall below an established criterion for intervention quality. Red-lined counselors do not see new study cases until adherence to intervention protocol has been demonstrated, at which time the counselor is reinstated.



Rollnick's Musings



Steve Rollnick

European eccentrics and getting published

European presence in this newsletter, I discover, contains an interview with my good mate Jeff Allison, the only person completely crazy enough to be a full-time MI trainer. It was he who had the inspiration to design the first MINTie gathering at a trainer's workshop.

A few weeks ago I was up in Scotland, his home ground, and I found myself standing next to his car, on a hill overlooking the most sublime silvery valley near Dundee. He pulled out some papers, laid them on the bonnet, and described the most imaginative set of conceptual developments, some apparently borne of a similar conversation with the reclusive Norwegian MINTie, Peter Prescott, the first person to publicly renounce the internet and withdraw communication, or so I gather. Now these guys work happiest in the spoken tongue and don't, to my great regret, write and publish. That's such a pity.

Can't we produce a quick-response MI journal, not one that imitates academic paper journals, but something more suited to the internet? Like a well-edited magazine, with a firm editorial eye, short pieces, not too verbose, and a quick turn-around.

Anyone interested in working on this? The MINT Steering Committee recently discussed this notion and quite rightly felt that an MI journal should not undermine this newsletter and that none of the present group on the Committee could manage

this task. If there is an eccentric out there who would like to do this kind of work, I'll volunteer to edit for a year or two, if you get your head around the technicalities. I don't anticipate such a publication coming out often, maybe once or twice a year. Let me know if the spirit moves.

Going ga ga about listening

My mother used this phrase affectionately to describe the mental state of someone who loses it now and then. Is this happening to us over MI and listening? I read and hear about "an MI way of doing things" and many similar phrases, and beneath them appears to lie the assumption that this group of MINTies should promote a new (?) approach, which has reflective listening at its heart. I have some worries about this.

The fact that listening is not at the heart of authoritarian institutions such as the military and the corrections service is not in question. But is our role in these places to introduce listening? Is that what MI is offering? To take another example, is it realistic or worthwhile to have empathic listening at the heart of family interaction? Do I want to go around the house empathising with my Stefan (aged 4) when he wants his third ice-cream of the day? There are some differences in the ethical boundaries and power relationships in conversations in different settings. I cannot see how we can simply transfer what we think is useful in a counselling context into others, without addressing these differences and understanding what is functional in other approaches to communication.

Is effective MI just about listening? This is an interesting research question, which Doug Sellman has addressed in a study in New Zealand. I don't want to steal his fire, but I can tell you that his findings do not provide a ringing endorsement for plain listening with problem drinkers. There's something else that is also needed. Direction? Structure? Coaching? If we agree about this, then how do we characterise "an MI way of doing things?" Is it merely the absence of confrontation and the co-operative use of listening?

I guess its obvious that I remain a skeptic about the broader application of MI if the idea is simply to encourage listening and non-confrontation, even though I appreciate so much the incredible value and subtlety of reflective listening in counselling. I am also happy with this state of ambivalence, happy to listen to other ideas, but have no inclination to change!

Horses: Out of Africa

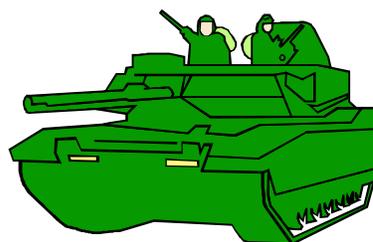
I had a strange experience. I was walking through a parched game reserve in Kenya with an eminent naturalist and a guard. The naturalist was a true British eccentric who had museums asking him for his insect collection when he was 8 years old. Then two tall figures clad in orange appeared on the horizon, moving in graceful, loping strides. "How," I asked, "do the Masai tribesmen walk through this reserve, with lions and buffalo around, while we need a guide with a gun?" "They understand the animals, and if a lion comes by, they walk in big strides towards it, and it goes away...". Then, out of the blue he said: "The gypsies understand animals. On my grandfather's estate in England we had gypsies who used to tame wild horses by looking at them and talking to them. They have been doing this for centuries." So the "horse whisperer" story has some other roots?

Doing another MI study with plenty of spice

Like it or not, I am working on an MI proposal to use that SPICE training method on-site in everyday primary care, in a controlled trial of MI with family doctors. This training method has now been piloted in a number of settings, including a renal transplant environment, where there are behaviour change challenges with life and death implications embedded in everyday conversations between patients and caregivers. I saw a nurse discover the value of structured listening to wonderful effect. The training method really does work, although it isn't cheaper to use than workshop training. When our paper describing this method is completed, I'll get a draft out on the website.

Listening and ordering in the military

I listened carefully on one occasion when I was in the South African army aged 17, to great effect. I was ordered to my room, so I listened. And I never came out. I slept for days. Then a sergeant came in fuming: "Where have you been for two days you bloody Jewish hippy?" "Here, Sergeant, because I was told to come here." "Why are you not on the parade ground, worm?" "Because I never heard anyone telling me to go out there, Sergeant." "Get out there, worm." "Yes Sergeant." You could try that trick only once. I was a marked man for the next 9 months. They were preparing for war. In the end I fled to the UK. Wild horses (!) would not have encouraged me to listen to any of their arguments for fighting an evil, racist war. Their only solution was to threaten and order me around. Until I left, this worked. Troops on the ground get rebellious, tired and angry. Some of them loved being told what to do. In fact, I must confess, I loved the marching to orders. Such superb rhythms, click, clack, click clack.....and your mind goes blank, and you feel at one with a group of people..... So those of you who want to do MI in the military, remember that the culture of ordering is functional at least most of the time. By the same token, other approaches to treatment are not *necessarily* dysfunctional?





More From the European Continent

Different training for different groups

Peter Prescott – Bergen, Norway

Most of my MI teaching has been with either staff from addiction specialist services or social workers consulting social welfare clients with drug/alcohol problems. The last couple of years, however, I've done more and more training with health care professionals. In the beginning, I just tried to adapt our usual addiction course by replacing client examples with relevant patient cases. This seemed to work well with nurses and doctors working with patients with chronic diseases (lung, heart, etc.), patients with psychiatric problems, serious smokers, unwilling teenagers and other coerced "resistant" patients. However, it can be a mismatch giving full MI-training to professionals in primary health care. Some doctors find full MI training a boring waste of time. They say they just don't need it with a majority of patients. For them it's like shooting a sparrow with a cannon.

I have also been watching video recordings of role-play consultations in health care and social welfare settings. Even though it's only simulated patients/clients, it has helped to illuminate the need for different training in different contexts. To say it bluntly, just watching doctor-patient interactions has given me a picture of what's actually going on.

Two very different patients illustrate differences in consultation complexity and the professional's "MI-needs":

The medical setting:

Kari is in her forties, employed, and married with grown children. She's an interested patient with personal resources and probably a good deal of general and specific self-efficacy. She's come to the doctor of her own free will, because of stomach irritation. She wants a renewal of her prescription for acid neutralizing medication. The doctor's main MI-task seems to be to explore with the patient possible connections between lifestyle behavior and health problems. It's largely a question of giving information and advice in an effective manner. (Steve's model of information exchange will be applicable here, but maybe it's not so necessary with emphasis on resistance.)

There is also a question of medical ethics in this consultation: Should one give a prescription for symptoms that could possibly be eliminated by reducing alcohol consumption and smoking? The doctor's position of a benign, powerful expert can of course in some ways pose difficulties, but mostly it has a huge advantage by giving the doctor a paved shortcut to legitimacy and credibility and thereby a readymade position of influence. In contrast to other social and health professionals, a GP seldom has to establish a relationship from scratch. Likely a productive doctor-patient relationship is there before the patient walks through the door.

The full MI does not seem necessary for "simpler" encounters such as this, but some MI sub-skills and strategies could be useful; for example:

- Communication skills, especially open questions and summaries. (Reflection is for more advanced training.)
- Addressing touchy subjects: getting permission and giving an introduction or rationale as to **why** the professional wishes to explore these areas. Make sure the patient doesn't sit and wonder "*Now why does she want to talk about this??*"
- Negotiating skills with headstrong patients who know what they want and need.

- Motivation and confidence: how to give information and advice in effective ways. How to elicit a person's own motivation and ability to change.

The social welfare office setting:

Rita is in her thirties, unemployed and a dropout from college. She has considerable problems with alcohol and prescription drugs. She lives with a violent, oppressive man with massive drug and alcohol problems who is slowly and steadily driving her to destruction. She is aware of this, but doesn't think she'll be able to manage on her own and says *"I still love him and I don't know what will happen to him if I leave him."* She's ashamed of her life situation and of throwing away her abilities. Her life is in chaos and every problem seems to be connected to some other problem in some way or another. Any change will be a formidable task. Rita's need for change is almost unlimited, the demands on her are extraordinary, and her self-efficacy is marginal. She's very aware of the extent of her problems, but is ambivalent and has very little realistic hope of changing her situation.

She's been forced to come to the doctor by her family and the unemployment office. She is very wary of the counsellor. The demands on the counsellor are impressive: Establishing a functional relationship, keeping the consultation on track, determining what areas to focus on, balancing exploration of motivation, decision making and self-efficacy, and managing Rita's hopelessness, ambivalence and "resistance." Just being able to increase the chance of her coming to the next appointment is a challenge.

Full MI training for Rita is both necessary and desirable. Teaching even a few quick strategies may go astray. In addition to specific MI-strategies a workshop should include (among other things):

- Establishing a working relationship
- Advanced communication skills
- Understanding the fine balance between taking the lead and following when trying to influence and "change" the client.

- Understanding and handling "resistance," especially counsellor contributions
- Respect for complexity and ambivalence
- Handling ambivalence and tolerating chaos
- Removing barriers
- Focusing on hope

Should everything be called Motivational Interviewing training?

Lifestyle management and prevention in medical settings is quite different from business as usual in specialist addiction work. Steve has repeated this emphatically several times. (Though he hasn't yet taken off his shoe and pounded his point home.) The Rollnick, Mason and Butler book is called "Health Behavior Change" and not something such as "Motivational Interviewing in Medical Settings" to underline that MI in addiction work is different from adaptations to medical contexts. Perhaps we should make this difference more explicit when offering training workshops to different professional groups working in different contexts.

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MI Professional Training Videotapes

The professional video training tapes created in Albuquerque will be distributed in Europe by the Bergen Clinics Foundation, in VHS-PAL format. For more information or to receive an order form just call, fax or email Tom Barth at:

- The Bergen Clinics Foundation
- P.O. Box 297
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- Phone: +47 55 90 8600
- Fax: +47 55 90 8610 Email: tfwb@online.com



Comments on Cultural Differences and Richness

Antoni Gual

Escribir sobre las diferencias entre Europa y América al regreso del meeting de Minties en Quebec resulta un poco exótico... si uno decide hacerlo a medio camino, desde la república dominicana y con la amable perspectiva que dan las vacaciones.

Empecemos por el principio: ¿Donde estoy?. El mapa me dice que en América, en el Caribe. Pero la verdad es que esto no parece New York... y mucho menos Quebec. Tampoco es España aunque se hable español. Desde aquí, donde impera el mestizaje, se ve con claridad que el problema es la simplificación. Si el espíritu de las entrevistas motivacionales se inspira en la escucha reflexiva, porque no escuchamos las culturas que nos rodean? Parece lógico que si nuestras intervenciones se centran en entender a los clientes, cuando nos dirigimos a colectivos mayores intentemos entender su cultura, sus culturas.

No es correcto hablar de Europa, hay muchas Europas distintas, igual que hay una gran diversidad de Americas. Es probable que pronto lleguemos a la Aldea Global, pero de momento un minuto de tiempo no dura lo mismo en el Caribe, en New York, en Barcelona o en Bergen. Sólo nuestro etnocentrismo nos permite ignorar que la calabaza es un signo festivo en el Halloween americano y un símbolo de fracaso en la cultura española.

Otro ejemplo, en España la gente suele sentirse ridícula cuando se la invita a aplaudir. El aplauso se reserva para las grandes ocasiones. Suele ser más una señal de admiración que de agradecimiento. Hay códigos no escritos que marcan el comportamiento del individuo: sabían ustedes que en España preguntar al ponente es casi un signo de mala educación?. Se entiende tácitamente que el que pregunta o bien quiere mostrar lo mucho que sabe, o bien quiere dejar al ponente en ridículo. Del mismo modo las entrevistas simuladas generan mayor sensación de ridículo, y por tanto mayores resistencias en los alumnos hispanos que en el mundo anglosajón.

No quisiera que de este discurso se hiciese una lectura negativa. Bien al contrario. Detrás de la diversidad se encuentra la fuerza. Las diferencias generan riqueza, estímulo personal y, cuando se entienden correctamente, incluso pueden llegar a ser muy automotivacionales. Pero no es este el único aspecto positivo. Desde mi punto de vista el análisis transcultural del uso de las técnicas motivacionales debería ser sumamente útil para seguir investigando en uno de los terrenos que mas nos interesan en la actualidad: los elementos esenciales que definen el modelo motivacional.

Desde la tranquilidad que dan las vacaciones, dejadme lanzar un mensaje de apoyo a los que quieran atreverse con esta aventura. Que cuenten conmigo. Y si se me puede permitir una licencia, me gustaría también decir mi opinión al respecto. Desde mi punto de vista la esencia de las entrevistas motivacionales se basa en la delimitación de responsabilidades. Si se es capaz de definir y entender con claridad donde llegan las responsabilidades propias y hasta donde llegan las del cliente, lo demás son sólo técnicas relativamente fáciles de aprender.

In English:

Writing about differences between Europe and America after returning from the meeting of MINTies looks a bit exotic, especially when you decide to do it from the Dominican Republic, on the way back home, but still on vacation and inspired by the Caribbean air..

Let's start from the beginning: Where am I? The map says America, in the Caribbean. But the truth is that it doesn't look like New York and much less like Quebec. It isn't Spain though people speak Spanish. From here, where multi-ethnicity is very common, you can see clearly that simplification is the problem. If Motivational Interviewing has as its basis reflective listening, why don't we listen to the cultures that surround us? It seems logical that if our interventions are based in understanding our clients, we should also try to understand their culture, their cultures. No doubt understanding cultural background makes it much easier to understand individuals.

To speak about Europe is not right, because there are lots of different "Europes" just like there is a great diversity of Americas. We will probably reach the Global Village soon, but for the moment a minute of time doesn't last the same in the Caribbean, New York, Barcelona or Bergen. Only our ethnocentrism lets us ignore that a pumpkin is a festival sign in the American Halloween and a symbol of failure in the Spanish culture.

Another example: in Spain people normally feel ridiculous when they're invited to applaud. Applause is reserved for the great occasions. It is more an admiration signal than a thankful one. There are unwritten rules that direct the behavior of people: Did you know that in Spain to ask questions to a speaker is almost a sign of impoliteness? People understand tacitly that the one who asks either wants to show how much he knows or wants the person who is speaking to feel ridiculous. In the same way, simulated interviews create more sensation of ridiculous and more resistance in the Spanish trainees than in the Anglo-Saxon world.

I wouldn't like this speech to appear negative, just the opposite. It is my thought that diversity is a source of strength and richness. Differences stimulate individuals and enhance self-esteem, and when properly understood they can be highly self-motivational. But this is not the only advantage. From my point of view, the trans-cultural analysis of motivational techniques should be very useful in reaching one of our major goals: identifying the

essential elements that define the motivational model.

From the calmness that vacations produce, let me send a message to those who are dealing with this goal. Count on me. And let me also tell you what I think about it: according to my point of view, the essence of motivational interviewing lies in 'responsibility.' When you are able to clearly define the boundaries of your own responsibility and the client's, the rest are just techniques easy to learn and practice.

Translated by:
Fernando Espi Forcen
Murcia, Spain



MINTERVIEW with Jeff Allison

by European co-editor Tore Børtveit

Jeff Allison has worked in the addictions field since 1976, as a specialist social worker in a variety of detoxification, residential and day care drug and alcohol services. Before becoming a full-time trainer he spent four years as an addiction specialist with the probation service in Yorkshire.

Since late 1996 he has worked as an independent trainer, providing short courses in the UK for the probation service, social services and social work departments, addiction agencies, health authorities and NHS trusts. In mainland Europe he has completed training events in four countries for the European Addiction Training Institute and two countries in Eastern Europe for the European

Commission's PHARE Project. He also led an event in the 'delivery room' of MI, the Bergen Clinics Foundation in Norway. He co-organised the 1st MINT Trainers' Forum in 1997, the 1st European Summer School on Motivational Interviewing, held in November 1998, and the 2nd European Summer School held in September 1999. Jeff lives in Edinburgh.

Tore:

*When will we first see you dressed in skirts, Jeff?
Or to put it in other words, how do you find living in Scotland?*

Jeff:

I presume you refer to the kilt? The short answer is, never. One of the surest ways to upset the Scots is for an Englishman to parade in a kilt. The Scots don't need any more encouragement to make disparaging remarks about us. At this time of year in Edinburgh, the only men one sees in kilts are either American tourists "doing Scotland" or the military performing at the Tattoo. And believe me, one could never mistake the one for the other (sorry, US MINTies.) Although, to be honest, I do harbour a secret desire to dress in the full Highland outfit--just once. Despite my height (or lack of it) I think I have fine legs for the kilt! By the way, Tore, did you know that, in common with many words in this part of the world, "kilt" is of Scandinavian origin--from a Swedish dialect word, "kilta" meaning a swathe (of cloth). But to answer your question, I love living in Scotland (malts, mountains, mists) and last year took up golf. I've even found myself of late using golfing metaphor in training, which I'm told is a little sad. Middle age is an insidious process.

Tore: *What was it with the MI method/perspective that caught your interest in the first place?*

Jeff: I was staying with Rollnick in Sydney in 1990 when Bill and he were writing the first book. It wasn't so much that it caught my interest, but that Steve thrust drafts into my lap and asked me to read. Having gone 12,000 miles for a holiday I read them more out of politeness than a burning passion for the subject--that came later. Steve was high as a kite at that time, and it was a little infectious. I'd never read Bill's earlier writing on

MI. Like too many social workers in the addictions field, I'd learnt to survive on minimal academic input, gleaning most of my knowledge from courses, conferences and debate. In truth, I was a lazy practitioner, who knew enough to get by. Or thought he did. Having said that, the drafts, and later the book, really grabbed me. It made so much sense. It was like someone saying clearly all the stuff floating around in my own head. Ideas that intuitively I suspected were correct, here consolidated in a "method" largely underwritten by research and sound theory that spoke to me. I remember, the first time I read the book, I sat smiling to myself. As Rollinck is wont to say, "F**k, man, s**t!" - his Cape Town slang for, "Absolutely correct; yes indeed." I remember thinking that here was something of great importance, and of very practical application, for it stripped away a lot of unnecessary stuff of little value and amplified the core components of good, effective practice. It wasn't just the full set of clubs, it was the wise old caddie alongside; it was St. Andrews on a fresh spring morning (you see how easy it is?) Most particularly, the spirit or essence of MI--the importance of therapeutic collaboration, rather than the authoritarian mentality of so much work in addictions--came shining through. It was so optimistic; the possibility of change, the emphasis of the "natural" and irrepressible tendency for people, given the right conditions, to sort themselves out, and our potential role in attending that process. I just wished MI had been described in 1976 when I first started in the field. Most importantly, it wasn't gooey caring/sharing nonsense --the usual vacuous counselling antidote to directive stances that leaves clients wandering around in circles--but a rigorous method that retained the main premises of person-centred styles yet added necessary purposeful therapist activity. The central role of ambivalence in MI was what made such sense. It is the understanding of the complexity of ambivalence that I try to get across to trainees, for it is in this understanding that the problems and solutions are to be found.

Tore: *In what ways have your views or your experiences on these issues changed over the years?*

Jeff: A difficult question to answer briefly. At first, I wanted to "learn" it and "do" it. I was too impatient. It is something I often witness in trainees; a desire to cut to the chase, an attitude--quite understandable in busy professionals - of wanting to learn the "tricks" for making patients "perform." There are too many would-be lion tamers out there. When I first started training, similarly, I wanted to demonstrate smart tricks-of-the-trade. This was a gross error. It took me a long time to fully understand Bill's often quoted remarks about MI as a way of being *with* people as opposed to doing things *to* people. It's fascinating, though alarming, how many practitioners, ostensibly having been trained in MI can't relinquish the adversarial posture--*which is also a way of being with people*. It's deep set in basic training in so many professions. Another metaphor: I remember in 1982 trying to learn how to skydive in Florida. I was having real difficulties remaining in a stable and comfortable position in freefall. A rather stoned "skygod" took me aside and said, "Jeff, don't fight it, gravity is your friend, be subtle man, relax - it's just falling, accept that it's stronger than all of us, so learn to use the breeze around you while you have the chance. Time is short!" I don't remember if he had a ginger beard or not, but he was spot-on. To continue in this American idiom, this '*being with*' shit is the key. In an age of hard-nosed, give me the proof science it's not so cool to pursue this line with trainees. In fact, it can result in masked expressions of disdain or ridicule. And yet, in my opinion, MI works best when there is a sense of solid quietude in the therapist as a counterpoint to the often chaotic tangle in the patient, and it is only from this "platform," if trust is earned and respect demonstrated, that the so-called technical matters--the strategic conversational devices--may have effect. The question is, how might trainees come to understand the delicate dance of genuine disinterest in outcome and a passionate interest in patients disentangling their motives and clarifying their goals? A truly respectful posture is one in which one accepts the autonomy of the patient. Letting go of the erroneous responsibility to push and cajole people, however softly carried out, is so liberating for the therapist. What I feel has changed in my views on training is that, whereas in my first years as a trainer I earnestly 'vomited'

(Rollnick's expression) technique over trainees, I am now trying hard to do less of "technique" and more of "spirit" with people in a helpful manner. What concerns me is that I am ever more convinced as time goes on that there are an awful lot of folk who just couldn't ever be accomplished at MI. I'm not certain what differentiates one group from the other, but I certainly know, in training, when I'm in the presence of someone "unsuited" to MI. By the same token, I believe clients sense it too. My hunch is that it's part fear of otherness, part disgust, and part an incurious disposition, although difficulties in application are also due to trainees' inability to be both in the moment of the conversation and also alongside the moment in analysing and planning.

So a part of me wants to be optimistic and trust trainees to reach their own conclusions; that is, to respect *their* autonomy to make their own mistakes and learn from it, while another part of me seeks to understand why therapists continue to do the things they do, despite the evidence to the contrary. I want to 'correct' them, to put them right. Old habits, etc. The process of training mimics therapy to such an amazing degree that the acid test of the therapist/trainer is as trainer/therapist.

Tore: *What are your thoughts on the discussion about the "true spirit of MI," the "real MI": in what direction do you see this discussion heading?*

Jeff: Well, I guess I've already started to answer this question in the previous. There's an almost indefinable *something* that emerges between therapist and patient--not peculiar to MI--when things are going well. To paraphrase Bill (I think), it's "doing Rogers": his core conditions. I get nervous, because I'm not sure you can necessarily learn it, but how do the human qualities of "good" therapists form? It's a big issue. More than this, "real MI" as you put it, is undoubtedly directive. A "real MI" practitioner operates on different levels--again, not unlike all competent therapists--there's the very human visible face (the presence) and behind it, the intellectual detachment critiquing and considering the many layers of the conversation, guiding the course, deploying the strategies; selective, cautious, curious--a party to,

and apart from. And yet there is an insufficiency in this brief description. If I had to bring it down to a few words, I think I'd say, therapeutic optimism for change.

Tore: How do you deal with the dilemma between teaching or prioritising the techniques of MI on the one hand and teaching the general attitudes or spirit of MI on the other, especially when you are training people you consider in need of basic skills and techniques of communication?

Jeff: Another complex question, Tore. My brief answer is to quote Rollnick, "Do a few things well and have faith that if you hint at the tremendous possibilities, trainees will make the effort to fill the gaps for themselves." Most of the events I lead are no more than 2 or 3 days--not through my choice, but due to the usual limitations of time and competing demands--so I'm still trying, after over 100 training events--to moderate my own enthusiasm to include everything. I usually get it wrong and force-feed trainees. I wish I could be more comfortable with the buffet model in which trainees pick and choose what they fancy. They'll come back for more if it tastes good. I think the best way to handle the limitations of time and the needs of trainees is through co-operation, by saying what you have and asking what they want. That is, by starting with an appreciation of the difficulties they themselves identify. Let the trainees prioritise their own training needs and do your best to explore with them if MI has anything to offer. It usually has a great deal.

Tore: When doing an MI workshop in Bergen, Norway in June 1998, you made a comment on handling resistance. It was something like, "... in dealing with resistant clients there is no magic formula ... resistance should just make you behave even more in accordance with the spirit of MI." If this is what you actually said in Bergen, can you elaborate, please?

Jeff: It sounds like something I would have said. But what I think has changed in my thinking is the very notion of "resistant clients." The language we use to describe the phenomenon--the parties wrestling--is, I believe, faulty. Can one person wrestle? The phenomenon can only exist in a

dynamic sense. What trainees "hear" is the emphasis on difficult client behaviour (the problem) and strategies for handling it (the solution). Whereas, for example, audiotape analysis often demonstrates the mutually significant roles in causing disengagement or damaged rapport. The years I spent working in the probation service taught me the ease with which the label of 'difficult client' was attached, when the continuity of their behaviour was consequent upon the consistent manner in which they were treated by staff.

I'm certain there's a lot more work to be done on understanding the fabulously complex nature of what we have termed resistance. Other adjacent fields are equally interested. For example, I just bought a book on investigative interviewing--the same issues arise. Rollnick kindly let me read the draft chapter on resistance in MI-2. Having read it, I've written a response. I'm not sure I agree with B&S, but there's not space here to explain why. I don't think all resistance is counter-motivational. There's talk of using the listserve to publish brief articles, so if it happens I'll offer my thoughts for discussion in that arena. However, the spirit of MI is the way forward in learning how to co-operate with our clients. I don't know what else there is. The question, though, is how the spirit becomes manifest, or distorted, in difficult conversations about change.

Tore: Complete the following sentences:

Being an MI trainer can be like hell when

Jeff: Trainees respond to everything one says with, "Yes, but surely the facts of the matter are..." (sometimes, I want to kill!) Worse than this, trainees who refuse, point blank, to participate in any exercises because they, "already do all this anyway" when clearly they do not. Perhaps worst of all is simply the totally quiet group who lack any curiosity or enthusiasm for their work. But the absolute worst experience I've had is quite personal, Rik Bes and I were leading a 3-day workshop in Athens and I was suffering from a very uncomfortable UT infection. I'll leave you to consider the consequences (Rik, bless him, found it all most amusing.)

Tore: *Being an MI trainer is best when*

Jeff: You see trainees having that, "Ah ha!" moment--when the penny drops, and everything starts to happen just like you suggested it might. The warm handshake and smile at the end of training, or better still, the letter a few weeks later reporting a real change in the atmosphere between themselves and their patients/clients. It's the same sense of optimism for the future that clients report--that they can make things better through my own labour. My personal objective as a trainer is the development of more effective practice not praise, but I'd be dishonest if I didn't admit to enjoying the (all too infrequent) heartfelt thanks of trainees.

Tore: *Any discussions on MI related issues, or MI training related issues you especially welcome?*

First, more discussion of how much training is necessary to achieve a sufficient level of competency, and how much/what forms of supervision are best for maintaining competency. Second, the pressing issue of accreditation for trainers and trainees. This nettle must be grasped because whether we (MINT) like it or not someone is going to start doing it in a big way, with us or without us.

Tore: *What will happen to the European Summer School on MI?*

Jeff: You tell me! The first two were a great success--due entirely to the sheer energy and enthusiasm of the 150 participants. I'd love to be involved in a third event. If the next MINT Meeting of Trainers is in Europe why not link the two? However, the first two events were in the UK, so perhaps mainland Europe should host it this time. Italy in spring?

Tore: *MI in Scotland?*

There are a small number of excellent trainers in Scotland (not all MINTies). My dear friend Tom Frank has been labouring remorselessly for years in the alcohol and criminal justice fields. I'm just about to become involved, as a trainer, with a research study training midwives in Glasgow working with young pregnant smokers. Also, I'm

leading a small group of criminal justice social workers--all previously MI trained--who are meeting every month over a year to review audiotapes of actual interviews. We strip conversations to the nuts and bolts, and it's absolutely fascinating. I think it fair to say that, at least in theory, MI is the prevailing mode of therapeutic engagement in Scotland in the addictions field. But what goes on the privacy of the consulting room may be another matter.

Any advice for MINTies about to start leading training?

Experience has taught me to be humble, to be honest, and to approach training as a collaborative process. My advice is that MI works as a training method too because, put simply, participants are usually highly ambivalent about changing their practice. Why shouldn't they be? To consider change is to accept the likely need for change, and that's painful. Be prepared to throw out all your carefully prepared notes and materials and start again. You can never get it right, only better than it was. Finally, when everything goes wrong, there's always a fine Scottish single malt to sip whilst one reflects upon the day's adventures. But just one glass, of course.

Thank you

A New Training Resource

As part of a videotape series on "Brief Therapy for Addictions," the American publishing firm Allyn & Bacon has released a new training tape on "Motivational Interviewing, with Dr. William R. Miller." It was an interesting experience making it. They flew me into Chicago and had three actual clients scheduled for me to see at one-hour intervals. I knew nothing about them in advance, and met each of them just before the cameras started rolling. After completing an interview with each of them, I consulted with the series editors, Drs. Judy Lewis and Jon Carlson, to select the one interview that we thought best illustrated motivational interviewing. The fellow whose

interview we chose was a man with a polydrug history, who came in quite angry about experiences he had had in addiction treatment, and announced early on that he was there just to do a favor for a friend and was not motivated for change. I liked him almost immediately, and enjoyed our lively interview. This clinical demonstration is preceded on the tape by a brief interview about MI and followed by taped discussion of the session with a professional audience after they and I saw it for the first time. The whole thing is around 90 minutes, the demonstration comprising about 45 minutes of the tape. All in all, I'm quite pleased with it. My only reservation is that it's part of a larger videotape series entitled (shudder), "Learn from the Experts."

Bill Miller

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 web www.abacom.com Price: US\$95

Regional MINT Meetings

Please let us know if you are holding a regional MINT meeting.

MINUET Contributions

As a reminder, MINTies, subscribers (and others interested in MI) are invited to submit pieces for the MINUET. Remember that it doesn't have to be perfect. MINTies consistently state that hearing from other trainers is one of their greatest desires for this newsletter. So, send it on in.

Important MINT Dates

Submission	Publication
12/1/00	1/1/01
4/1/00	5/1/01
8/1/01	9/1/01



From the Editor, currently in the Great Northeast

Denise Ernst

Traveling provides lots of opportunities for reflection. This has been a great gift! Because much of my work revolves around teaching, I spend a lot of time reflecting on the art and science of teaching. Can one teach empathy? How does one teach a good listener to be directive, how does one even articulate the process in a meaningful way? I also am involved in research and the research community as well as the MINT community is continuously reflecting on defining MI, identifying the key elements, figuring out how it works, determining what is important to teach and what you can't teach, and figuring out who can do this work. Lately, I found myself reflecting on learning, my own learning, of MI. I thought I would share some of those reflections.

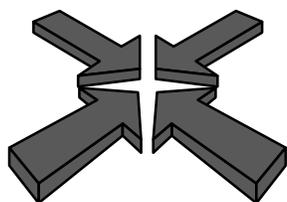
I was inspired. From my earliest connections with MI, something resonated deep within my core values. That resonance moved me to seek further opportunities to practice, to learn and to experiment. As I look at the inspiration, it seems it was created mostly by the book itself. I had some training mostly done by people who were excited but not very skilled and lacking deep understanding. I had a couple of coworkers who were equally inspired and we decided to set up practice sessions, continue working the exercises in the book, and discuss how this new model could be used in our already existing research projects. We practiced together and began to train others. I

would put myself in the highly inspired and not very skilled category. Yesterday, I had the opportunity to speak with a woman who was present at one of those early trainings. She told me again how much she was affected by the training. She probably isn't practicing, but it seems she was inspired.

As a group we talk a lot about MI as a way of being. We struggle with what that means and whether it can be taught. Well, for myself, I had several, often conflicting, ways of being when I approached MI. I had always been a fairly good listening ear; friends were able to talk with me. I had been through enough struggles of my own, often in very non-empathic environments, that I recognized the value of empathy. However, I had a pretty strong and judgmental "take responsibility for yourself and buck up" side that was also active. And there were others. None of these ways of being were extinguished, but with years of determined practice and personal commitment, I have learned to choose a way of being more appropriate. For me to choose an empathic, non-judgmental, and accepting way of being with a person, I must be connected at a very deep level to my own imperfection, failure, and struggle as well as hope. This does not happen naturally—it just isn't who I am, and it is easy to forget. I must actively remember. I wonder about all the people I have taught, particularly those that I gave up on because they just didn't get the "way of being." I wonder if there isn't something we can do to awaken the remembering at a deeper level? And if we could, is it our role to do so? And is it appropriate for training?

It might be obvious, but listening in a deeply reflective manner was not my main mode of communicating. I love to talk. I enjoy hearing myself think out loud. In my younger years I thrived on arguing for the pure joy of the discourse. I spent many years on the soapbox trying to convince others of what I "knew" to be right. I was pretty skilled verbally so as you might imagine, I had gotten a long ways doing the verbal dance. It was prior to my association with MI that I got tired and realized how ineffective constant babbling was. I began my journey (still going on) to shut up. Reflective listening was a great boost to this effort. It provided meaning and structure to the silence. It gave my brain something to do. But learning it was not easy. Actually, I'm still learning and probably always will be. I remember struggling with trying to hear the person with my brain formulating many responses and making feeble attempts at evaluating them. I remember missing things, not recognizing the importance of something, or making assumptions based on my own thoughts and values. It looks so easy when someone with skill demonstrates. I wonder if I do enough with my trainees to help them understand the complexity of the process and to experience the essence. What is it that will encourage them to keep going even when they perceive failure? For me, it was the inspiration, the resonance with what I value highly.

Thank you for the opportunity to share some of my reflections. It is very helpful to me and I hope it stimulates a sharing of learning experiences.



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