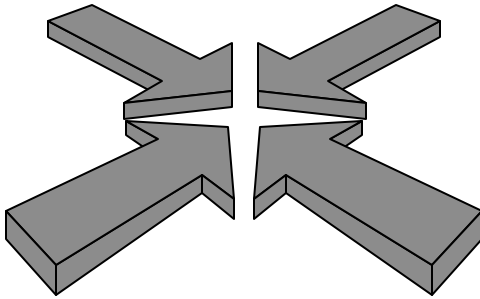


Motivational Interviewing Newsletter: Updates, Education and Training

August, 2002

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New Perspectives

EDITOR'S NOTE

Go and say "sorry" . . .

"Everyone procrastinates, at least occasionally." (Ferrari, Johnson & McCown, 1995, p. 1). Here is a procrastinator's newsletter . . . Sorry! Anyway, this issue contains some very interesting pieces. Although the timeline for this newsletter was extremely short Bill sent some notes from the New Mexican desert to Münster (where it's always raining). Thanks a lot!

Carl Åke Farbring from Sweden wrote down his thoughts on affirming: "Short reflections on affirm – the least emphasized method in MI . . ." Personally, I totally agree with Carl's view: Obviously, there are cultural differences in the way of expressing respect for the client (we had a discussion about this at the MINT Forum 2001 in Italy). Most of the examples in "Motivational Interviewing" wouldn't work in Germany or other (European) countries (see page 73 in the second edition and Antoni Gual's reflections on this topic in issue 7.3).

I asked some of the MINTies attending the MINT Forum in Paris to send me their presentations for publication in the newsletter.

Sven Andréasson (Stockholm, Sweden) and Ken Resnicow (Atlanta, Georgia) replied immediately and mailed me their presentations on value clarification and the implementation of (secondary) prevention programs in Sweden, respectively. Thanks a lot, Ken and Sven. Ken also added the "three chairs exercise". We practiced this exercise with the participants of the Paris TNT and they really liked it. I hope to include more pieces from the Maui and Paris meetings in the next issue.

David B. Rosengren (Seattle, Washington) made extensive notes during the MINT Forum 2001 in Italy (available on request: demmel@psy.uni-muenster.de). His notes had been very helpful when I wrote down some personal reflections on this meeting. Thanks a lot, David!

Support inflated self-efficacy?

I like "importance & confidence" for several reasons: It's simple, clear and intuitive. Moreover, it combines assessment and intervention in a very economic and elegant way. Currently, we run a randomized controlled trial of behavior change counselling in primary care (Project BrIAN: **B**rief **I**ntervention for **A**lcohol Problems and **N**icotine Dependence). "Importance & confidence" is the key element of the intervention (Figure 1). But we are confronted with a problem often described in the literature dealing with self-efficacy expectations of alcohol-dependent inpatients (e.g., Goldbeck, Myatt & Aitchison, 1997). Some patients tend to be overconfident and make inflated self-efficacy ratings: "If I really had a problem and wanted to stop drinking I could do so without any effort . . ." How to cope with these inflated self-efficacy ratings? How much confidence is "enough"? According to Bandura

“perceived self-efficacy is defined as people’s judgments of their capabilities to organize and execute courses of action required to attain designated types of performances” (1986, p. 391). Consequently, self-efficacy ratings can’t be “wrong” . . . But social learning theory also states that “performance experiences” are the most important source of self-efficacy (Maddux, 1995). What are the consequences for secondary prevention and treatment?

In a recent study we identified several personality correlates (extraversion, repression etc.) of inflated self-efficacy ratings (Demmel & Rist, 2002). We defined overconfidence as the persistence of high self-efficacy ratings following relapse. I don’t like the results of this study but the data are very clear: Certain people continue to make very high and “dysfunctional” confidence ratings regardless of their past or current experiences of failure. I don’t want to frustrate my patients. So how should I handle overconfidence in a client-centered and empathic way?

Something completely different . . .

Did Marlon Brando read Miller and Rollnick? Undoubtedly! His successful attempt to recruit Matthew Broderick in “The Freshman” is a masterpiece of “rolling with resistance”.

After watching this movie with your trainees you will have to discuss some serious ethical issues (manipulation of clients, misuse of MI etc.).

All the best,
Ralf

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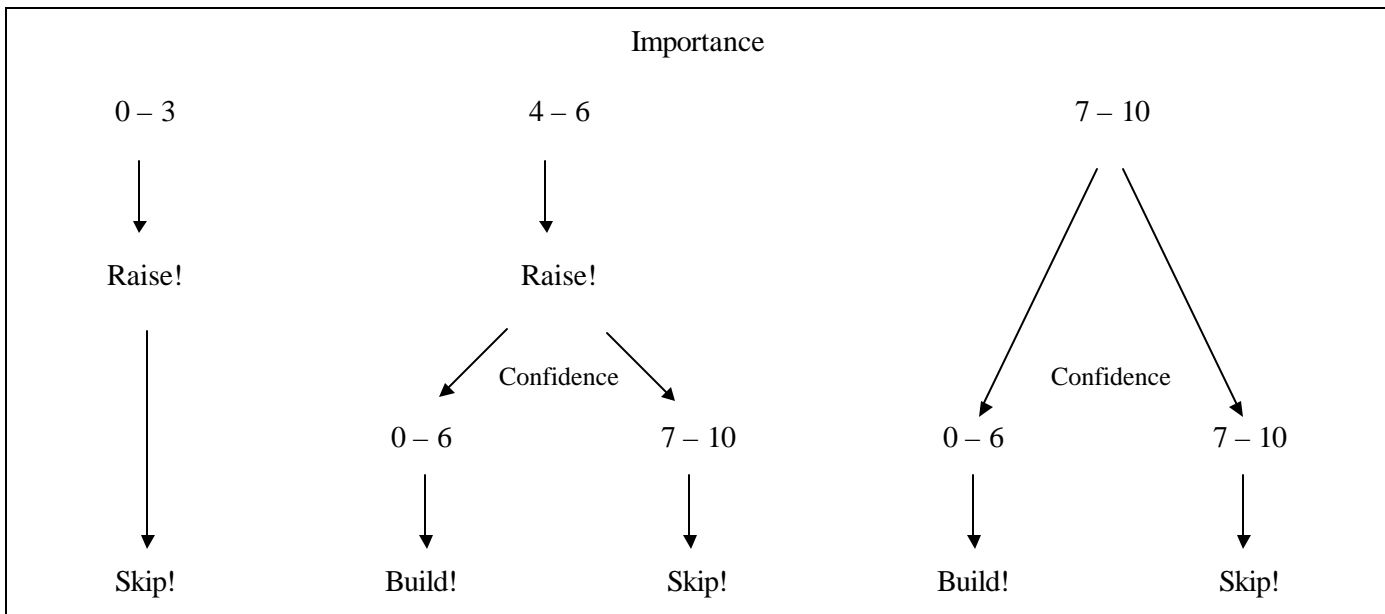
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Figure 1





FROM THE DESERT

An MI General Practitioner

Whom Should You Call?

There was a time before the care of persons became segmented into physical, psychological, and spiritual. Even now there are cultures in the American Southwest (and elsewhere in the world) where there is a single healer, a medicine man or woman to whom people turn for the resolution of all types of dis-ease.

In my own culture, however, caring suffers from a high degree of specialization. The essence of a problem is first categorized as falling primarily within domain of a particular class of change agents, including:

- physical physician, dentist, physical therapist, chiropractor
- behavioral psychologist, substance abuse counselor, family therapist
- spiritual clergy, pastoral counselor, exorcist, spiritual director
- moral/legal police, attorney, corrections
- economic welfare, financial counselor, investment broker

Within each of these broad domains, there is often a generalist whom one sees first for consultation. This person completes a further diagnosis of the problem, and may refer on to a specialist who attends to one particular subtype of problems. Care thus becomes segmented into ever smaller spheres of concern. This may work reasonably well as long as one has a very specific problem. A plantar's wart on the foot can be dealt with reasonably well by seeing a general practitioner, who may or may not refer the person on to a podiatrist.

Most of the people I have seen over the course of my career, however, have had inter-related problems in all of the above areas. Each system or specialist to whom a person presents may address only one piece of the puzzle, and may or may not screen for possible concerns in other areas. If problems in another area are detected, they may be seen as being of secondary importance, or may be addressed by referral to another specialist. It is not uncommon for a client to be sent to CASAA for substance abuse treatment, to a mental health clinic for treatment of a psychological problem, to a psychiatrist for evaluation for medication, to a pharmacy to fill prescriptions, to a primary care physician for medical care, to a welfare office for financial assistance, to an employment office for job counseling or training, to AA meetings for spiritual support, and to a probation officer for court mandated monitoring. All of these services are provided at separate locations, miles apart from each other in Albuquerque. Our clients typically have very limited resources, social support, child care, or transportation.

Add to this situation some further complications. Each program or specialist wants to talk to the client about only one particular area of concern. There is little rationale for the order in which problems should be addressed, though each program may want or require the person to resolve other concerns first. There is little or no coordination or communication across services, and their requirements often conflict.

Specialist or Generalist MI

Now consider the role of motivational interviewing within this situation. In any of the component programs, there might be a staff member trained to practice MI in order to promote a particular kind of change. The employment counselor practices MI to enhance motivation for finding a job. The substance abuse counselor focuses on stopping drinking. The pharmacist uses MI to encourage medication adherence, the dental assistant to promote flossing. None may obtain a larger understanding of the person's life, values,

concerns, or goals. They meet only the motivations that impinge on their particular focus of concern.

When we code such a consultation, we define “change talk” in relation to a particular goal, typically one defined by the context. In coding a substance abuse counseling session, change talk is that which indicates the client’s concern about and desire, intention, or optimism to change substance use. Talk about getting a job may not be change talk (and might even be resistance) unless it is linked to the goal of decreasing substance use. Change talk is defined in relation to a particular change goal.

What is missing here is an advocate for the client (rather than for the client’s making a particular kind of change). What are the client’s concerns, values and goals? Of all the possible opportunities and concerns, which matter most to the client? How does the client think about their inter-relatedness, and which should be addressed first? How does the client think about what various programs recommend, expect, or require? Here, it seems to me, is a role for an MI generalist, a person who helps clients sort out their own priorities and motivations in relation to multiple possible change goals.

Steve already has a model for this from his work with general medical practitioners, who might talk with their patients about any of a range of health topics including diet, smoking, alcohol, skin care, medication, blood pressure, exercise, weight, or infant care. He offers patients with a menu of topics that could be discussed, and asks which might be of most interest. In client-centered style, it is the patient who defines the topic of conversation, at least within the practitioner’s domain.

What I am pondering is a bit broader. It encompasses a liaison role among the many specialists and systems with which an individual may have to interact. That alone is of value, in that these different entities may communicate and coordinate with each other little or not at all. An MI generalist, however, would also be asking

bigger (and of course open) questions about the person’s values, goals, desires, choices. Too often a patient gets swept along in a specialist myopia, without asking such larger questions. I envision, for an MI generalist, some combination of listener and advocate, clarifier and coordinator, counselor and companion. It is what Americans imagine the country doctor once was – wisdom, compassion, expertise and patience all rolled into one. That’s too much to ask of any but the saints, of course, and with MI one focuses more on evoking those things from the client. And that’s what intrigues me about the MI generalist idea. Perhaps we have, each of us, our own inner country doctor.

The timeline for this newsletter issue is short, and my thoughts on this are not well formulated. Mostly I envision a possibility here, a generalist role for which MI may be an ideal skill and approach. As the care of persons becomes fragmented into ever smaller and more isolated specialties, perhaps there is a new (and very old) role to be created.

**Short Reflections on Affirm –
The Least Emphasized Method in MI...**

Carl Åke Farbring

Based on almost 20 years of clinical experience with heavy drug addicts within a prison-based therapeutic community in Stockholm, I would like to offer – to those who are interested – a few elaborations on “affirm” – possibly one of the most important elements in MI. Compared to a matched control group we managed to engender statistically significant change within our TC; this study by the way is now part of Douglas Lipton’s recent world, wide meta analysis on effective interventions with offenders. The causes of this outcome have been much discussed and they are of course not exclusively a product of treatment but may also have been influenced by other things, format, etc. Now in what way does this have a bearing on MI?

The Favourite Teacher

I would guess that many of us trainers are using the “favourite teacher exercise” in MI. Typically you always have a nearly perfect correlation between performing well and positive opinions about the teacher. When you ask why, one answer that eventually will emerge and that always strikes me is...“S/he made me feel noticed and seen as a person, not just as a student...”

Participants after some discussion always agree on the important elements to make someone feel noticed or “seen”.

At least in Scandinavian culture another way of affirming that works well is by making personal positive attributions. This is an overhead that I use (Figure 2).

Making these kinds of positive attributions often have dramatic effects on clients and of course on people in general; it’s instant rapport. The examples in the overhead above are phrases that I have used with clients and in some cases with staff. I could give many examples here where these words have changed a relationship from being neutral and detached to being close and confidential. In some of the workshops that I have led lately participants have suggested other ways of showing interest in the personal sphere of the client. Some say that they learn the names of the wife, children and other relatives that are important persons in the life of the client so that they can ask about them to show genuine interest in the private sphere of the client. Some have said that affirming is a total experience, meaning that the way a client is received starts at the door as the client enters the office, not just in the room of the probation officer. Clients are often registered first by a receptionist and have to walk through a long corridor before they come to the room of the counselor. Those moments are often sensitive for the client and should be recognised as the first chord of the counseling session.

How much depends on the person

- How much do you think depends on yourself as a person – personality, style?
- What do you think it takes to help other people change? Education? Charisma?
- What was your favourite teacher like in school? Did you perform well in his/her subject? What were his/hers characteristics?

OPINION ABOUT TEACHER	+			Is there a correlation?
	-			
		-	+	
		MARKS		

motivational interviewing, workshopmaterial carl ke farbring -2001

Exercise

To open up this perspective in a workshop a short exercise can be useful. Present a scenario in which the client has close ties with relatives, children, friends etc. and give these people names. Assume that the knowledge of these people has been introduced in a previous session. Let the counselor practice communicating about what is going on in their lives that seems relevant at the moment. You can also include hobbies like music, sports etc. in the sphere of the client but be careful not to overload this exercise with too much facts. When I started to use this exercise some participants said that there was too much to read and to learn. Finally you can give the client a short script or just a few lines to say just to give opportunity for the counselor to make positive

Allude and Attribute (A & A)

In both editions of the Miller & Rollnick book affirming is exemplified by sentences like...“That sounds like a good idea”; “I think you’re right about that”; “Thanks for coming on time today”; “That’s a good suggestion”; “I must say, if I were in your position , I might have a hard time dealing with that amount of stress”. The counselor is alluding on what has been said or done by the client.

personal attributions. Here is an example:
 Client: I never engage in any activity that I don't know what it is about...
 Counselor: You are a little bit like a scientist. You want to assess carefully before you make up your mind like a scientist.

Make sure that the counselor is focusing mainly on alluding and attributing during this short exercise and saving other skills for other exercises. So far this exercise has worked well for me. I would be very happy to have feedback from anyone in the MINT group who had the patience to read this all the way.

Figure 2

AFFIRM = A & A

Reflective listening has an affirming quality of itself but affirming and reinforcing by alluding to what has been said is also supportive.

I. Allusions

- That sounds like a good idea...
- I think that could work...
- I think you're right about that...
- It's important to you to be a good parent...
- I can see how that would concern you...

Another powerful way of affirming is to make positive attributions about the client as a person...

II. Attributions =

To make someone feel noticed and "seen" as a person...

- You are a bit of a philosopher really. You are reflecting on some really deep issues here...
- You are the kind of person who cares a lot for other people...
- You are a very creative person. It reflects a lot in your personality...
- You have what it takes to be a leader. Other people listen to you...
- You are the kind of person who does not like to talk behind the backs of other people. You have a lot of integrity...

MINT Forum 2001 in Santa Margherita
Ligure: Epilogue

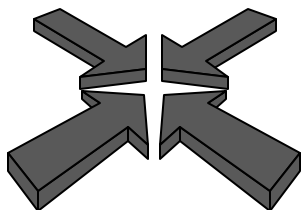
Ralf Demmel

What do I think of first when looking back at the MINT Forum in Italy? Mark Farrall and the “action methods”! I really enjoyed Mark’s exercises . . . What comes to my mind next? As a researcher I learned a lot from Gillian Tober’s presentation on the **United Kingdom Alcohol Treatment Trial** (“Achieving and Maintaining Competence in Motivational Interviewing”) and the discussion about ongoing MI projects during the research workshop: The (process) evaluation of internal validity (skill level, manual adherence etc.) was one of the most often highlighted topics of the presented research.

What changed my daily practice most? Steve’s presentation on context-bound training (“Spicing up learning experience: An example of context-bound training”). One year later it’s amazing to realize what strong influence Steve’s ideas had on both my research and training activities . . .

The notes taken by David include descriptions of several exercises introduced by Tom Barth (Bergen, Norway), Christina Näsholm (Resö, Sweden) and others as well as details on the other workshops: Obviously, there is a great need for advanced level exercises and a great interest in the evaluation of different training formats.

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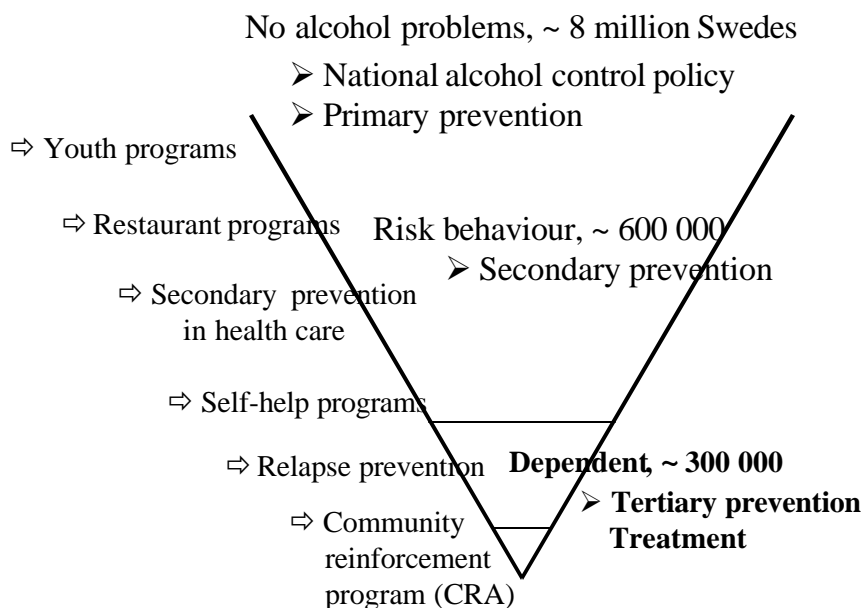
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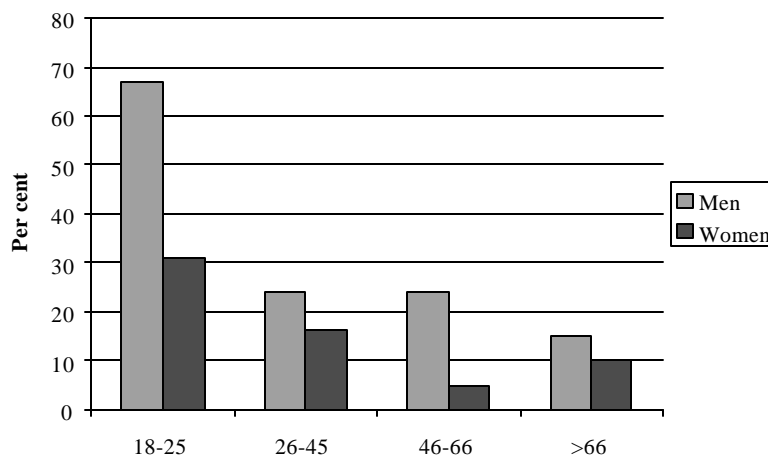
Appendix A

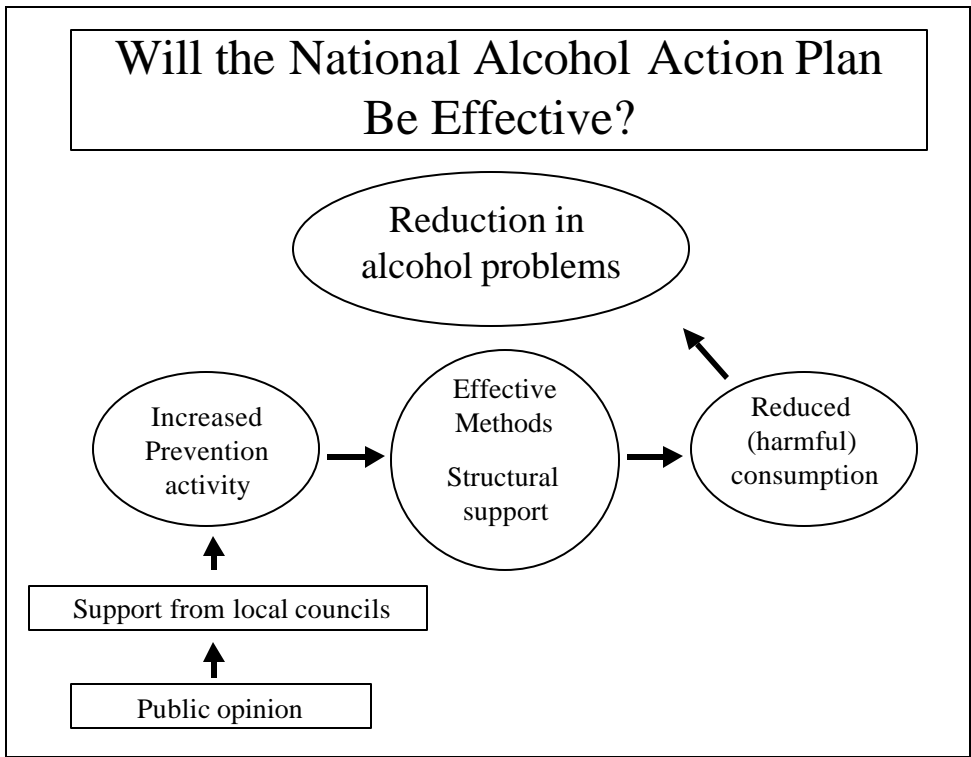
**PowerPoint Presentation by
Sven Andréasson**

The Alcohol Problem in Sweden



Binge Drinking Twice per Month or More Often





Secondary Prevention in Health Care

- Screening
- Motivational counselling

Gap Between Theory and Practice

- Effective methods are known
- but not applied
 - Lessons from research on the diffusion of innovations

Factors Behind Successful Diffusion

- ① Receiver perceives new method to be better than the existing
- ② The new method fits in with the culture and organisation of the receiver
- ③ The new method is easy to use
- ④ The new method can be implemented fast
- ⑤ The method is not perceived as risky for the receiver

Barriers to Implementation

- Lack of time
- Not a medical task
- Ineffective

Effectiveness

- 25 RCTs including 9 000 patients
- 30% of high consumers reduce their consumption, compared with 20% in the control groups

Barriers to Implementation

- Lack of time
- Not a medical task
- Ineffective
- Lack of knowledge

Training Institute for Alcohol Prevention in PHC and Occupational Health

- Organise training
- Technical support
- R & D

Introduction: Alcohol and Health Care

2 hours lecture:

- Basics about alcohol
- Screening and brief advice
- FRAMES

→ Entire staff at PHC or OCH,
including physicians

Basics in Alcohol Advice Giving

4 hours workshop:

- Develop advice giving (FRAMES)
- Everyday problems faced by participants
- Handling resistance
- Basics in treatment of alcohol dependency

→ Entire staff at PHC or OCH,
including physicians

Motivational Interviewing

2-3 days workshop:

- Change processes
- Eliciting change talk
- Handling resistance
- Context bound training

→ Key personnel from
PHC or OCH, eg nurses

Further Training

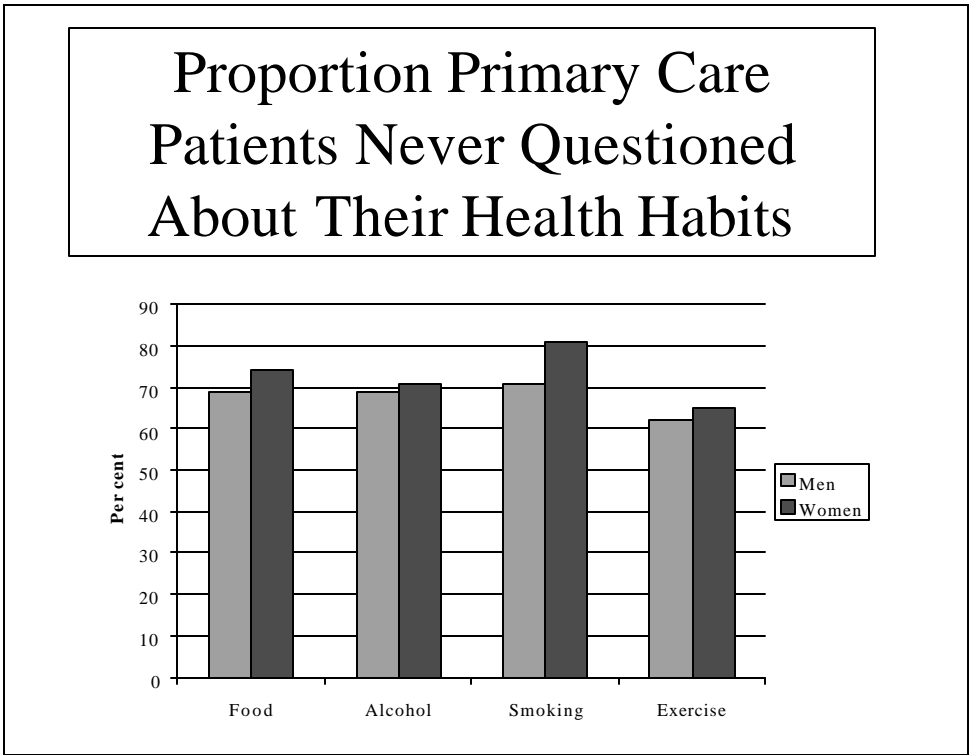
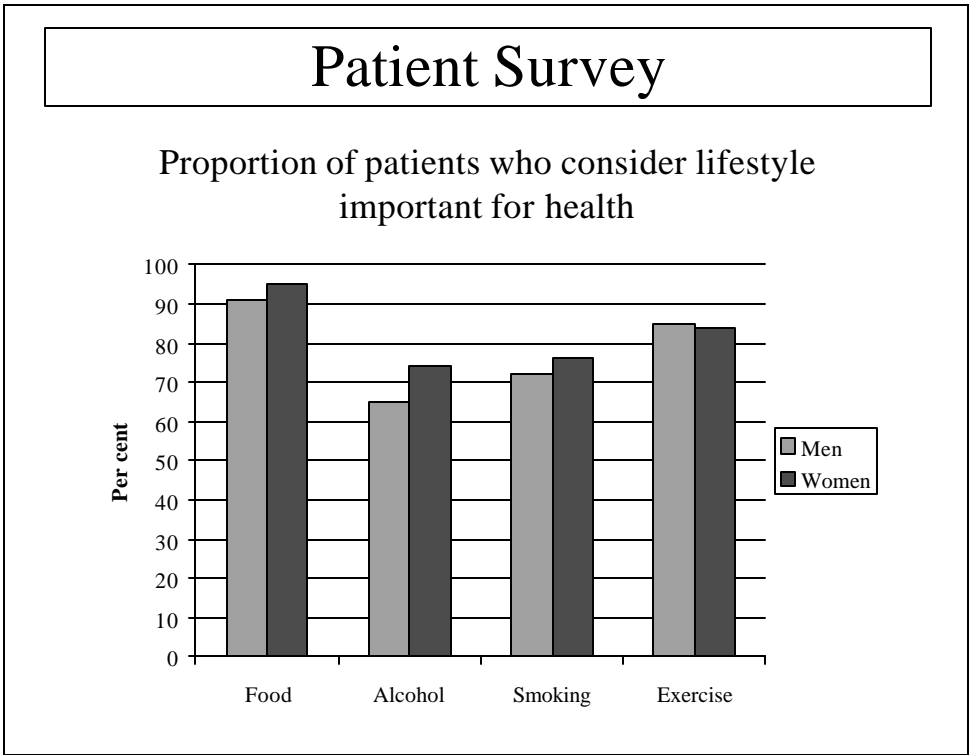
Advanced MI

- Advanced skills training

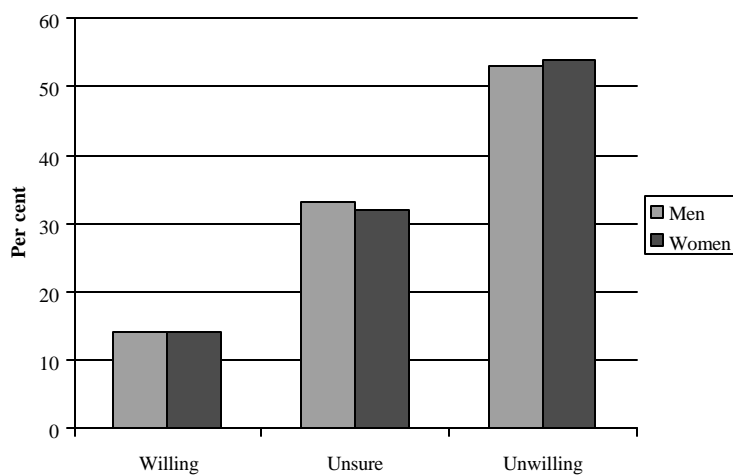
Training of trainers

Barriers to Implementation

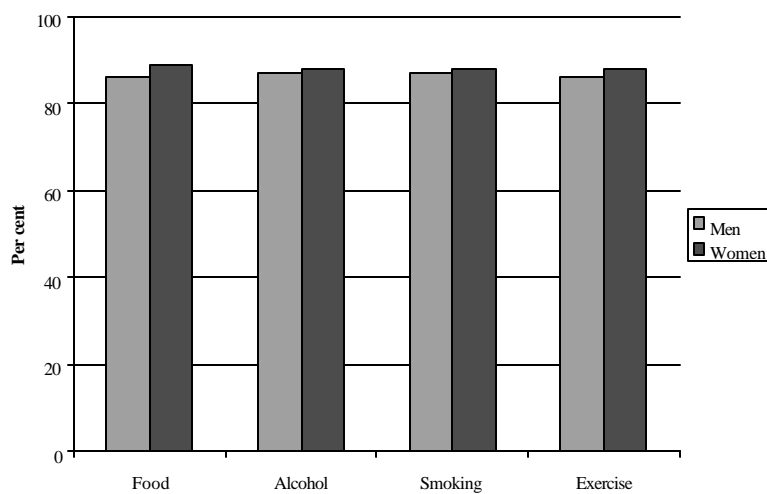
- Lack of time
- Not a medical task
- Ineffective
- Lack of knowledge
- Alcohol touchy subject



Want to Discuss Health Habits With Their GP



Proportion Who Think It Is Important That Health Habits Are Discussed in Health Care



Community Support

... support from those affected

... support from professionals involved

... support from decision makers

Appendix B
PowerPoint Presentation by
Ken Resnicow

Why Values Clarification?

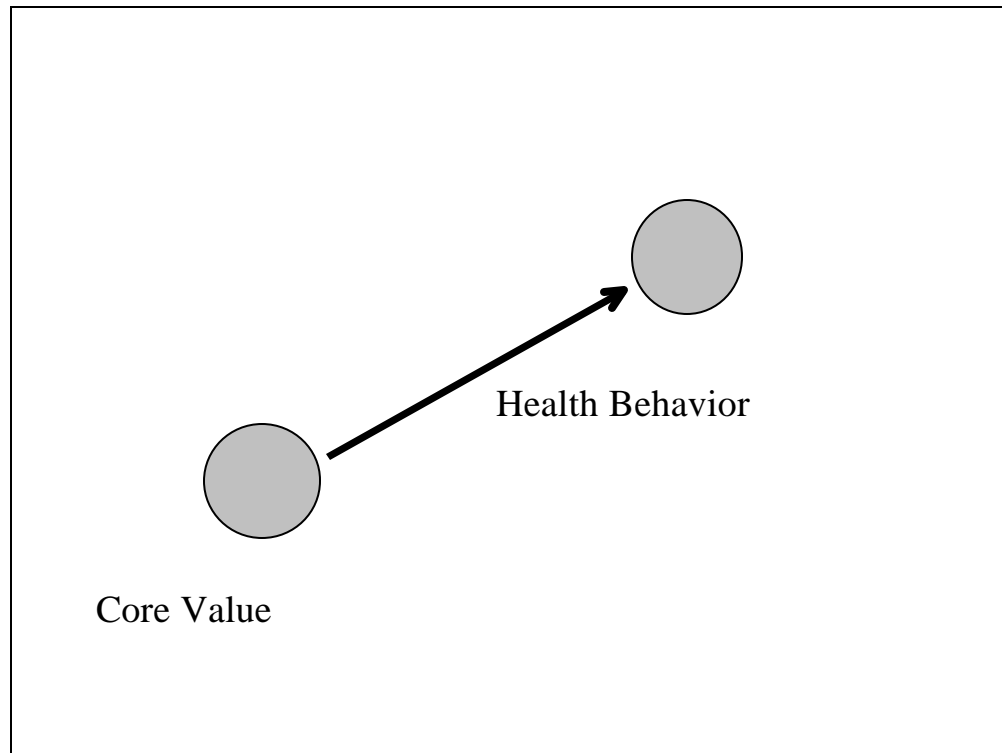
- 0-10, Pros & Cons, and other strategies often fail to tap deeper levels of motivation
- Builds discrepancy
- Link health behavior to person's bottom line
- Elicits new and different change talk

Values List: African Americans in Churches

Which of the Following Values, Traits, or Characteristics are Important to you?

- | | |
|-------------------------------------|---------------------|
| Good Parent | Attractive |
| Good Spouse/Partner | Disciplined |
| Good Community Member | Responsible |
| Strong | In Control |
| On top of things | Respected at work |
| Competent | Athletic |
| Spiritual | Not hypocritical |
| Respected at home | Energetic |
| Good Christian (or Jew, Muslim etc) | Considerate |
| Successful | Youthful (Older) |
| Popular (Youth) | Independent (Older) |

Choose your top 3 or 4



Explore linkages

- Current Behavior
- If you Changed the Behavior

If not raised by client.....

- Your Health
- Losing your Health

Developing Values Discrepancy: Probes

How, if at all, does your *current* behavior affect your ability to achieve these goals or live out any or all of these values?

How, if at all, would *changing this behavior* affect your ability to achieve these goals or live out any or all of these values?

What connection, if any, do you see between your *health* and any of these values/goals?

How if it all, might *losing your health*, affect your ability to leave out any or all of these values and goals?

Building Value Discrepancy: Issues to consider

- Values should be tailored to target population
Determined by formative research
- Some values could lead to entrenchment
e.g., Pleasure, Excitement

List of values, attributes, and goals and rates of endorsement
in the Healthy Body, Healthy Spirit Project (n = 135)

Good Parent	49%	Attractive	5%
Good Spouse/Partner	38%	Disciplined	16%
Good Community Member	13%	Responsible	22%
Strong	13%	In Control	10%
On top of things	7%	Respected at work	8%
Competent	8%	Athletic	2%
Spiritual	55%	Not hypocritical	7%
Respected at home	4%	Energetic	10%
Good Christian	46%	Considerate	18%
Successful	13%	Youthful	3%
Independent	16%		

Numbers in parentheses represent the percentage of participants in the HBHS project to date that have chosen as one of their core values.

Values for Adolescents

<i>Good student</i>	Disciplined
<i>Healthy & fit</i>	<i>Respected at school</i>
Strong	In control
Responsible	<i>Good to my parents</i>
On top of things	Athletic
Competent	Confident
Spiritual	Energetic
<i>Respected at Home</i>	<i>Mature</i>
Successful	<i>Independent</i>
<i>Popular</i>	Other_____
Attractive	

Values for Parents of Overweight Youth

Values For Your Child

Be Healthy
 Be Strong
 Have many friends
 Being fit
 Not feeling abnormal
 Not being teased
 Not feeling left out
 Be able to communicate
 his/her feelings
 Fulfill her potential
 Have high self-esteem

Values for You

Good Parent
 Responsible
 Disciplined
 Good Spouse
 Respected at Home
 On top of things
 Spiritual

Values for Your Family

Cohesive
 Healthy
 Peaceful Meals
 Getting along
 Spending time together

Bringing it all together

Get permission
 Assess 1-10 interest/confidence
 Probe lower/higher
 Reflect/Summarize
 Assess core values
 Link behavior to values
 Summarize
 Where does that leave you?
 Where do we go from here?

Building Value Discrepancy: Issues to consider

- Not necessary (or possible) to link behavior to EACH value
- Determine if you want health as a value vs spontaneous link
- Can be conducted via telephone and possibly automated counseling systems
- Populations where it may not work
- When it bombs
- Variations in theme/Cross cultural applications

Alternative Values List

Which three are most important to you?

- Responsibility**, to do what I said I would do
- Purpose**, to have meaning and direction in my life
- Helpfulness**, to reach out to others
- Inner peace**, to find a sense of quiet/calmness
- Justice**, to promote fair and equal treatment for all
- Hope**, to see what happens in life in a positive way
- Independence**, to be able to meet my own needs
- God's will**, to follow God's plan for me
- Loving**, to give and receive love
- Family**, to have a happy, loving family
- Spirituality**, to grow and mature spiritually
- Forgiveness**, to be forgiving of others
- Strength, to be physically fit and capable**
- Mental strength, to be mentally alert**
- Humor**, to see the funny side of life
- Friendship**, to have close, supportive friends
- Growth**, to keep changing and growing
- Health**, to be physically well
- Other** _____

Appendix C

**The “Three Chairs Exercise” by
Ken Resnicow**

Motivational Interviewing Training Exercise

Title: THREE CHAIRS
Contributor(s): Ken Resnicow and Jacki Hecht
Purpose: 1) To highlight generally negative impact of advice giving 2) Demonstrate difference of surface vs deep reflections
Format: Groups of 4 or 5
Approximate Time Required: 10 – 15 minutes (plus extra debriefing time)
Supplies Needed: A whiteboard or large writing pad/flip chart for debriefing
<p>Instructions: Divide the larger group into groups of 4 or 5. Each group sits in a circle, facing each other. Each person selects a defined role from the following:</p> <ol style="list-style-type: none"> 1. One person is the speaker. 2. One can only make “you should” statements. 3. One only makes content (surface) reflections. 4. One only makes deep reflections (reflecting feeling or meaning). 5. If there’s a 5th person, this person can be an objective observer or coach. <p>The speaker begins with a statement such as:</p> <ul style="list-style-type: none"> ❖ “<i>Something I would like to change about myself is...</i>” ❖ “<i>A health behavior I would like to change is...</i>” ❖ “<i>Something others would like to change about me is...</i>” <p>After the speaker offers the opening statement, person # 2 offers a “<i>you should</i>” statement. The speaker then responds with a single statement. Person # 3 continues with a content reflection, and the speaker responds with a single statement. Person # 4 continues with a deep reflection, and the speaker responds with a single statement. Person # 2 goes again, and this cycle is repeated for about 4 or 5 rounds.</p> <p>Debriefing: How was it to be the speaker in this exercise? What did the speaker notice about his/her responses to the different types of statements? More specifically, what was the speaker’s reaction to the “you should” statements? How did this reaction differ from hearing the various forms of reflection? Which types of reflective statements were most helpful to the speaker?</p> <p>How was it for person # 2 to only provide “you should” statements? How did the speaker respond to these? What else did person # 2 want to do?</p> <p>How was it for person # 3 to only provide content reflections? How well did the content reflections help to engage the speaker and clarify his/her situation? In what ways was person # 3 limited? What else did person # 3 want to do?</p> <p>How was it for person # 4 to provide only deeper reflections? How difficult was it to formulate these reflections? How did the speaker’s response(s) affect person # 4’s ability to continue to formulate these deeper reflections?</p> <p>What insights were learned (or relearned) from this exercise? Are there people who may prefer giving and or receiving advice?</p>