A MINTy Kind of *Festschrift*

Allan Zuckoff

A *Festschrift,* or "celebration publication,' is an academic tradition in which, to honor the life's work of a member of the community who is viewed as having made seminal contributions to his or her field, colleagues, students, and others whose own work has been influenced by the honoree offer scholarly considerations of its impact. When I put out a call for contributions to MINT members for a *Festschrift* in honor of Bill Miller's retirement from the University of New Mexico, and of the profound impact of the counseling method he introduced in "Motivational Interviewing with Problem Drinkers," I anticipated that the our MINT community would extend the boundaries of the form to encompass personal as well as intellectual responses. And so they have. I'm pleased to present those responses here, in alphabetical order by author, with one exception—a contribution that seems to me a very MINTy way to end this special issue.

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How Bill Miller Touched Our Corner of the World

Sharone Abramowitz

Our primary care medical clinic belongs to a county hospital in Northern California where our community's uninsured go for their health care. Our patients come from all corners of the world, but the corner of the world where our patients now live is only a couple of miles from Alice Water's five star restaurant and a hotel where President Clinton once lodged. Their world is filled with tired workers cleaning bedpans and guarding banks, stressed mothers and grandmothers who have far too little to take care of far too much, and street corners ruled by drug dealers, where stray bullets fly. They don't hop into a late model SUV and drive to their medical appointments; they rely on an old car that may be on its last legs or an unreliable bus system. By the time they meet up with their resident physician, who may be from Miami, Baghdad, or Seoul, they are worn out and stressed.

This is the space which I walk into in my role as a psychiatrist who teaches behavioral health. Our well-meaning young physicians want these patients to stop smoking when that might be their only moments of relaxation, to lose weight when snacks are the only indulgences they can afford, and to stop snorting when a momentary cocaine high is the last moment of escape left. The doctors, usually younger, always more affluent, tell these usually older patients, who have heard it all, what they 'should' do, 'need' to do and 'must' do. And 17 years ago, when I started this work, I would struggle with how to teach these young physicians to bridge this wide gap between themselves and their patients, to respect and empathize, and to bring their well-meaning hearts under the control of skilled communication. But it wasn't until 10 years ago, after I was introduced to MI, that I had the tools that I needed to get this task done.

Over the years, we have shown dozens of doctors the video of Bill talking to the Native American man struggling with alcohol and marital problems, and they have sat and watched with eyes open, eager to emulate the kind, bearded man listening and reflecting. When they have learned MI's philosophy and realized that it is from within the patient that the motivation for change comes, and that they are there to facilitate this, not to dictate this, they feel inspired for the first time to counsel when that had been the least inspiring of their tasks. More importantly, when the doctors practice MI, the patients (who usually feel ignored, disrespected and discounted) feel seen, heard and supported about health behavior struggles that they would usually rather not discuss. Just recently, a 42-year-old man, who suffers with chronic pain from injuries to his limbs due to a car accident, came into the clinic treasuring the time he has with his ten cigarettes per day. Since he didn't have symptoms from his smoking, why give up this one small pleasure? He didn't suffer the shortness of breath that other smokers do, and he was sure grateful that he didn't have cancer. And by the time he surveyed the damage that smoking had not caused him, he realized that he didn't want to have to face that sometime in the future. Yes, he said, that might be something he'd like to stop.

Thank you, Bill, for your wisdom, generosity, and openness as a teacher to us all. Your work, just so you know, has saved the lives of many of our patients. And maybe just as important, it has supported the dignity of those who the world often discards, while it has guided the hearts of those who take care of them.

Dear Bill

Tom Barth

In 1982 you turned up as a visiting professor at Hjellestadklinikken. You were on a sabbatical from your university, and perhaps a little in refuge from the US. We were a group of young, radical, and enthusiastic psychologists at the clinic, influenced by behavioural approaches to treatment of addictions, but also by community psychology, the family therapy tradition, and general systems theory.

We agreed to have a weekly supervision group, and started by discussing the content of our planned meetings. You told us about areas you felt competent in, and gave us "a menu of options." We were not impressed. This was not a very long time after the war in Vietnam and other international affairs, and we had a sceptical attitude towards Americans coming to us, saying they knew something.

We ended up talking about what we believed was working in treatment, and why, and how to be respectful of our clients. (Perhaps even considering how we could apply the Maoist slogan of "serving the people" to the treatment world.) Themes like 'resistance', 'motivation', 'evidence', 'controlled drinking' were central.

The initial scepticism was easily overcome. We were impressed by your outlook and insight, your interest and understanding, and your work capacity. We could have a discussion in our meeting, you could say "there is some research on this," and the next day we would find a written overview in our mailboxes—with references, short summaries, and comments about how this could relate to our discussion. This was long before computers and the Internet. You had brought an extensive box of reference cards, and in fact served us as a knowledge base as well as giving input and initiatives to our discussions.

You also spent time taking us through a communication skills manual—giving us a model for how to teach it to others.

When one day you turned up with the draft of an article, "Motivational Interviewing with Problem Drinkers," I instantly recognized it as the spirit and the essence of what I was trying to do (and what I have done ever since). I still have the original copy—34 pages long, including a hypothetical example of a conversation with a client, and a diagram in the form of an electric wiring map to illustrate the treatment process. It still amazes me to see how much of MI as we know it now was already there in that paper.

The relationship between us was special, the obvious closeness and at the same time the distance. You were never arrogant or impatient or uninterested. Always listening and supporting and giving advice when asked. You were friendly and sharing and personal. And at the same time very far away. Difficult to know what you were thinking. I'm not sure I got to know you very well. You were sort of untouchable—or unreachable...

As the years have passed, we have met less frequently—in fact less and less. But there is always the same respect and openness. Also in questions where I do not entirely agree with you in your views of MI—when I feel you can be too solution-focused, too limited in scope and goal-setting.

But I am very thankful for your guiding of the MINT organisation—preventing it from turning into a business, or a closed and exclusive society.

In my professional life, you have been the most influential person. You have been an inspirer and model, but most important is that you have given words and structure to "my" way of thinking and working, and you have continued to evolve the structure, helping me towards an ever deeper understanding of I am trying to do.

I am very happy that you were the one who came along at the time when I was ready for that kind of influence. And I am sure that, retirement or not, your influence will continue in the future.

A Letter to Bill

Sandy Downey

Dear Bill:

I wanted to tell you about the profound impact that motivational interviewing has had on my work and in my life. For a while I had difficulty finding the words to capture what I have experienced since I first began learning motivational interviewing in 1998. Then one evening when I found myself alone and able to reflect in a quiet house, as I sat down to write, it occurred to me that you had already described the essence of what I wanted to say.

In the February, 2004 issue of the *MINUET* (11.1), in an article entitled "Transcendent Moments," you described an experience that is sometimes reported by practitioners of MI in which the practitioner is fully present and experiences a transcendent, loving, and powerful moment of oneness with the individual before him or her. You write that practitioners have described it as "...a qualitative shift in my consciousness," and further summarize their experience by stating, "I am fully and literally present with the person...my whole loving attention is focused on the other, whom I experience with awe-filled respect." You offer further support of this experience in the writings of Carl Rogers when he asserted that, "Our relationship transcends itself and becomes a part of something larger. Profound growth and healing and energy are present." Then you note that Brian Thorne also described a mystical kind of experience as a counselor in which "...a new level of understanding is achieved and a sense of validating freedom is experienced by both client and counselor. The surge of well-being that follows such moments is almost indescribable."

When MI began to become for me a natural way of being with my clients, when I didn't have to concentrate so hard anymore on "what to do," I began to experience this type of meaningful connection within the therapeutic relationship. Over time, the experience has grown and intensified, and become a part of my daily experience surrounding my work as a therapist. It is apparent to me that the empathic, accepting, non-judgmental, strength-based and values-focused approach so central to MI facilitates this sense of oneness and purpose. This leads, I believe, to healing, growth, and transformation for both the client and therapist.

In the preface of *MI1*, you and Steve provide a word of caution and "informed consent" regarding the use of motivational interviewing, because practicing MI "changes you" as the practitioner. That certainly has been the case for me. It has transformed me in many ways, both inwardly and outwardly.

Outwardly, for example, I have become a much stronger and more assertive advocate for my clients' needs. I actively seek to develop my knowledge and skills in a variety of clinical areas, to become a better therapist with a greater capacity to provide effective treatment for each person I see. I now take crazy risks, like traveling to another country by myself despite a travel phobia, so that I could attend the MINT Forum and be with others who share my value of helping people in a respectful manner. I used to shy away from counseling-related speaking engagements and now I eagerly await my next opportunity to help others learn motivational interviewing. I remember to be accepting and kind to all others, more often.

My inward changes are more

difficult to describe, but reflect the deeper connection I feel with my clients on a daily basis. I deeply trust their inner wisdom, personal strengths, and unique gifts and talents. Their desire and ability to have a better life and develop who they were meant to be is moving. I literally experience a "high" following many of my individual and group therapy sessions! This feeling stays with me, and gives me strength to continue on in this meaningful and sometimes difficult work. I am energized by my work with my clients and feel privileged to work with them. I am aware that I learn so much from them and they help me to be a better person and therapist through this collaborative therapeutic relationship. Motivational interviewing is indeed powerful!

Of greater significance than MI's influence on me is the transformation I have been fortunate to witness in the lives of my clients. Returning to the idea of "profound growth and healing" that you referenced in your article, I have observed countless moments of growth, healing, courage, positive risk-taking, caring for others and efforts to change that are truly inspirational. MI creates an environment that enables my clients to feel safe to explore all aspects of their behavior. They are afforded the time and space to come to a decision at their own pace regarding their readiness to make changes. Through MI, they experience empathic understanding and caring, and are fully accepted as they are within this therapeutic relationship. Because of this, I continually observe my clients giving voice to their own concerns about behavior they hope to change. I see them grow in their confidence to change, begin to take steps towards a brighter future, and develop a clearer sense of who they truly are.

It is common for my clients to share their reactions to this therapeutic experience, in both individual and group therapy sessions. To illustrate, a young woman who was very angry and depressed said "I felt happy" following her first MI therapy session; she shared that she had rarely felt happy in her life and was surprised to feel this way. Another nearly despondent man later shared that he had asked himself following his initial session, "Could this be the start of something good?" It was! He has made many difficult changes already and continues to set new goals for himself. In my group work, I often listen intently as clients report finding therapy to be a positive, enjoyable, and beneficial experience despite having been coerced into treatment by others. Recently, a group member referred by her probation officer and initially angry about being there, spoke of how her treatment has become something she looks forward to at the end of the day, two nights per week. Another member on this same evening declared that even though her required treatment was complete, she was choosing to stay on a voluntary basis to work on additional goals.

Experiencing a sense of oneness and purpose in my work with my clients, and witnessing once unimaginable life changes occur for so many, continues to amaze, inspire and transform me. I am grateful to you for your work in developing this transformational therapeutic approach. It has provided me with a renewed understanding of the capacity of people to achieve their very best, and it has provided my clients with an experience of caring, compassion, and hopefulness that makes change possible.

Respectfully,
Sandy Downey

Bill Miller in Swedish Corrections

Carl Åke Farbring

Bill Comes to Sweden and MI Goes to Prison

Somewhere Bill has written, "MI belongs in prison." I became aware of motivational interviewing at the end of the 90's. It was immediately obvious to me that MI was fundamental for any kind of treatment with clients, particularly in prison and probation, and even for the many evidence based CBT programs for offenders that we had just started to use, because MI touched on and even defined in behavior terms relationship factors and ways of communication between counselors and clients that were crucial for change. Furthermore, these factors had been essentially overlooked in our organization.

I went to the Training of New Trainers in Tarragona, Spain, and almost immediately began a large scale training and implementation in prison and probation here in Sweden. Early in 2001 I wrote to Bill and asked if he would consider coming to a big "What Works?" conference here in Stockholm for a few days and address some 200 senior head staff in prison and probation and introduce MI to them as part of a treatment launch. The first responses I received were close to resistance: he did not want to travel, he felt obligations to his family, etc. He was even a bit hesitant, as I understood it, about this way of implementing MI; perhaps he feared that my enthusiasm would reflect a top-down perspective and would be opposite to the spirit of MI?

I received many e-mails from Bill with questions that I thought reflected his wish to stay at home. So I didn't push, but rolled with it and just waited for him to make up his mind. Suddenly, in the summer of 2001 in Santa Margherita, Bill passed by me exhausted after just having played with his young son, smiled and said, "Ok, I'll come." Perhaps it was just his good mood after playing with Jayson. But I had also noticed, waiting for his final response, that

although he might fear a top-down perspective, he was still interested in taking MI in a large scale way to prison and probation and seeing what would happen.

Stockholm, December 2001: no snow, greyish weather, sometimes rain. The day prior to the conference Bill met with a few of my trainers and a professor of psychology from Uppsala University, Lennart Melin (a member of our scientific accreditation panel) who I had invited. It was a memorable moment for them, which Melin still talks about (sometimes followed by his asking me if I think that I can get Bill to come visit us again). At the conference Bill met with more than 200 senior head staff who, at that time, were not sure of what MI really was. His presentation was, as you can imagine, impressive and fascinating. One of its most important aspects was to give a solid scientific base for MI; at that time, there were people who said that MI was just another *mode* and that it would be followed by others. On the second day of the conference Bill gave a workshop in listening skills. Afterwards, our own director general—a former army general—said that he now understood what he had been doing wrong during most of his career (the righting reflex). The minister of justice and the director general gave full support for the launch of a large scale treatment program to reduce recidivism. We sold nearly one hundred copies of MI1 and about twenty copies of *Quantum Change*; later, we translated the entire conference word for word, printed it and distributed it all over corrections (*What Works III, 2001*), which enhanced the importance of the conference message.

To Bill this may just have been another few days at work, but to MI trainers and others who just knew him from books and video tapes they were memorable ones. To me personally it also meant glory (really!) and support for my work. Also I got to know Bill a bit more personally: his humanistic life philosophy, his thoughts on quantum change, his dislike for war toys for children. There were many dinners at nice old restaurants in the Old Town of Stockholm with colleagues from the UK (Bill later invited David Perry, head of "What Works" from the Home Office to the ICTAB conference in Heidelberg) and later with MINTies. We visited the Wasa Museum (the Wasa, a Swedish warship, only made it a few hundred meters on her maiden journey in 1628; it was found in 1956 on the bottom of the sea, and a museum was built to "celebrate" this failure. The ship was magnificent; the king had ordered more canons to make it look respectable, but that also made it far from sea worthy, of course). We took a nice boat trip to the home of MINTies Lars and Kerstin Forsberg in the archipelago, where we had a Christmas "smörgåsbord lunch" (a Swedish tradition—it takes hours) at a very famous restaurant by the sea.

MI has become extremely important in Swedish corrections since 2001-2002. Today manualized MI is the most used intervention in Swedish prisons and probation. We have about forty monitoring groups around Sweden and the demand for next year, by clients and counselors, exceeds our best expectations by far. In fact, MI has contributed to something of a cultural revolution here: we have had clients assessing the climate for treatment in prisons (in 16 dimensions—treatment, staff, relations etc.), an unusual document that was published in October 2006. This would not have happened without MI setting the standard for the treatment relationship with clients.

Translating *MI2* into Swedish I could hear Bill's voice at hopefully the right places. I have read "The Drama of Change" (p. 109) many times and I hope I did it justice in Swedish. Since Guilford did not succeed in finding a professional book company in Sweden to publish it they signed a contract with us; we have sold thousands of copies already. It's almost a burden for the people working in our publications department because they get orders from book shops and private persons every day. I have met Bill many times since 2001 and I can't think of any person who has influenced me more. My now retired psychology professor, Sten Rönnberg, eager participant in many ICTAB conferences, told me years ago (and I agree with him): "I like to learn from Bill Miller…"

MI in Corrections

In retrospect, during a long clinical career I can remember doing a few things right even before I learned about MI, but unfortunately a few things wrong as well, even though I had my clients' very best interests in mind. A few of these still make me wonder a bit and maybe they have bearing on my conception of MI theory today.

Listening reflectively was the skill that I relied upon almost instinctively in my early work—but there were quite a few times when it ended up in disaster. In corrections it is very common for clients to start a conversation by complaining about rules, guards, wrong decisions, etc., often in an accusatory way, but calmly as a way of making conversation. For example, a client said:

Boy (smiling), you are really doing everything to hurt me and my family. I am not allowed to see my kid this weekend and play football with him, even though it's his birthday. There are people here who really enjoy making us suffer…

In response I reflected what he was saying, compassionately. He then continued with more of the same. The more I reflected, the more he continued. I helped him to develop new cognitions of how badly he was treated and from a calm and smiling atmosphere I managed to get the client to talk himself into a rage. (But I would have scored high on reflective listening!) Now he was in outright *resistance*—an emotional state where I simply had to follow and

make *affirmations* (attributions of interesting qualities that I thought he would like).

At this time I had no knowledge of what I have come to call "compass direction," a sense of where I wanted my client to go. Today, when I encounter this sort of attitude, I have learned to respond differently:

I know you are the kind of father who really wants the best for your son,like the chance to play football with him, since you used to be extremely good at that (affirmation, attributing interesting qualities to his personality). *What do you think about that? What do you want your son to expect from you in the future?*

Bill and Steve would probably call this "continuing the paragraph"—a brilliant development of reflective listening as I see it in *MI2*, which changes the direction of the conversation and should be followed by an open-ended question that emphasises the new direction. This kind of response recognizes that the client was not initially in a state of resistance, but that resistance can be developed with the "helpful" response of an unskilled counsellor. Now when I teach MI I pay attention to compass direction, and I use the Miller, Moyers, Amrhein and Rollnick (2006) consensus statement about change talk and the nomenclature in Figure 1 (A Nomenclature for Client Language, adapted from T. Moyers, PhD, ICTAB 2006:

Because not only sustain talk, but also "neutral" statements, can lead the whole conversation off course if the counsellor simply follows the client using reflective listening, to the Miller et al. (2006) consensus statement and the nomenclature I have added a neutral category of client speech:

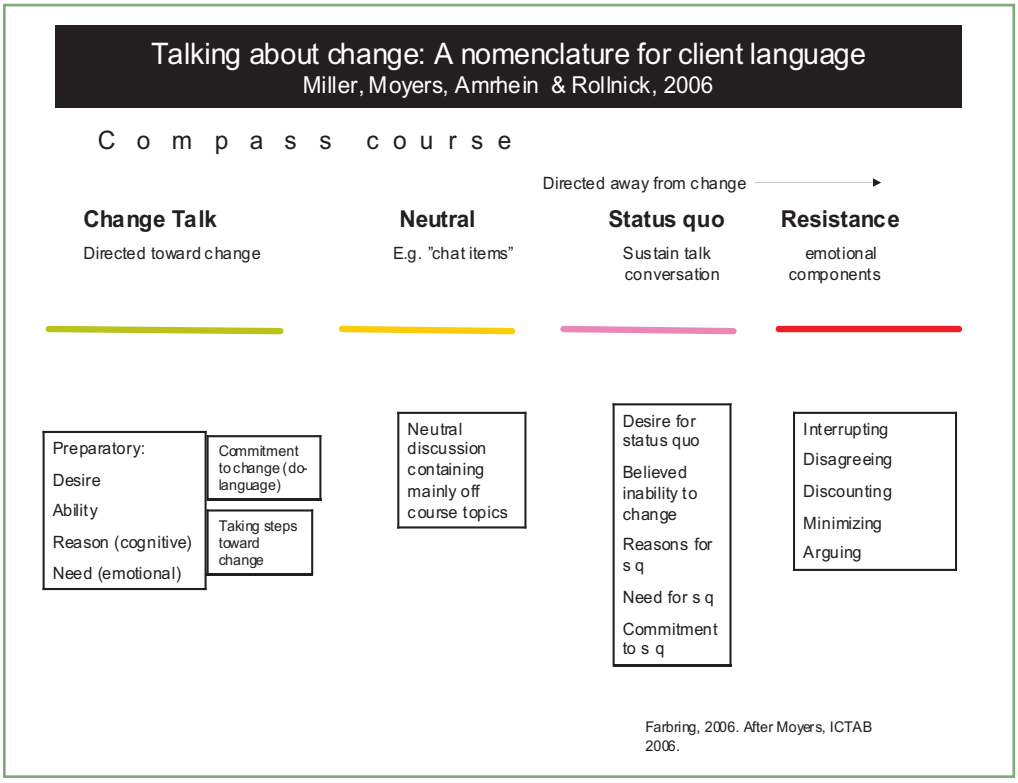
Client: *Look, I was on my way to the treatment house, but my car broke down. It was raining and I had to walk for two hours to the nearest gas station. Nobody would give me a lift. I called Tom from there and you can guess the rest...*

Counselor Response 1 (risky reflections that may lead off course): *That must have been terrible for you. You must have been exhausted having to walk that long and with all that rain... And Tom on top of that...*

Counselor Response 2 (increasing the probability of leading back on course): *That must have been terrible for you. But this was not what you wanted. You had your mind set on going the treatment house... So what happens now?*

Change talk has changed my way of thinking about MI. I worried about exploring the down side of ambivalence—especially at length—even before I read Ashton and also Bill's and Paul's worries (Amrhein & Miller, 2008) about motivation with respect to substance use outcomes. Clearly it cannot be right to help clients talk themselves more into doubt about change?! This is how I teach it:

- *Positive change talk:* this is the home beacon light for counselling—reflect on preparatory change talk to elicit more. Be attentive to where the client is, because often the problem recognition comes first (reason); increase discrepancy with focus on emotional need; try to keep balance between desire and ability (we don't have enough good exercises on enhancing ability in our teaching so we may be overdoing the desire part because it is easier; but without balance with ability desire will fade down to the ability level anyway). Don't elicit commitment language until the client is ready but don't miss the opportunity once the chance is there. If the client is not ready "to do," maybe you can use subjunctive language: *Well, Peter, I understand that it may be a little early for you to make up your mind, but if you would do something, what would be best for you?* (This paves the way for cognitions on the commitment dimension without the press of obligation.)
- *Status Quo (sustain talk):* use "continuing the paragraph" listening and open-ended ques-



tions to change course. Don't just follow, although it may sound empathic to do so.

- *Neutral conversation:* see status quo. Reflect on as much as you have to be credibly empathic but then try to get back on course.
- *Resistance:* mainly an emotional state; roll and follow the resistance protocol in MI.

Bill has recently indicated that he thinks that affirmations have probably been underestimated as an effective element in MI, referring to a study by Marsha Linehan (2002) in which a "validation" control group (merely subjected to affirmations) did just as well as a group treated with dialectical behaviour therapy (DBT). I couldn't agree more. In issues 9.2 and 9.3 of the *MINUET* David Rosengren and I exchanged a few ideas on this topic. Affirmations (earlier I used to call them social reinforcements) are extremely powerful and sometimes so powerful that they should not be used if you are not prepared to continue counselling with your client for some time. When you attribute interesting and rewarding personal qualities to your client it makes the client feel "seen" as a person—somebody really special—which makes him/her grow. Clients seem to perceive this as empathic understanding. In corrections the opposite is more common—clients are constantly addressed and referred to as harmful, problems, failures etc. No wonder positive attributions make clients bond with their counsellors. I am looking forward to further elaborations on this by Bill, and perhaps a study, in *MI3.*

MI is a wonderful world to be in. In MINT I think we all reflect on, try to understand and try out MI every day. I am committed to the present Miller view on MI emphasizing change talk, direction, and data. That is something that I have also learnt from Bill. Bill's blend of humble humanism and scientific evidence is something that the world needs more of.

Thanks Bill, for helping establish MI in corrections! It really belongs here. I think any worries that this large scale implementation would harm the spirit of MI or the way that it is perceived were unfounded, and I believe that today Bill would agree. MI has changed the culture in prison and probation in Sweden, the way even uniformed staff talk to prisoners and probationers, far beyond my expectations. Even heads of the organizations who have no detailed understanding of MI often talk about how important MI is. It is a precious privilege to be part of the MINT and to have access to Bill's mind and thoughts. MI is where my citizenship is most dear to me!

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Use the Force

Claire Lane

When I look back at my life seven years ago and then look at where I am now, I don't think I ever could have predicted that I would end up where I have. After graduating in 1999, I began working with the long term unemployed in my native East London. I loved doing this kind of work. It was real hands-on people stuff, and although according to the powers that be it was my job to make these people get a job, I think my colleagues and I soon realised that our role was much more than that. The down side was that I often didn't feel intellectually stimulated by it. I was fresh out of university, and my time as an undergraduate was one of the best times of my life. I loved studying and developing my thinking, and I was feeling frustrated that although there were a lot of things about my job that I loved, I didn't seem to draw on any of the knowledge and skills that I had developed while obtaining my linguistics degree.

I therefore decided to consider undertaking a research degree. The one thing holding me back was the fact that I wasn't sure I could take another 4 years living on pasta, in a damp, cold student house. Therefore if I was going to do this, I had to make sure I could get some kind of bursary that I could live on. I identified the areas that I was interested in studying from the vast array of fascinating subjects I had studied at undergraduate level. These were speech/language pathology, child language acquisition and communication in healthcare.

As if by magic, an advertisement for a funded studentship in communication in healthcare appeared. It might as well have said 'Perfect opportunity for Claire Lane, please apply here!' It was with some guy called 'Dr. Stephen Rollnick', who I'd never heard of before. It was based in Cardiff, where my romantic attachment was based (more about him later!). So, before making 'informal enquiries', I decided to do a literature search on this Rollnick guy to get a feel for what he was all about. It was only at that point that I became familiar with the name Bill Miller. I must admit that my first reaction was 'Psychology? No way—this is applied linguistics!' Despite this, my way of thinking was enough to secure me the studentship.

I attended the TNT in Amsterdam in 2005, and I was actually really excited because I knew that Bill was going to be there (insert picture of 'sad', star-

struck groupie here!). Having had 'the Rollnick experience' for four years, I was eager to see the other half of the equation. I have to admit that I was actually quite surprised by Bill. In my mind's eye, I had kind of grouped him and Steve into being one and the same kind of person. In reality, I was faced with someone who to some extent was everything that my boss wasn't. He was tall, fair...and much less of an extrovert! Bill seemed to be quiet, thoughtful and rather calm. It's amusing that Bill was everything that my fellow trainees expected—whereas I just expected him to be an American version of Steve! I was actually quite blown away by just how different they seemed to be to each other, yet they seemed to merge together really well—a bit like cornflakes and milk. A fellow MINTie once commented that this was a 'Perfect metaphor for them. After all, if you leave them together too long, they are likely to go a bit soggy...'

So, how has Bill's work changed my life then? Well, the use of MI in the home has certainly proved useful. In 2001, I bought a house with my boyfriend Graham. I married him in 2003. Now, my old colleagues in the primary care department in Cardiff have all sorts of jokes about me using MI to motivate a poor unsuspecting bloke to marry me, and I guess it could be argued that there is many a true word said in jest. Would he have proposed had I not used reflections to diffuse the situation when we argued? (I particularly recommend the use of amplified reflections, by the way!) There are several occasions when he has said 'Thanks for that talk we had last night—it really helped.' They were all occasions where I switched into reflective listening mode, and helped him to explore ambivalence.

I stupidly made the mistake of getting Graham to read my PhD thesis before I submitted it. This in turn led to me having to explain that, yes, I use several skills common to MI to facilitate better understanding and communication with him; no, I don't practice MI with him; and no, MINTies are not like Jedi knights who go around 'using the force' on people (if only it was that simple!). Thankfully, the one thing my husband is not ambivalent about is how much he loves me! If he was, well, I'm sure I could help him resolve that ambivalence one way or another [cough, cough].

On a more serious note though, MI has taught me a lot about listening to others, respecting them, and empathising with them. It has encouraged me to get involved in some fantastic voluntary work providing emotional support to individuals in distress and despair, which has brought a sense of satisfaction and purpose in life I can't even begin to describe. It has enhanced my relationships with friends and family, and has reminded me that 'difficult' people are rarely 'difficult'. I wish I had learned about MI before working with my unemployed clients—it might have made the job a little easier! It has also led me to want to change my career again, and enter the clinical psychology arena. This is something I would probably never have considered, had I not encountered Bill's work in the way I did.

Bill, enjoy your well-earned retirement—and make sure you don't 'go soggy'. May the MINT be with you, always!

MI's Impact on the Evolution of the Field of Substance Abuse

Patricia Lincourt

This *Festschrift* offers an opportunity to acknowledge the impact of motivational interviewing and Bill's thinking on the addiction field. The importance of MI is in the evolution in the field of substance abuse treatment as a whole and that is what has intrigued and heartened me. I imagine that my own experience is similar to that of other MINTies in that this evolution parallels my own professional development and thinking.

I was introduced to substance abuse treatment at a mental health day treatment program where many of the patients were using alcohol and other substances and not able or willing to access treatment in the substance abuse system. I attended some training in addiction treatment and began working with a substance abuse counselor to start a MICA (Mentally Ill Chemical Abusers) treatment group. The expectation of recovery, clear problem focus, and interest of the clients attracted me to working in the addiction field.

One of the first clients I worked with helped me to better understand the problems with the addiction treatment system in the late 80's. A 24 year old female client who was severely alcohol dependent with an unimaginable trauma history began talking with me about the possibility of stopping her drinking. She was at a point we would now refer to as "contemplative." After a time, she made the decision to attend a session at a local substance abuse outpatient clinic and I was thrilled for her. A short while later I heard from the clinic that this woman was being discharged administratively for failure to follow the program recommendations. She had a panic disorder and refused to attend group sessions, and had had a relapse and would not go to an inpatient program. As hard as I tried there was no convincing this program to work a little longer with this woman. This was simply the condition of addiction treatment in the late 80's.

I was open to hearing the arguments of many caring colleagues who believed sincerely that by "enabling" people by treating them when they were not abstinent I was harmful to them. I was informed that substance abusing clients are "different" and will not respond to the "warm and fuzzy." They had

significant and specific defenses somehow (although the mechanism was always unclear to me) caused by the substance ingestion. It was a strongly held belief and I understood it and came to accept it myself to a large degree. After all the people I was seeing did seem especially resistant when I confronted them with the consequences of their use.

However, my experience with that first client, and my own social work training that encouraged "starting where the client is," left nagging doubts. In the absence of other options I managed an outpatient clinic where we provided education groups including grainy video of the well-known Dr. Ohms providing what I knew then to be an inaccurate understanding of the causes of alcoholism and "Chalk-talk," a video that characterized substance abuse as a problem of judgment. I was becoming increasingly uncomfortable with the many dilemmas of this type of treatment. Education was mostly dismissed by clients as not relevant to them and I often felt that what the client offered themselves as reasons for their use and ways that would be best to address it made sense. I began to consider that not listening and telling people what to do rather than listening to their own wisdom was causing more harm than it was helping.

I was contemplating a return to mental health treatment. It was possible that I simply was not cut out for this. It was then that I picked up a journal and saw an article that Bill had written entitled "Warm Turkey." It was warmly written, somewhat light and right on in terms of working with clients not quite ready for abstinence. It was the first time I saw in print an acknowledgment that not everyone in need of substance abuse treatment may be ready for abstinence but that there was much a therapist could do to with such clients to work towards it. It gave me hope and fit with my experience. I had convinced many people to go to rehab and self-help groups, but having them convince themselves of the need for change was much more likely to lead to real change.

I went on to read *Motivational Interviewing* and found not only hope but empirical data demonstrating that these radical concepts actually work. I was able to work with the clients I had come to love and do it in a way that I felt was humane and congruent with my social work values. I do not have to tell others who have been around since the late 80's and early 90's in the USA, just how radical the concepts of listening warmly and trusting in a substance abusing client's own ambivalence was. I do not think I am exaggerating to call it groundbreaking. If Bill had not been also a meticulous researcher, I fear that his ideas may have been lost forever.

I began training others in MI late in the 90's, and from that role was able to witness the astounding changes that occurred in the attitudes of participants. At first there was suspiciousness, along with curiosity. Participants would share their own discomfort with more confrontational approaches. They would laugh as they saw themselves in the persuasion exercises. It struck me that I had been unaware that others in the field shared the discomfort with the confront/educate approach that was prevalent. Of course not everyone was so receptive, and there were also many challenges to the efficacy and prudence of such a major paradigm change.

Long before I saw evidence of it I began to hear people talk about changes in the substance abuse field as a whole. Now, it is rare for me to find someone in the field who has not attended an MI training, and most people express agreement with the principles. It seems to me that we have talked ourselves through the ambivalence and into what I expect is real change with the guidance of leaders like Bill Miller. In fact, it is much more likely to hear participants ask "How is this different from what I am already doing?" than for them to see MI as controversial.

I recently heard from a fellow MINTie that she was asked to remove the term "motivational interviewing" from a title of her presentation for a drug court conference. We still have work to do in separating treatment from the accountability necessary in the criminal justice field. Today, thanks to Bill and others with the courage to challenge the conventional wisdom of the addiction field, if that first alcohol dependent client of mine was interested in talking with someone about her drinking, I know that there would be a program that would be able to work with her.

A Bill Miller Memory

John Martin

I have a number of memories of my dear friend and colleague, Bill Miller, that stand out, but two that might be nice for him to remember and perhaps others to hear, on the occasion of his "passing on into the night" of academic career closure at UNM and into a new life and career of … (is it still, Bill, liturgical music? I suspect so).

The first memory, or encounter with Bill, I find worthy of recalling here was in 1983-4 when I called Bill in my capacity as Chair of the National Conference Program for the 1984 AABT (Association for Advancement of Behavior Therapy) meeting in Philadelphia, to ask him to be on my program committee. Bill said yes, and our friendship began. I'm not sure how much longer after that it was that I called Bill and ran this really "crazy idea" by him: I wanted to put together a symposium on integrating spiritual and behavioral approaches to behavior change. I had recently undergone a profound person-

al spiritual epiphany and thought it might be a great topic for us behavior therapists to address. Back then some might indeed recall, it was literally and professionally a "crazy idea" to even use the word spiritual in a behavioral context, much less suggest having it as a topic for a high level symposium amongst behavioral scientists and research psychologists! But Bill loved the idea, and his response literally saved it from the round file of my crazy initial meanderings of a program chair in over his head. I remember to this day his specific response: there was dead silence on the phone for some time—probably about 5 seconds, maybe less, though it seemed like minutes (Bill is comfortable with the kind of silence that drives most of the rest of us kinda crazy)–while he apparently thought about it (a thing Bill is wont to do when thinking and not speaking is in order). I knew he hated the ridiculous idea and was even about to break in and say, yes, it was a goofy idea, and what was I thinking? To my surprise (then, certainly not now would I be surprised) he said not only that he loved the idea but that he was putting together a very different symposium and he would stop that to concentrate more on the one I had suggested. We talked other times after that about who might present (risking their careers of course on such a wild-eyed and certainly unscientific topic) and were able to interest even some very well known behavior therapist type speakers for it who had been no doubt working VERY quietly on that sort of thing, including Alan Bergin and a well known and published psychiatrist-scientist in his field (a gap in my long lost memories). Interestingly, most of the presenters we put together were Christians, quietly practicing ones generally not out of their spiritual closets as it were, and was I nuts to throw my growing science career to the secular science 'dogs' by doing such an insane thing (a number of my colleagues and friends warned me when they heard about it)? But Bill, never one to avoid a controversy or a conflict of importance, loved it. Given this encouragement, I inserted it without review (of course) into the convention program, despite my program committee's shocked warnings, and scheduled it in the afternoon of the final conference day.

I believe I can speak for Bill in saying we were quite surprised (and pleased) to find it standing room only in attendance, with audience left standing in the back when the chairs were all filled. It went so well that Bill, in the way he has done with so many of us, thought BIG IDEA, and suggested setting up an interest group in AABT for those interested in spiritual and religious issues in behavior therapy (which we did, and it lasted some years and included a newsletter he and I took turns publishing and editing), in addition to turning the whole "bit" into a book! The next thing I knew about 2 years later we were putting the finishing touches on an edited book by the two of us, with others, based on that symposium, titled *Behavior Therapy and Religion: Integrating Spiritual and Behavioral Approaches to Change* (Sage Press, 1988). (I remember Bill asking me years later when it was out of print if I wanted to buy any of the last copies he had bought up—so this was how he had maintained such a great relationship with his publishers!) My working with Bill 'the Editor', not so much Bill the friend and colleague and fellow spiritual seeker and finder, was an amazing learning experience for me—including re-write after re-write to get my parts and chapter "right." Phew. Many of us have probably had this experience with Bill the Editor: exacting, tough, even demanding (especially when it came to publishing and contract time-lines), and a bit of pest. But it all worked out, thanks to him. I have since forgotten the writing pain and frustration he put me through on this one, and look back so fondly on the whole experience.

I have one other memory of Bill—classically Bill—that is much shorter. I was sitting on a national committee, hand picked by Bill, devoted to a similar issue of spiritual and religious issues in health (mental and physical) funded by the Templeton Foundation in Washington, DC. An argument broke out between two opposing scientists and it was getting a bit heated; the whole committee was uncomfortable with the angry interchange. I distinctly remember looking over at Bill, the Chair, and wondering when he was going to intervene and put a damper on the more and more heated argument. He didn't. He just kept listening, looking left and right, to the one speaker (arguer, that is) and then to the other, back and forth, back and forth, with a gentleness of facial expression that didn't seem to show the slightest discomfort. Back and forth his head went, like watching a tennis match, as the 'players' hurled even some insults at each other. This went on for some time, and then when it had run it nasty course, Bill waited, and then very calmly offered a new topic and direction. I had never seen anyone so comfortable with conflict. Bill later told me in a more private moment that he rather liked conflict, saw it as an adventure in learning and understanding, a challenge, even when it was directed at him. I knew then that my friend and colleague Bill was a strange man. A very strange and unusual man. Wonderfully strange and abnormal.

Bill, I celebrate and congratulate you for a job well done—good and faithful servant of behavioral science and academia, vast contributor to the addictions field, motivation science and spirituality research. You've played such an important role, and have served as a model and even mentor for so many of us. I hope to follow your new career with interest as a friend and compatriot in the quest for knowledge and transformation power. Now you with a different kind of transforming—music and liturgy (I'm guessing)—and what you've blessed me with, my new

career direction in translating MI to the developing 3rd world in Southern Africa, ground zero for HIV/AIDS. Bill, thank you for all you've done and given to so many. May God bless you even more richly than He has.

To Sustain or Not To Sustain: That is the Question

Gary Rose

MI is growing up! We've been around about as long as the personal computer, have a nice bed of evidence upon which to rest, and now have the freedom and wherewithal to look inward. In the process of such, a difference of opinion has come forth regarding the proper place of listening to sustain talk. One point of view, frequently offered by our European colleagues, suggests that the complete understanding of sustain talk is critical to effective motivational interviewing. The other, more decidedly North American point of view (espoused by Bill Miller and, he would argue, nascent in his earliest description of MI in 1982) is that, whereas sustain talk ought to be understood and "rolled with" when it arrives at one's therapeutic doorstep, restraint is the order of the day; for the larger goal of the MI clinician is to elicit and selectively reinforce DARN in the service of C. I don't believe that there has been any real meeting of the MINTie minds on this issue; rather, I suspect that politeness has resulted in an agreement to disagree. The North Americans, no doubt, are waiting for the data to either support or refute their position, whereas the Europeans are awaiting the development of more passion on this side of the Pond!

This debate regarding the proper place of the "dark side" of change in our MI conversations is as old as the ages. Indeed, the conundrums of comparative philosophy might enlighten this polite disagreement. One could as easily have overheard Plato and Aristotle chortling about the emphasis one ought to place on utterances such as "smoking relaxes me," "they need a good spanking once in awhile," or "wearing clothing is way overrated" as in the conversation of any two 21st century MINTies. For we are apparently discussing the proper place of dialectical reasoning in our lovely counseling style.

Dialectical reasoning refers to two sets of ideas. First is the postulate that all concepts, affects, and values are essentially bipolar: good implies bad; love implies hate; beauty implies ugliness, etc. The dialectician believes that to truly understand the meaning of any concept, one must also understand its opposite; there is no way to "know" justice unless you also "know" injustice. Second, the dialectician asserts that the pursuit of truth is itself a dialectical process; this is exemplified by the famous Socratic dialogs; to Socrates and his most famous of students, Plato, one could effectively come to understand the essence of democracy by having a conversation about autocracy, of freedom by starting a conversation about servitude. Since all concepts are bipolar, all the dialectician needs to do to be on the road to truth is to have a sincere interest in understanding the concept from all sides. Truth will be revealed through the juxtaposition and eventual integration of the opposites: thesis, antithesis, synthesis.

Dialectical reasoning as an epistemology and as a method of discovering truth is commonly identified with Socrates and Plato; it has been with us throughout the evolution of modern thought, deeply embedded in Eastern philosophies and in the modern Western World since the 18th century, represented by the great Renaissance philosophers Leibniz and Kant. The Platonic/Kantian worldview is associated with the concept of an active, predicating mind, wherein the human "comes at life" as much as life "comes at" the individual, making sense of experience in an often highly personal and creative manner. In our fields of endeavor, the dialectical perspective has been nurtured by the likes of Jung, Freud (reluctantly), and our own Grand-pappy, Carl Rogers, among many other humanistic and existential theorists. I would maintain that the MINTies that are supporting the "muck around in status quo talk for its own sake" side of the current debate would make Socrates, Plato, and Immanuel Kant beam for joy!

But, the story continues...

Along comes Aristotle, the most famous of Platonic disciples. Being a practical kind of guy, Aristotle observes that, as noble as the dialectical process may be, it is open to manipulation by folks who might use the process of dialog not for the noble cause of discovering truth, but, rather, with a predetermined outcome in mind. Thus, although they might appear to be freely engaging in the intellectual dance, they will already have decided what side of the dance floor at which they want to end, and will skillfully move their intellectual partner thereto. This process was called sophistry, after the Sophists, a group of pseudo-dialecticians for hire, progenitors to the modern legal profession. A modern-day example of sophistry is "selective reflection," the careful juxtaposition of ambivalence in the service of positive change.

Having thusly observed that dialectical reasoning was fraught with opportunities for error, intended or unintended, Aristotle formulated the 2nd great approach to logical discourse, *demonstrative reasoning*. Whereas dialectical reasoning starts with an arbitrary premise, either pole of the concept under "discovery," demonstrative reasoning begins with a "primary and true" premise; something that is true by definition ("All MINTies have completed a TNT")

or true by observation ("The two things we cannot escape are death and taxes"). The discovery of truth then flows forth in the linear fashion that we are all familiar with: "All MINTies have completed a TNT," "Mary is a MINTie," "Mary has completed a TNT." In Aristotle's system of demonstrative logic, bipolar meanings are relegated mostly to the world of artists and the feeble-minded. Life is much more straightforward than it is otherwise. The Aristotelian tradition is manifest in the Renaissance philosophies of the British Empiricists (Locke, Hobbes, Hume), and in the classical physics of Sir Isaac Newton. Locke is commonly associated with the "tabula rasa," blank slate model of mind, in which all truth comes in from the outside, with human creativity limited to "simple reckoning," and Sir Isaac helped us make sense of how big things move from here to there in a universe where time, space, and motion were unchanging entities operating in a 3-dimensional grid. In our field, the Lockean tradition is represented by the behaviorists, cognitive behaviorists, and social learning theorists, and it remains the philosophy of science that underlies most academic psychology. The MINTies that value the elicitation and selective reflection of change talk are closely aligned with this epistemology.

So, I would assert that what we have brewing in our little community is nothing short of a classic Lockean – Kantian debate about the proper place of dialectical reasoning. As much as the Lockeans would prefer to resolve this debate by "running the numbers," it won't happen, for we are dealing with two worldviews that in general do an equally fine job of explaining the universe and its component parts. (Kind of like trying to run the numbers on whose religion is truer.) Whereas the Lockean feels compelled to resolve this debate in the court of empirical science, the Kantian prefers to "sit with" the tension, in an attempt to make sense through the integration of the apparent contradictions.

Let's try to do that with respect to Carl Rogers. Rogers was a card carrying Kantian—as a holist, he maintained that the distinction between environment and organism was spurious, for life was experienced as a "phenomenological whole;" he also did not venerate time, as the knowledge of one's past and how the past has colored the present was much less important to Rogers than was the unfettered experience of the present and its implications for the future. The Lockean concept of experiences being imputed from the outside into a mind that essentially just added things up makes no sense from the Rogerian point of view. Truth comes from the inside out; not the outside in. Rogers was also quite the dialectician—the human experience could only be made sense of if one was willing to throw off the shackles of belief in "primary and true" premises and was willing to explore one's inner experience, however contradictory it might be, and wherever it might lead. The therapist's task was to facilitate this process through the wonderful mirroring tool that we call empathic listening, and to avoid mucking things up with conditions of regard or other contingent responses: a dialectical therapeutic process to facilitate a decidedly dialectical self-exploration.

Now, what would Rogers make of the oft-cited observation that he was a failed non-directive listener? Rather than admitting to being a closet Sophist, I think he would chalk this up to human error. If he were provided with empirical data suggesting that his intuitive selective reflection actually facilitated change, I believe that he would assert that the ethical principle of non-contingent joining with the client superseded the value of selective reflection as a behavior change technique. If Rogers were truly Rogerian, it would take a mess of data to convince him to forsake the core value of "thou shalt not manipulate" for the sake of a more efficient means of facilitating commitment to change. Now, this is a fairly provocative statement for many reasons, including the fact that Rogers was the first Platonic/Kantian theorist to put his humanistic therapy to the test of the empirical method.

In conclusion, I believe that we have unwittingly fallen into a classical debate about the nature of humanity, mind, truth, self-discovery, and the creative process. Are our Kantian MINTies correct, that the values of respect, acceptance, and empowerment indicate that we must explore sustain talk with the same passion with which we explore change talk? Or will our more demonstrative Lockean humanists carry the day? Some of the answers will come from the careful study of the process of MI; the work of Terri Moyers, Tim Martin, and others with regard to the sequential coding of consultations would make both Locke and Kant smile.

We are learning and teaching an "evidence based" humanistic approach to behavior change. In a decidedly Platonic fashion, this may well result in a dialectical opposition of two core values: humanism vs. empiricism. In the late 1700's, Immanuel Kant was awoken from his "dogmatic slumbers" by the haunting image of humanity implicit in the mechanistic worldview of Isaac Newton. We MINTies may also need to remove a few dogs from our eyes as we decide to sustain or not to sustain.

The Impact of Motivational Interviewing in the Field of Dual/Multiple Disorders of Co-occurring Mental Illness, Drug Addiction and Alcoholism

Kathleen Sciacca

I was astonished when I discovered motivational interviewing (MI), the work of Dr. William R. Miller (Miller & Rollnick, 1991), in 1992. I could not have been more eager to apply each of the elements of MI in my work in the field of dual diagnosis of co-occurring mental illness, substance disorders, HIV, and other problems (being homeless, criminal behavior). Motivational interviewing provided a second comprehensive approach to treating co-occurring disorders, importantly, an approach that evolved from the addiction field. This balanced out the cross-training initiatives necessary to co-occurring disorders with contributions that evolved from both mental health and substance abuse and also provided additional new skills for everyone.

MI and the Science of Psychology

As I prepared to write about Dr. Miller's contributions to dual disorder treatment I thought about the words of Wolfgang Kohler, his proposed premise for the study of psychology. It is clear that motivational interviewing is a natural derivative of this premise. In *Gestalt Psychology*, Kohler (1947) began his first chapter as follows:

> *There seems to be a single starting point for psychology, exactly as for all the other sciences: the world as we find it, naively and uncritically. The naivete' may be lost as we proceed. Problems may be found that were at first completely hidden from our eyes. For their solution it may be necessary to devise concepts which seem to have little contact with primary experience. Nevertheless, the whole development must begin with a naïve picture of the world. This origin is necessary because there is no other basis from which a science can arise.*

In the 1970's and 1980's it was my experience and the experience of many of my colleagues that people who had co-occurring disorders of mental illness, substance disorders, HIV, etc. were not accepted or received uncritically into our systems of care. Rather they were (and in some cases still are) an unwanted population of clients who did not fit in to either the mental health system or the substance abuse system.

The practice of MI defies this critical bias. In Dr. Miller's terms, the terms of MI, "acceptance facilitates change"—a premise that dates back to his first description of MI (Miller, 1982/2008). From that uncritical premise follows the recognition of numerous correlating observations, including the importance of "expressing empathy"(the power of the alliance and feeling understood), "supporting self-efficacy" (increased confidence that one can effectuate change results in diminished belief in the positive expectancies of the behavior), and "rolling with resistance" (as resistance decreases potential for behavior change increases); the power of hope and faith (people experience improvement from placebo interventions); that counselor expectancies affect client outcome; and that MI equals "a way of being with people" (a collaborative partnership versus an authority/expert and novice relationship). Dr. Miller considers the concept of "natural change:" *Treatment can be thought of as facilitating what is a natural process of change* (Miller & Rollnick, 2002, pp. 4-5). He points to the documented effectiveness of "brief interventions" in speeding up or facilitating the process of change as an example.

From Dr. Miller's scientific and clinical observations of many inherent properties of behavior change have evolved counseling principles and strategies that facilitate the possibility of a dually diagnosed client's exploration of his or her ambivalence, the potential resolution of ambivalence and movement on to decision making regarding behavior change. Furthermore, as a result of the diligent research and scientific focus that Dr. Miller has applied to his work, MI is heralded as an evidence-based approach in the field of co-occurring disorders. MI research is cited in the *SAMHSA Report to Congress on the Prevention and Treatment of Co-occurring Substance Disorders and Mental Disorders* (2002) endorsing the use of MI in the field of dual diagnosis. He has not only articulated accepting, respectful, humane, and highly effective interventions that have clear utilization, but he has done so through laborious research that has documented his findings. In all of this he has set out to achieve the most important goal, that of effectuating improved client care and successful outcome.

The Field of Co-occurring Disorders and MI

In the early 1970's I discovered people with severe mental illness and co-occurring chemical abuse and addiction residing in a traditional therapeutic community. These clients had active acute mental health symptoms and they were heavily medicated. Their active symptoms were apparently the result of confrontational interventions and intense programming. These clients could no longer participate in treatment or other elements of the program.

Later, in the mid to late 1970's, I discovered Vietnam War veterans (among others who had co-occurring disorders) in a methadone maintenance program in the South Bronx in New York City. Deemed as heroin addicts by the Veteran's Administration, all of their problems were deferred to the methadone maintenance staff. Their symptoms of posttrau-

matic stress, including hallucinations and dissociative flashback episodes, were untreated.

In 1984 I discovered the population who came to be known more widely as MICAA (mentally ill chemical abusers and addicted), those with Axis 1, severe persistent mental illness (SPMI), chemical abuse and addiction in a New York State Psychiatric system of care both inpatient and outpatient. These clients were "critically" viewed by many (although thankfully not all) as people for whom there was little hope for improvement. They were essentially unwanted, believed to be untreatable and costly to the systems. They presented clinical challenges that were not considered to be within the domain of the mental health practitioner or the substance abuse practitioner.

It was in this setting that the concept of dual disorders became known to me and where I tested all of the systems for their responsiveness to clients who had this clinical profile. I discovered that none of the systems were responsive. This was later corroborated by the New York State Commission on the Quality of Care (Sundram, Platt, & Cashen, 1986).

In 1984, with the encouragement of my immediate supervisor, Dr. Anthony Salerno, I proceeded to evolve a dual diagnosis treatment approach within a psychiatric day treatment program. Dr. Salerno believed in the continual renewal of programming and his relationship to clients included a collaborative spirit. Shortly afterwards this integrated treatment model was implemented across a number of inpatient and outpatient services and proceeded to be implemented across systems (Sciacca, 1996). This approach by necessity adhered to Kohler's premise. There was no way to intervene unless one accepted the obvious conditions of each client. In 1984 interventions were "non-confrontational," group treatment was implemented, phases of treatment were identified and treatment became "phase specific." A readiness scale was designed to measure clients' starting points and progress along a continuum of readiness to change (Sciacca, 1990-2008). Treatment frequently began with clients who were physically addicted to drugs and/or alcohol, actively using substances, and had active mental health symptoms. Treatment proceeded from denial through recovery, with phase-specific interventions, with clear strategies and treatment content (Sciacca, 1987; Sciacca, 1991; Sciacca & Thompson, 1996).

This premise or criterion for acceptance into treatment had previously been unheard of and was categorically rejected by many providers. As the field of dual diagnosis forged ahead, providers of all disciplines from a variety of systems were included in all training events and program development initiatives. In addition, it was clarified that the substance abuse system had its own profile of dually diagnosed clients, the Chemical Abusing Mentally Ill, CAMI. This denoted clients who had chemical dependency and personality disorders, incidents of trauma, and depression in varying degrees including Post Traumatic Stress Disorder. Interventions and dual diagnosis programs were designed within the substance abuse system specifically for this client population. These interventions were also non-confrontational, phase specific and included attention to each client's readiness to change.

When I learned about the book *Motivational Interviewing* in 1992 (Miller & Rollnick, 1991) I became excitedly aware of the similarities of the basic premises between MI and the dual diagnosis model (Sciacca, 1997)—namely acceptance, non-confrontation, recognition of various readiness levels—the stages of change (Prochaska & DiClemente, 1984), provider and client collaboration, as well as interventions that facilitated clients' movement along a continuum leading to behavior change. The book described an "addiction" model that advocated departures from traditional confrontational and action-oriented addiction treatment that stemmed from Miller's early writings (Miller, 1982/2008). This was a major breakthrough in the field of dual diagnosis as both models could now be presented to cross-trained audiences.

Through their detailed examination of the origins and perpetuation of the confrontational approach, Drs. Miller and Rollnick (Miller & Rollnick,1991, pp. 5-13) provided much needed clarity in relationship to controversies about the use of confrontation as treatment. These controversies rage on until today. Their detailed examination of the literature regarding the use of confrontation as an intervention is an important contribution to the addiction field and to the field of dual diagnosis. In particular, in working with MICAA and CAMI clients confrontation can result in decompensation and activation or exacerbation of mental health symptoms.

MI Integrated into Dual Diagnosis Treatment

As my own experience and understanding of MI continually deepened through teaching, training, and practice, I went on to become an MI trainer in 1995. Since 1992 motivational interviewing has been included in dual diagnosis treatment, training, and program development throughout my own work. This includes the Stages of Change (Prochaska & DiClemente, 1984) which are utilized as a second model of advancement through incremental change and the practice of client-centered reflective listening (Rogers, 1946) that is included as a necessary intervention and skill.

The field of dual diagnosis proposes that all symptoms and related behaviors should be treated simultaneously. MI is effective in the treatment of both mental health symptoms and substance disorder symptoms and related behaviors and can be applied within a combined simultaneous treatment plan.

Some of the benefits of integrating motivational interviewing into

Dual Diagnosis treatment are:

- Empathic, accepting interventions improve the engagement potential for many dually diagnosed clients who have been disengaged from treatment due to rejection or a lack of competent care.
- Client-centered interventions (Rogers, 1946), namely, reflective listening, facilitate gaining knowledge and understanding of the client's true self (including her or his understanding of symptoms and behaviors, readiness to engage in behavior change, goals, aspirations, disappointments, etc) and deepen the interventions beyond the medical model and symptom-focused approaches. Client-centered interventions can validate numerous statements a provider may encounter from clients relative to both substance disorders and mental illness without accompanying evaluation or analysis—for example, delusions, resistance, positive expectancies, pros and cons and others.
- Group treatment has evolved as an effective method of treatment for dual disorders. The inclusion of motivational interviewing strategies and materials in dual diagnosis groups (Sciacca, 2007) or in groups that exclusively adhere to MI strategies and materials is highly effective, adding important learning experiences within the psychoeducation component and enhancing the recovery process of dually diagnosed clients; Theme-Centered Interactional Group Leading (Sciacca, 2001) has been an integral part of dual diagnosis group leading since 1984 and is highly compatible with MI.
- Providers who treat co-occurring disorders learn another comprehensive set of principles, strategies and skills that enhance their professional competence and have the potential to greatly improve the outcome of their clients. These include: asking open questions; affirming; listening reflectively; facilitating the exploration and the resolution of ambivalence; summarizing with directive strategies; attending to, enhancing and eliciting change talk; developing discrepancy; supporting self efficacy; pros and cons; the decisional balance; minimizing resistance; exploring values; building on strengths; and more.

The Broader Impact of MI

MI provides a wealth of knowledge, skill, and wisdom for each practitioner who subscribes to it regardless of her or his clinical orientation or system of care. The acceptance of clients regardless of their clinical profile is essential. Discarding negative interpretations of behavior while promoting awareness of the difficulties and hardships that all symptoms impose upon clients evokes empathy and opens the path to alliances and engagement. This allows the process of the examination of ambivalence to go forward and facilitates an exploration that may result in the decision to change one's behavior. The benefits to clients who receive MI interventions include genuine alliances and caring, and a listener who wants to understand their perspectives and facilitate a respectful exploration of their ideas and feelings as they relate to their present issues and goals.

Programs and systems also benefit from the inclusion of MI. A departure from the premise that all clients are in the "action" stage and systemic recognition of the client's level of readiness and motivation to change (including the fact that the client may be at different stages of readiness to change different behaviors) changes a program from one that is failing to bring clients into "action" to a program that is charting successful outcome along a number of more incremental and realistic criteria. This benefits both programs and systems in their accountability and outcome.

Providers and clients also receive these benefits. By accurately defining progress and outcome clients who were once considered treatment failures because they did not go into action now evidence progress and outcome as defined incrementally. The provider and the client thereby both have a successful outcome, supporting the self-efficacy of both.

In sum, Dr. Miller's development and articulation of motivational interviewing, its principles, and strategies has resulted in numerous benefits and has helped to redefine success and outcome. Where the "action" focused model leads to interpretations of client, provider, program and systems failure, programs that utilize incremental strategies and measurements of change demonstrate success in each of these areas. Emphasis on client change talk and strategies to elicit and strengthen it, and on minimizing client resistant behaviors and strategies to do so, are two important focuses that facilitate potential behavior change.

From this perspective the effectiveness and popularity of motivational interviewing serves to revolutionize the way we view behavior change and how we document progress within our programs and for our clients. MI provides principles, strategies, and interventions that correlate to client' readiness, including some that are directive in facilitating movement. Dr. Miller's impact on all programs and systems who reach this realization is immense.

From my own professional experience I feel very fortunate to know Dr. Miller and to have received training from him. I know him to be a kind, generous man who embodies the "spirit" of motivational interviewing. My respect for his work, my belief in the effectiveness of the MI approach and the enormity of his contributions make it possible for me to teach motivational interviewing with enthusiasm and inspiration.

I know that his contributions will ensue, and although he has retired from the University of New

Mexico he will continue to pass along the wealth of his experience and knowledge.

Note: Dual Diagnosis Website: http://pobox.com/~dualdiagnosis

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Bill has done a lot

Christiane Farentinos
Portland, Oregon (with a Brazilian heart)

Bill has used his will
To will the field into thinking
Thinking the person first
Yes, that person that crosses the door step
Of out treatment space
That person unsure, ashamed, ambivalent,
Bill has that person in mind first

Bill has willed us all
To look beyond the person
To look at numbers and data rigorously
To find once again the person
Suffering, confused, unwilling
But willing to talk if someone will listen
A person willing to change and commit

Bill has done more than that
Bill has taught me skills and spirited me
Bill has inspired me to strive for more
And to never think I understood it
Bill has made me inquire
Bill might not know that
But Bill is my mentor

Thank you Bill