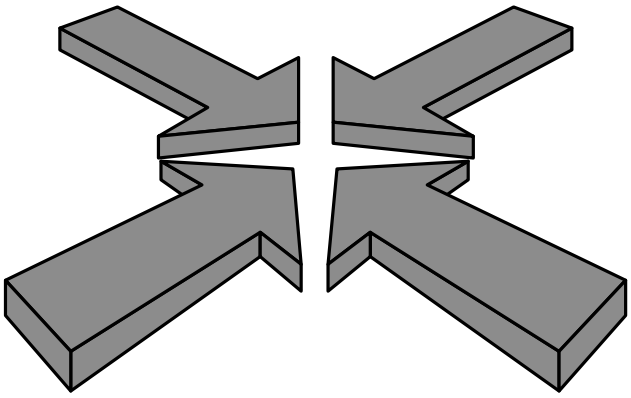
Motivational Interviewing Newsletter for Trainers

January 1, 1996, Volume 3, Issue 1



New Perspectives

From Across the Pond

Stephen Rollnick

REFLECTIONS ON MINT III.
Such a variety of people attend the 3rd MINT Italy/October workshop, mostly from Western European countries. Alison Bell came from Sydney, Australia. Penetration of training is probably greater there than anywhere else, thanks largely to her hard work.

There was also a vibrant team from Bergen, Norway, a growing band from Italy, a trickle from other countries (Netherlands, Switzerland, Spain) and a truly eccentric mob from the UK. I was struck by the variety of settings they all came form: besides the usual addiction settings, there were eating disorder specialists, a doctor working in the field of AIDS prevention, two specialist dietitians, a health promotion expert, and a team of exercise experts. One of the latter group, Dr. Norman T. Anstiss, doubles as a TV personality, and was a recent contestant in the famous Gladiators program on BBC. Norman, I don't want to sound rude, but don't give up the day job just yet, OK?

The workshop was conducted in English. Some of the Italian participants were truly impressive, looking up hundreds of words in their dictionaries. Our host, the Italian psychiatrist Gian Paolo Guelfi, whose English is near perfect, admitted that he had spent most of the first day wondering why we so often talked about the Chinese, until he realized that we were saying "trainees"! He also told us that in Italy it is widely recognized that English is an impossible language - "they pronounce it as Manchester and spell it as Liverpool".

Thank you to Gian Paolo for your endless kindness and hospitality, and to Delilah Yao from Albuquerque for all your support with administration.

THE 21 CENTURY & REID HESTER
They go together in my brain. Reid attended the 1st MINT training and offered to help us communicate through the Internet. I decided that he was a wildly eccentric computer freak (which he is), and wished that he would go away and dig for gold (which, apparently, he still does). As the millennium draws near I think about this more and more. Reid is right. It would be ideal for a group like ourselves, if only we would listen to Reid. I am willing, able, and ready, if Reid has not given up on me.

TWO NEW PAPERS
Mann, R. & Rollnick, S. (in press) Motivational interviewing with a sex offender who believed he was innocent. *Behavioral & Cognitive Psychotherapy.*

Butler, C., Rollnick, S. & Stott, N. (in press) The doctor, the patient and resistance to change: Fresh ideas on compliance. *Canadian Medical Journal*

PROJECT MATCH
The results of this major multi-center controlled trail will have serious implications for motivational interviewing. We should know about the findings in the coming months, and I am sure that Bill, who is very involved in this work, will give us his views as soon as he is able.

THE UK MINT NETWORK
We decided to set this up as a self-help group, not only to keep in touch with each other, but to deal with the potential for overzealous application of MI already apparent in the UK. Any other European MINTies who would like to join, please let me know. Our concern is with the way in which the method might be viewed as a panacea, particularly in primary care settings where practitioners have little or no training time to acquire

reflective listening skills. We have prepared a position statement, which contains, among other points, the following assertions:

- We urge caution against the overzealous application of motivational interviewing and methods derived from it. Precise minimum standards for training have yet to be established, there is no centralized training system, and research evidence is still lacking in many areas.

- Motivational interviewing is a counseling style developed in a specialist setting. It is best suited to that kind of setting, where counselors spend one or more hours with clients. This requires acknowledged competence in counseling techniques like reflective listening. The method should not be taught to people who do not plan to acquire these skills.

I have not hear similar sentiments in the US. Why is this? Are you just more enthusiastic about new ideas? I think this is an oversimplified explanation. In the UK, and in many other European countries, we have a strong generalist primary care system which is separate from the specialist world. New specialist ideas are not taken up as readily as in the US.

THE INNOVATIVE KAISER MOB

Some of the most innovative medical applications I have come across are among the Kaiser Permanent MINTies in Portland, Oregon, where I recently spent a few days. Perhaps most striking was the 1-minute intervention I saw Kathy Mount demonstrate. Can you put this in the newsletter, Kathy?

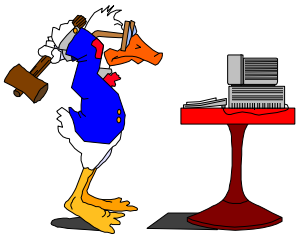
ANYBODY GOT EVIDENCE OF CHANGE (IN TRAINEES)?

Somebody said to me - I think it was you, Bill - that, "I have more faith in clients changing their behavior than I do in the ability of therapists to change theirs." What a statement to make about training! Since it has a ring of truth to it, why are we so quick to run controlled trials on the behavior change of clients, and not on counselors?

I got some evidence last week. This came from the telephone interviews conducted by my close colleague Dr. Chris Butler, among general practitioner trainees who had attended a 2-hour course we ran on brief negotiation among smokers. Not only had they remembered the spirit and content of the method, but described actual changes in their consulting behavior. Anybody know of some harder evidence?

A HEARTENING STORY FROM AUCKLAND

Capital of New Zealand. They have a medical school, in which communication skills, and the teaching of reflective listening, are given a high priority. The top applicants for a place in the school are taken through a rigorous assessment in communication skills. Poor communicators are not offered a place. After qualification, when they enter demanding hospital work, nurses in local hospitals can tell whether a young doctor was trained in Auckland or one of the other schools. The good communicators are from Auckland. Valerie Grant, the psychologist in charge of this program, has written the following brief paper: Grant, V. (1995) Therapy of "The Word": New Goals in teaching communication skills. *Health Care Analysis,* 3, 71-74.



A Message from Cyberspace

Dear Colleagues,

I am writing to invite you to join and participate in two discussion groups we have recently set up for psychologists. The first is a Computers Special Interest Group of AABT. It's is a forum to discuss computer related issues as they pertain to the practice and science of psychology. The second group is for clinical researchers and clinicians interested in the area of addictive behaviors. We set this group up following discussions at the most recent ICTAB (International Conference on Treatment of Addictive Behaviors-#7) in Holland last month. Its purpose is to share ideas, concerns, preprints, manuscripts, etc..

Here's how to subscribe to each list. Send an e-mail message to listserv@unm.edu Leave the subject field blank. In the body of the message type SUBSCRIBE AABT_COMPUTER_SIG-L FIRSTNAME LASTNAME Put no other text in the message. You will receive a confirmation message and instructions on how to post messages, unsubscribe, etc..

To join the ICTAB-L follow the same process but insert ICTAB-L instead of AABT_COMPUTER_SIG-L.

Please consider joining either or both these discussion groups. I think they have great potential.

Reid.

Editor's Cup

David Rosengren

Group Applications of MI

I have been exploring the extension of "MI technology" to group settings. I find myself thinking in a fuzzy fashion about what are the critical elements of MI, are these uniquely MI, and can these be extrapolated to a group setting? Is it possible to have a MI group? Does it make more sense to think in terms of a "Motivational Intervention" group, as in Saunders, Wilkinson, and Allsop (1991)? Obviously, I am not the only one muddling about in these issues.

Fred Willoughby, Ph.D., a MINTie from the Olin E. Teague Veterans Center in Temple, TX, developed a group-based form of Motivational Enhancement Therapy that expanded techniques developed in MET into entire group sessions. Fred's work was discussed in a previous newsletter. As I reviewed the content, this seemed like a direction that had merit. At the same time, I was concerned about both the number of sessions (16) and the nagging feeling that perhaps this was more like Cognitive-Behavioral Therapy within a MI framework, than uniquely MI. Fred, I'd be interested in hearing your thoughts about your format and it's utility.

Craig Noonan, Ph.C. at UNM has worked on extrapolating the Drinker's Check-Up in a group format. If my memory serves correctly, Craig was going to be doing this in a single session. I am not sure if there was any follow-up contact between therapist and clients. Although this is an interesting investigation, it is different than the use of MI as a method for ongoing group intervention.

The sum of all this seems to be some interesting starts, but still no clarity on the issues presented initially. What follows are ideas included in a manual for a project that has group case management as one element. The goal was to design a group that had case management as a goal, but was MI-based. This effort had these additional parameters: open membership, probable irregular attendance, and preceded other formal treatment. These parameters led to a design where each group meeting is considered freestanding. These ideas, though heavily influenced by the setting, may provide a launching point for discussion in this area. Of interest, because of changes in our project population and environment, this group has not been implemented. Therefore, the ideas represented have not yet been client tested.

Background

The groups use a blend of macro and micro skills taken directly from the MI bible. The five principles of MI, as always, are the foundation for all the therapists efforts. For reference sake, these five principles are:

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy

These principles provide the "spirit" of how the MI group is conducted and represent macroskills. The microskills are also consistent with what the individual therapist does. Microskills include: eliciting self-motivational statements, using reflective listening, asking open-ended questions, summarizing, and affirming clients. Other microskills are listed in the attached table (Appendix A). These skills are described in the context of an individual intervention (e.g., providing test feedback). The application of these macro and microskills may be used with little modification is most instances, though they do need to be done as a group intervention rather than simply individual work within the context of a group. In addition, therapists may use specific motivational strategies to assist in the process of consolidating commitment. These are discussed below.

Group Structure

Group's have three phases:

- an initial check-in and agenda-go-around;
- the main section
- conclusion and termination of session.

The group opening is designed to begin the session in a way that builds the structure of the group each time. Even when group membership remains relatively consistent this is necessary. The therapists are very active initially in structuring the group and in defining its parameters. However, whenever possible, the group members are used to provide the requisite information. So, for example, clients are asked to state the group rules and the therapist guides and shapes these as needed.

The therapists begin each session with a structuring statement. This includes a welcome to both "old" and "new" members, a statement of time parameters and a review of what the group is and is not. This is followed by a discussion of the rules of the group. Finally, an agenda go around is completed. At the end of the agenda go around, the therapist will conclude with a summarizing statement and an evocative question.

The initial check-in and agenda-go-around serve dual purposes. First, it provides the framework for understanding the client's explicitly stated needs for that session. Second, it allows the therapist to do an assessment of the group and the individuals comprising the group. Beyond the typical assessment tasks of a therapist in this setting (e.g., member identification, cohesion, leadership), the therapist is also doing a Stages of Change Assessment. This occurs at both the group and individual level, and in combination with the themes elicited during the check-in, leads to the selection of interventions matched to the individual and group needs.

The main section typically begins with an exploration of themes elicited in check-in. This exploration is open-ended and is intended to provide direction for further interventions. However, this is not intended to be a process therapy group that focuses on the here and now. Instead, the group has a psychoeducational focus that may capitalize on process factors, including the use of here and now issues, but remains focused on problem-resolution and consolidating commitment to change. The therapist's use microskills as they might in an individual session to move members and the group forward in resolving ambivalence towards change. The therapist may also select from the menu of exercises for the group. There is no expectation that a strategy has to be used in each group or that only one strategy can be used in any group. Rather the exercises represent tools in the therapist's repertoire of responses.

The closing of the MI session is not simply an after-thought, but is an integrated part of the session. This is an opportunity to consolidate gains and commitment, affirm plans developed, and reinforce the client's sense of self-efficacy. This is also a time where information is provided about additional services, management of problems are discussed, and remaining questions are answered.

Strategies

Five specific motivational strategies have been adapted for use in a group format. These include the following:

- Looking Forward
- Looking Back
- Goals and Values Clarification
- Decisional Balance
- Change Plan Worksheet

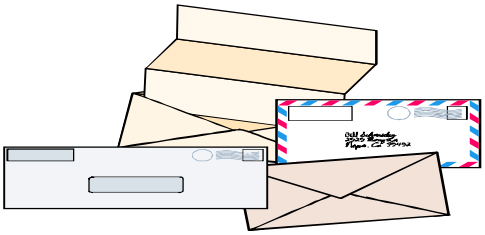
These strategies can be conducted in a number of ways within the group. Therapists have a general description of the exercise and then select an approach based upon the specifics of that group. So, for example, a high functioning group may respond in a free form manner to an evocative question, while a less comfortable group may need to do parts as a written exercise which is then shared. Since this is not conceptualized as a process-oriented group, the therapist is somewhat freer to choose interventions that are not here-and-now focused. Descriptions of these Exercises are attached to this newsletter (Exercises).

The strategies are sufficiently flexible to be used across different categories of readiness to change while still being targeted to specific issues. Looking Forward, Looking Back and Goals/Values Clarification exercises are designed to assist the precontemplator or contemplator in moving forward by examining which goals/values are most important and by reviewing how things either have changed or may change. The decisional balance helps the contemplation and the determination stage individual commit to the change process by making explicit the issues keeping them ambivalent. The change plan worksheet is for use by determination and action stage individuals in initiating the change process by developing explicit plans for change.

Group members are resources for problem-solutions. Whenever a client raises a problem, one of the first tasks of the therapists is to see what suggestions are available from the rest of the group. This process allows the group to build on the collective knowledge available, provides a method for supporting members while building self-efficacy, and may help develop connections among group members. The therapist is available to both supplement and correct this information as needed.

Concluding Thoughts

The main section of the group, the heart of the therapy, remains ill-defined. This is both by design and by lack of experience. The design piece is tied to the "spirit of MI" which holds that a way of being with clients is more important than a prescription of techniques. The elements of how this group is conceptualized are provided with the belief that the practitioner must provide the specific plan for implementation based upon the particular needs for that group on that day. However, the lack of a real world test means the data that may have informed a more specific recipe of group ingredients is not available. We are hopeful or remedying this at some point. Finally, I wonder if the same question asked of Fred is not relevant here, "Is this uniquely MI or CBT with a MI Twist?" Thoughts?



Mail Call

Packaging
Editor's Note:
Chris Dunn passed along the following acronyms as training tips. Previously, Chris and I have discussed trainees difficulties with integrating all the information they receive. Chris came up with acronyms as one solution to this problem. This allows "chunking" information together to make learning and recall easier. By the way, did you know that Chris was an Olympic High Jumper for the USA?

Chris writes:
Because I much prefer rearranging the ideas of others to generating my own, I came up with the following training acronyms. For the first one, I heisted Bill and Steve's five principles of MI to spell grace, which reminds me of the spirit of MET:

Gap stretching: increase awareness of the discrepancy (gap) between how one wants things to be versus how they are before change
Roll with Resistance
Argue not
Can do: raise self-efficacy with a "can do" attitude
Empathy: the whole umbrella you hold up for the client, under which all else happens

The second acronym is **"OARS"**. OARS are how the counselor "rows" with the current, when crossing the waters of change readiness.

Open questions: ask lots of them
Affirm
Reflect
Summarize

I'm trying to teach folks that no matter what micro strategy they may try, the results will be best when they do so within the OARS framework. For example, eliciting the good and the less-good things, or looking toward the future can both be done using OARS. It's a way of checking if you're staying within the spirit of MI: Are you rowing with or against the current?

Potpourri
Editor's Note:
Diane Bailey sent a fax with a number of points of potential interest sprinkled about it. I have edited these for space.

Diane writes:

Anyone else had this problem?
I had a friend visiting who uses nicotine. He has been very interested in what I do, but when I tried Steve's questions he stopped me cold turkey, "I don't believe all that research stuff!" This is after several discussions where he intimated he was about ready to quit and knew he needed to (all self-initiated). If I've learned anything in the last few years, it is not to get into counseling sessions with friends and relatives....

Challenges in Training:
- "Its heresy to talk about the importance of supporting pregnant women so they reduce their use - abstinence is the only option."
- "I don't need to know about motivation. I just want to know how to stop somebody from using."
- I asked the audience for a challenge. My partner was too easy and then we lost the audience.

Don't try this at home:
I have used an episode of the Ricki Lane show, "Reasons to Quit", where she confronts a pregnant woman as an example of how not to intervene.

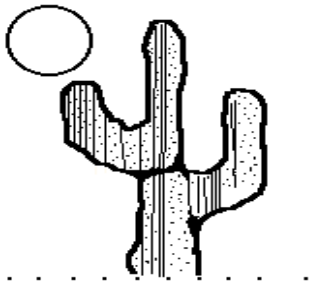
Professional sensitivity:
A message for psychologists who do not work with a lot of nurses. There are nurses who do not identify with this material, psychological principles and research in general. However, I have heard from other nurses that they are working to improve their methods of communicating with clients. So, don't lump us into a none capable or uninterested group.

Trainer Update
Nanette Stephens, a trainer from the University of Houston and the Institute for Family Treatment, dropped a line updating me on her activities. She completed her Ph.D. in Clinical Psychology in August of 1994 (Congratulations Nanette!) and has been doing a variety of activities (teaching, assessments, therapy, and parent training) to earn a living and complete those pesky post-doctoral supervision hours since then. She has done a couple of 16 hour workshops for first year graduate students at UH, an 8 hour work shop for personnel who work with dually diagnosed inmates, as well as integrating MI into work with her clients, and occasionally, her students.

It'll never work: A Response to Challenges in Training
Editor's Note:

I received a call from Carolina Yahne, Ph.D. shortly before this newsletter was due out. Carolina is a colleague of Bill Miller's and has done MI training since prior to the first MI Training for Trainers. She and Theresa Moyers (a MINTie from Albuquerque) have been doing training's together and thinking about the common objections encountered in this process. Attached to this newsletter you will find a copy of their article about what these objections are and responses to them. I found it interesting and hope you will as well. Thanks Carolina and Theresa.

This also provides an opportunity to reiterate the MINTie philosophy, policy, or general rule of thumb about contributions and subscriptions to this newsletter. These guidelines were set at the original MINT conference and are therefore irrevocably set in stone - unless we change our mind. Contributions are welcome from any quarter and are not limited to MINTies only. All submissions will be reviewed for content appropriateness (broadly interpreted) and edited for grammar (also broadly interpreted). Subscriptions are limited only to MINTie participants because of the costs involved in distribution. Again, a thanks is due to Bill, his staff and the people at UNM who make this available without cost to us. You are free to copy and distribute this newsletter to whomever you would like.



Notes From the Desert

Bill Miller

From the Desert

We've had an uncommonly warm and dry winter thus far, in contrast to many parts of the U.S. As I write this on December 15 it's been in the 60's and sunny. We're 3 inches low on our annual rainfall, which is serious when normal rainfall for the year is 9 inches!

But it certainly hasn't been calm and dry here in other respects. Project MATCH is putting the finishing touches on its primary outcome paper, and has committed to present the trial's findings at the June meeting of the Research Society on Alcoholism in Washington DC, if not before. Clearly that will be the largest study of motivational interviewing ever done (or every likely to be done, for that matter). At CASAA we are preparing to launch a 5-year NIDA-funded study of motivational interviewing for treatment-seeking polydrug users. At the Presbyterian New Heart Healthplex in Albuquerque, Dr. Richard Lueker is heading up a study of MI for MI's: motivational interviewing in rehabilitation for people who have suffered a heart attack. Among my graduate students, Lauren Aubrey is finishing up a study of MI with substance abusing adolescents, Craig Noonan is starting an evaluation of a group-therapy format for MI, and Frank Sanchez is testing an MI intervention with a more specific values-self-confrontation focus.

You've been busy out there as well. I receive regular training fliers from Michele Packard at the Sage Institute, who also continues to come up with new models and graphics. Delia Smith presented at AABT initial findings of her trial of MI with Type-II diabetics. Martha Sanchez-Craig has submitted findings from her study of an MI-like brief intervention delivered by telephone to residents of rural Ontario. Robert Rhode has been offering MI workshops frequently, and at last word was in the contemplation stage regarding a Drinker's Check-up program at the University of Arizona.

There's so much happening at the point that I am trying to keep at least a minimal log of it. Attached to this issue you will find an updated MI bibliography, which now also has a listing of ongoing research projects of which I am aware. If you know of other MI publications not listed in the bibliography, or other research projects not reflected here, please send me the citations. This lets me respond when someone calls and asks, "Who's doing something on motivational interviewing with _____?" I get these calls about once a week. We're also going to try a log of upcoming training events by MINTies, as reflected in an announcement in this issue.

Steve and I are discussing MINT-4, and at this point we're contemplating Portland, Oregon in November. If anyone has a favorite venue there, that you think would be a good place for training MINTies, let me know.

That's about it from the Land of Enchantment. I hope you all had real and enjoyable holidays, and I extend my best wishes for the new year.

Training? Let us know!

Bill receives periodic inquiries about when and where motivational interviewing training is available. He rarely offers workshops himself, and would like to hear about your upcoming training events. If you will be teaching motivational interviewing in a workshop in which others could enroll, please send this information to Delilah Yao, Department of Psychology, University of New Mexico, Albuquerque, NM 87131-1161:

Dates:	February 11-12
Place:	Madison Square Garden, New York City
Event:	Motivational Interviewing Training
For:	Primary Health Care Professionals
Trainer:	Ima Mintie, Ph.D.
Cost:	$75
Contact:	Dr. Mintie at 505-555-1212

Delilah will keep a listing of upcoming training events, for the information of those who call in search of training. If enrollment is not open (e.g., a special workshop being done for agency staff only), there is no need to send this information.

The Last Word (from the Editor)

My apologies for the late arrival of this issue. The combination of the Holidays, technical difficulties in Steve and myself connecting, the move of our research project across town, and a February 1 grant deadline conspired against me in trying to meet my duties. I pledge to do better next round.

For individuals who would like to contact Reid Hester for more information about the BBS, his titles and addresses are listed below:

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4/1/96	5/1/96
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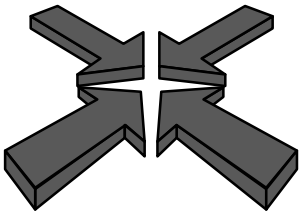

Inquiries and submissions for this newsletter should be forwarded to:
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This newsletter is made available through support by the University of New Mexico and the Alcohol & Drug Abuse Institute at the University of Washington.

Appendix A

SOC Tables

Client Stage	Therapist's primary motivational task	Strategies used
Pre-contemplation	Raise ***awareness*** and ***doubt***	Develop ***rapport*** by using empathy, reflective listening and asking open-ended questions; engage in some small-talk to set the stage Demonstrate ***attitude of respect*** for subject by accepting where the subject is presently in the motivational process and ***validate*** the subject's freedom to change or not change as they see fit Use caution and appropriate ***pacing***; avoid jumping ahead ***Roll with resistance*** (reluctance) to avoid confrontation-denial spiral ***Side-step labeling*** issue, ***blaming*** issue, avoid setting self up as "***expert***", etc. ! Elicit subject's ***concerns*** and ***problem recognition***. Evoke ***self-motivational statements*** with questions such as: • "In what ways does that concern you?" • "What do you think will happen if you don't make a change?" • "How has your use stopped you from doing what you want to do?" • "What worries you about your drug use?" • "What can you imagine happening to you?" ***Utilize*** these concerns to make a case for looking at additional information (i.e., feedback from assessment) If client has no/minimal concerns ***reflect*** that "maybe you're right and there's little to be concerned about" then ***bridge*** with "it's difficult to know without more information..." If subject is still reluctant to examine feedback then back off; consider shifting to ***paradoxical strategy*** of "withholding" information until subject displays more interest ("maybe it wouldn't be helpful to look at this information just yet...") If subject appears ready, offer individualized ***feedback*** from test results/inter view; include caveat that test results are merely "suggestive"; Examine possibility of subject having problems related to substance abuse as opposed to assuming subject has a "substance abuse problem"; Elicit subject's ongoing impression of feedback ("what do you make of that?") Check-in frequently with subject's desire to continue Introduce ***decisional balance*** if deemed appropriate (see below) Generally ***avoid giving advice*** ***Summarize*** situation based on subject's present view Elicit subject's "***next step***"

Contemplation	Examine ***pros/cons of status quo versus change*** with goal of helping subject tip the balance toward change	Utilize ***strategies*** listed ***above*** if appropriate ***Advice*** is more relevant Major emphasis for this stage is placed on examining the ***decisional balance***; it may be helpful to utilize a pictorial or "balance sheet" while doing this (see Decisional Balance Worksheet). Steps in decisional balance are adapted from Saunders, Wilkinson, Philips, Allsop, & Ryder (1991) as cited in Miller's book p. 280) Access client's perception of "good things" ***(benefits)*** about ***drug use*** Facilitate generation of the client's inventory of "less good things" ***(costs)*** about ***use*** Elicit ***current satisfaction*** with lifestyle, vis-à-vis that previously envisaged and that anticipated for the future. Help client determine which, if any of elicited problems are a ***concern*** Elicit possible "good things" ***(benefits)*** of making a ***change*** as well as "less good things" ***(costs)*** of making a ***change****,* do the same for status quo ***Compare/contrast*** benefits/costs of continuing with status quo versus making a change ***Highlight/reflect*** on areas of greatest concern/***discrepancy*** thereby generating discomfort for client current behavior which may act as motivation Elicit and agree on subject's ***next step***.

Determination	Help determine ***course of action***	Utilize ***strategies*** listed ***above*** if appropriate Elicit ***decisional balance*** as above or review decisional balance sheet Emphasis during this stage is on eliciting and developing ***strategies/options*** to pursue to address needs/desires ***Elicit goals/vision of future.*** Ask about: • Where do you hope to be in 5 or 10 years?" • "What is most important or dear in life to you?" • "Suppose that you went to sleep one night and while you were sleeping, a miracle occurred and the problem you are seeking treatment for is solved. However, because you were asleep, you don't know that the miracle has already happened. When you wake up, what differences will you notice that will show you that the miracle has happened?...What else?"....elicit image of world free from drug abuse problems. Examine ***needs.*** May utilize decisional balance sheet for this purpose. For example, look at reasons for drug use and distill/clarify underlying needs which are filled in part by use. Examine ***option of not changing***. Ask subject: • "Of course, one of your options is to not do anything in particular and keep using as you have been...if you decided to continue on this course, what's your sense of how it would turn out?" Reflect. • "What makes you think that perhaps you should do something about your use?...after all, one option would be to do nothing at all?" Ask about what would be the worst thing that could happen if subject went back to using as before if appropriate. Elicit and ***brainstorm*** possible ways subject may be able to meet needs/goals through means that reduce harm or that contribute to resources.

		Elicit change options from subject first; "Sounds like you're leaning towards doing something...what ideas do you have about things you could do?" While attending to person's resources, begin development of a ***plan*** As part of plan, ***Reinforce*** subject's decision to follow through with substance abuse program he/she is on waiting list for. Elicit desire to look at things subject can do during the waiting period and beyond. Consolidate ***commitment*** to further development of plan and/or to taking action. Utilize ***Change Plan Worksheet*** or suggest client fill it out after session. Elicit subject's ***next step***

Action	Help take steps toward change by sorting through options available, ***choosing course*** and following through with plan of action	Utilize ***strategies*** listed ***above*** if appropriate More emphasis is given on consolidating motivation for taking ***concrete steps*** toward change

Maintenance[1]	Help develop strategies/new skills to ***prevent relapse*** and develop life more fully	Utilize ***strategies*** listed ***above*** if appropriate Major focus is on ***relapse prevention,*** in part through: • elicitation of ***vulnerabilities*** toward relapse and past relapses • development of ***strategies*** to address these vulnerabilities • identifying ***adaptive behaviors*** in place of old less helpful behaviors (e.g., hobbies, seeking other sources of support) • examination of ***decisional balance*** for pursuing the development of these new behaviors (Lonn - This one is not clear to me. What do you have in mind?)

Relapse	***Facilitate subject re-entry*** into above stage processes without becoming stuck or demoralized	Encouragement with goal of ***re-engaging*** subject in process of change Re-examine decisional balance Emphasis on ***self-acceptance*** and understanding of lapses as being part of the recovery process for most people Explanation of the s***piral theory of change*** ("two steps back and three forward"). ***Reframing*** that subject has "just not yet hit upon" a combination of things which will work for them Emphasis on relapse being of ***educational*** importance...exploration of how recovery program/plan might be changed/adjusted so that relapse is less likely in future

Appendix B

Exercises

LOOKING FORWARD

Adapted from Motivational Interviewing, W. R. Miller & S Rollnick, 1991

Sometimes it is helpful to picture a changed future for yourself. How do **you** think things might be after a change? Say you were to quit or cut down on your drinking/using drugs; imagine, if you will, what life will be like and answer the following questions:

- What are your hopes for the future?...How would you like things to turn out?

- With regard to the frustrating things in your life now, how would you like things to be **different**?

- What are the options/choices for you now ? What **could** you do ?

- What is the best result you can imagine after you make a change?

LOOKING BACK

Adapted from Motivational Interviewing, W. R. Miller & S. Rollnick, 1991

Sometimes it is useful to remember times before the problem emerged, and to look at how it was then before all this stuff began happening and making your life difficult. Maybe there are things that you lost over time that you now would like to reclaim. Sometimes there are strengths you once had that you'd now like to rediscover.
Imagine now if you can what it was like and answer the following questions:

- Do you remember a time when things were going well for you? What were you doing that was helpful/enjoyable?

- What were things like before you started drinking/using so heavily? What were you like back then? What were some of your strengths, hopes and goals?

- What are the differences between the you of **10 years ago** and the you of **today**?

- How has your use of drugs/alcohol stopped you from moving forward?

EXPLORING GOALS

Adapted from Motivational Interviewing, W. R. Miller & S Rollnick, 1991

Sometimes it is useful to look at what are, for you, some of the most important things in your life. It is easy to lose track of what is important as a result of drug and alcohol use. Think about what is important to you. For example: how you want to be in the world; where you want to go in your life; what kinds of relationships you value; who your friends are; what things you would like to do; what your priorities are (what comes first); what are the things you prize most highly; and what are the things that you hold most dear. Think about these things and answer the following questions:

- What are the most dear/most important things to you? (e.g., my family, that people respect me...)

- List these things you value in order from most important to least important (highest to lowest).

- What were some of the ways in which your past behaviors got in the way, went against, or undermined these values?

- Most people who make the decision to seek treatment find that they have already begun to make small changes toward living a better life ***even before treatment begins***. What positive changes have you noticed so far?

WEIGHING THE GOOD AND NOT SO GOOD THINGS ABOUT MY USE

Adapted from Decisional Balance Measures, W. R. Miller

On the next page is a see-saw or balance scale. Take a moment to look at this scale now.

Imagine that on one side **(A)** are all the good things about drugs/alcohol in your life, the reasons why you might not want to quit or cut down. (For example; “helps me forget about problems”, “I don’t feel so lonely”, “helps me relax”, “I like the rush”...). Take a moment now to write down some of **the good things about your use** under **(A).**

Imagine that on the other side **(B)** are all of the not so good things about drugs/alcohol in your life, the reasons why you would want to quit or cut down. (For example; “lost my driver’s license”, “problems with my husband”, “job problems”, “feeling sick a lot”...). Take a moment now to write down some of **the not so good things about your use** under **(B)**.

Imagine that you are thinking about making a change in your use (for example, quitting or cutting down). What might be some of the hard or not so good things that might happen if you did change? (For example; “I might lose some friends”, “It would be a lot of work”, “I’m afraid I might fail”...). Take a moment now to write down some of these **not so good things about change** under **(C)** below.

Imagine that you are thinking about making a change in your use. What will be some of the good things that will happen when you do make a change? (For example; “I’ll feel better about myself”, “I’ll have more money”, “My wife will like me better”...). Take a moment now to write down some of these **good things about making a change** under **(D)** below.

After you have written these down, take a moment to look at your balance scale. What does it say to you?

BALANCE SCALE

LEFT SIDE (A+C)

A

Good things about Use

_____
_____
_____
_____
_____
_____
_____
_____

C

Not so Good things about Change

_____
_____
_____
_____
_____
_____
_____
_____

RIGHT SIDE (B+D)

B

Not so Good things about Use

_____
_____
_____
_____
_____
_____
_____
_____

D

Good things about Change

_____
_____
_____
_____
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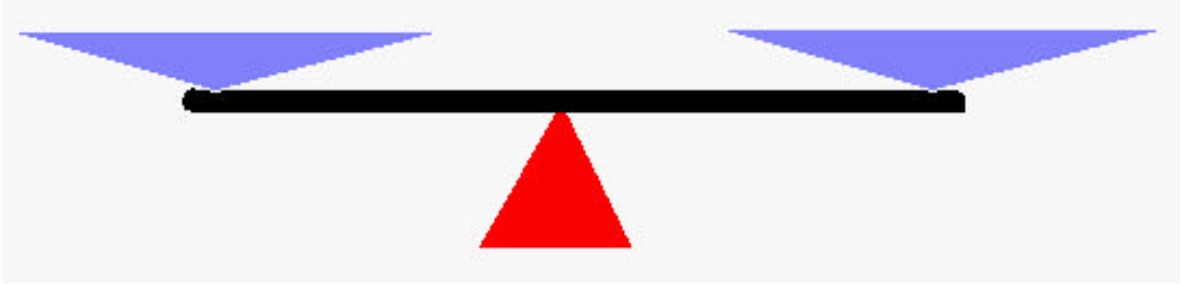

CHANGE PLAN WORKSHEET

Adapted from Miller et al., 1992

Some people find it helpful to write down a plan about how they intend to make changes. Here is one way you can do that...

1. The changes I want to make are:

2. The most important reasons why I want to make these changes are:

3. The steps I plan to take in changing are:

- ♦
- ♦
- ♦
- ♦

4. The ways other people can help me are:

Person/Program	Possible Ways to help

5. I will know my plan is working if:

6. Some things that could get in the way of my plans are:

THE MIRACLE QUESTION

(Adapted from The Miracle Method, S. Miller & I. K. Berg, 1995)

The following questions are sometimes useful in helping people to paint a picture of what life could be like if they made some changes in their life. This can be helpful in figuring out what some of your goals are.

SUPPOSE THAT ONE NIGHT, WHILE YOU ARE ASLEEP, THERE IS A MIRACLE AND THE PROBLEM THAT BROUGHT YOU HERE IS SOLVED. HOWEVER, BECAUSE YOU ARE ASLEEP YOU DON'T KNOW THE MIRACLE HAS ALREADY HAPPENED. WHEN YOU WAKE UP IN THE MORNING, WHAT WILL BE DIFFERENT THAT WILL TELL YOU THAT THIS MIRACLE HAS TAKEN PLACE?....THEN, WHAT ELSE?

NOW IMAGINE A TIME IN THE FUTURE WHEN THE PROBLEM NO LONGER EXISTS.....WHAT WILL IT BE LIKE FOR YOU?

HOW WILL YOUR LIFE BE DIFFERENT?

WHO WILL BE THE FIRST TO NOTICE? WHAT WILL HE/SHE DO OR SAY?

HOW WILL YOU RESPOND?

Two Possible Futures

Below, spaces are provided to write down two possible futures. Write down details of how your future might be if you go down two different roads. Afterward, reflect on the differences between the two.

Write down what your future might look like (say, in 5 years) if you make few changes in your life and continue on the path that you have been going on...

Write down what your future will look like (say, in 5 years) if you decide to make some changes in your drug/alcohol use...