Motivational Interviewing Newsletter for Trainers

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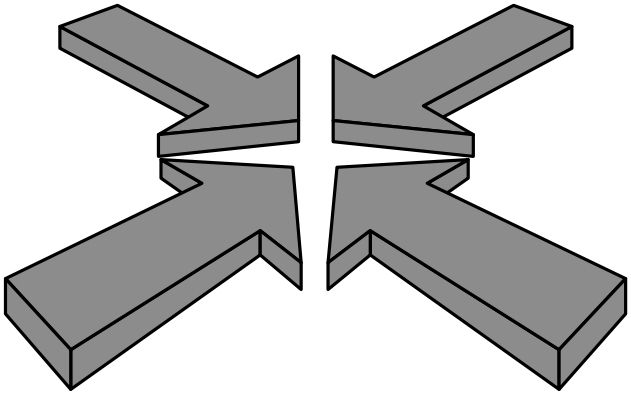


Sharing new perspectives

From Across the Bigger Pond

Doug Vaughn

I spent nearly three weeks in March training a new Intensive Family Preservation program (programme, now that I'm bilingual) in Adelaide, South Australia. Behavioral Sciences Institute has provided training to several other programs in Australia, helping them to start up family preservation training in other locations. In addition to the normal curriculum of family preservation training, I added two days of Motivational Interviewing training for this group. The feedback was wonderful.

Most of those in the group have worked in child protection, doing abuse investigation and (all too often) removal of children and placement in out of home care. During and following the training, most participants were telling me they love the approach and will now be finally doing what they got into human services to accomplish.

I presented Motivational Interviewing as "a way of being" with clients, not just as a technique to use when there are drug or alcohol concerns. Reflecting on Steve Rollnick's article in the last issue of this newsletter, it was the learning of the spirit of motivational interviewing that was exciting to them. They discussed how it was wonderful to validate clients, listen to them, affirm them, let them discuss the "problems" and solutions, and enhance their motivation to change. I quote from the project director, " We particularly appreciated the integration of motivational interviewing into the HOMEBUILDERS line staff training. Participants found the motivational interviewing principles and concepts very powerful, and as well as appreciating their usefulness in working with drug and alcohol affected families, and could also see their application to other family situations and circumstances."

I heard several comments, as we were debriefing the role plays, about how they thought they knew how to do these strategies yet found it was harder than they expected. They appreciated taking the time to practice such "simple" things as asking open-ended questions and doing simple reflective listening. The role play scenarios worked well with the Aussie group with only one exception. When I asked them to do a downward inflection at the end of a statement, they told me that is contrary to how Australians speak. They always reflect up, even on statements. It reminded me that there are always cultural issues to think about.

From Across the Pond

Steve Rollnick

The Spirit-Technique Distinction

Here is some good news! It's easy to convey the spirit of motivational interviewing when training. Get participants to role-play overt confrontation, for example. Describe the traps they fell into. Demonstrate yourself. Show them a videotape of yourself and someone else, and so on. Tell them about the distinction between spirit and technique, and that the former is fundamental.

We can only speculate about how many people enter a workshop needing to absorb the spirit before they work on technique. Among health care people, it can be as many as 80%; if I only have brief training time, I tend to leave out a lot of technique teaching.

Teaching technique is the problem. The closer one keeps to the clinical reality, the less specific one can be and, I suspect, the lower is the rate of skill acquisition. The more concrete one is, the greater the risk of oversimplification. I think I have found the right balance when teaching general health care interventions.

Training the Health Care Generalist

Trainees in health care settings often have glazed eyes when I teach them. It's taken awhile to understand why. Thankfully, it has little or nothing to do with me personally. They get bombarded by specialists. "Do more of this and less of that. Look out for 'x'" and then, in addition to everything else you do, use this specialist technique...!" Our jargon is the killer. In fact, one consequence of poor quality, specialist teaching is to "de-skill" the generalist.

Some of my basic rules are:

- Don't teach health care workers if you don't understand how they work. Stated positively, find out about their

environment before you teach. Ask about average consultation time, their main priorities, the current mental health of their profession, and so on.
- "De-jargonize" or die.
- Don't knock their traditional working styles. Build on them.
- Give them lists of "do's and don'ts"
- Give them concrete guidelines whenever possible, e.g., a readiness to change ruler, a balance sheet.
- Pay attention to the good quality design of materials.
- Be brief and be simple.
- Don't assume they will role-play!

Unstated thus far is what technique to teach them. My preference is for a general method which can be used with any behavior change problem. I have developed a new practitioners manual which is in press and will be happy to distribute this, along with the trainers guidelines, when it comes out of the printer's shop

Did You Know?

Two recent papers emerged in the British Medical Journal reporting no clear benefits of lifestyle counseling to general practice patients. A debate has erupted. Motivational interviewing principles or techniques were not evaluated.

Dr. Karen Emmons (Miriam Hospital, Providence, RI) is nearing the completion of an evaluation of brief motivational interviewing among hospitalized smokers. Watch this space.

The Great White North

Fran Jasiura

Firstly, a great big thank you to Dave Rosengren, Bill Miller, and Steve Rollnick for your first 2 newsletters. I rip open the envelope with great anticipation and am always thrilled! [Ed: This was not a solicited editorial. By the way Fran, your check is in the mail.] I certainly can feel isolated here in the `North', and invite any of you to call if you're in this "neck of the woods". I hope we will soon all be offering contributions to the newsletter, so as to keep to the original time-frames. There may only be an initial start-up lag as trainers incorporate the material.

I am getting more requests for information and training. Thanks to Bill and Steve for passing on my name. It certainly took me a lot of prep time for each piece. I needed to get a better handle on the Brief Intervention Research as that is such a vital backdrop to MI. In fact, staying on top of the research is a major job, and an obvious function for the newsletter.

Anyway, to date, I've done 2 full, 2-day training's with 40 youth-addiction specialists, 3-45 minute introductions with 45 addiction counsellors and a 2.5 hour introduction to MI. The feedback has been positive with participants: a) asking for follow-up; b) 2 day training is a bare minimum introduction to begin using MI; c) 20 to 1 ratio (participants to trainer) means only a few get direct experience in fishbowl. Great interest was shown by all 3 groups of counsellors in the introductory sessions for the full 2 day training.

Overview of 2 Day Training.

Content:

- Introduction to Brief Interventions research by presenting FRAMES, depicting it with Koumans (drop out) and Chafetz research (Referral Completion) & Project Match

(issues specific to this counsellor population);
- The other building block to MI, Motivational Research, was illustrated by reviewing Prochaska & DiClemente's Stages of Change (familiar to many),
- Introduce the Readiness to Change Ruler and working through the Decisional Balance with a volunteer (i.e. the costs & benefits of both indulgence and restraint in cigarette smoking);
- Summary conclusion that MI is a directive, client-centered style for enhancing motivation for change by helping the client clarify and resolve ambivalence.

2 Hour MI Introduction

This lecture was done with 40 IMPACT facilitators in Alberta (who do weekend interventions with groups of repeat impaired drivers, mandated to attend for license reinstatement). The goal was to introduce the spirit and content of MI and a preliminary discussion around 3 questions: a) What is motivation?; b) Can you change client motivation?; and c) How?

Content:

- Same introduction as 2 day workshop;
- Working and dictionary definitions of motivation;
- Review of Brief Intervention Research, FRAMES, and Project Match;
- Introducing 2 of 8 motivational models (Stages of Change & Conflict /Ambivalence);
- In small groups applying Decisional Balance to Impaired Drivers (cost/benefit of restraint/indulgence);
- Reviewing handouts What is Motivational Interviewing?
- Overview of 2 day MI Training.

Drinker's Check-up

In Kelowna, B.C., I am working with Dr. Bill de Bosch Kemper (Psychologist) and Dr. Lynn Reynolds (Physician) to introduce the DCU through existing EAP programs, initially targeting the police (RCMP).

Notes From the Desert

Bill Miller

As we prepare for the second Training for Trainers workshop, this time in Santa Fe, I am remembering how much Steve and I enjoyed working with all of you last year. Teaching MI is a real pleasure. I've not offered an MI workshop myself this year, and rather miss it!

Recent Developments

On my desk is an inquiry from an editor at Wiley, who would like to publish a book on motivating offenders to change. She says, "Motivation to change is a topic of considerable interest to practitioners in the field of offender rehabilitation. There is, to my knowledge, no text which deals specifically with offender issues. Indeed, your own book on motivational interviewing is the text we currently recommend to guide people in this area." Is anyone interested in the possibility of writing a book for the Wiley series in offender rehab? If so, please contact me.

Dr, Stephanie O'Malley, of the Department of Psychiatry at Yale, recently presented a workshop for the Taiwan Psychological Association, in which she covered Motivational Enhancement Therapy. She had called to get my permission to have my demonstration videotape dubbed in Chinese. So somewhere out there Lorenzo Luckie and I are prattling away in Chinese. Lorenzo, by the way, recently completed his Ph.D. here and is now Captain Luckie, serving the U.S. Army in Kansas. Besides being a psychologist, Lorenzo is a published novelist (Beware the Horse, Tor Books), an accomplished singer and professional actor, and quite a good dancer.

A resource manual for family physicians entitled Alcohol Risk Assessment and Intervention was published in 1993, and is

available from the ARAI Project, College of Family Physicians of Canada, 2630 Skymark Avenue, Missisauga, Ontario, Canada L4W 5A4. It is based on the work of Martha Sanchez-Craig at the Addiction Research Foundation in Toronto.

Work is proceeding on How to Help Your Patients Who Drink Too Much: A Physician Guide. For information, contact Fran Cotter at NIAAA in Rockville.

The program "Worcester Fights Back" is evaluating the effectiveness of MET in enhancing readiness for change among substance abusers. Employees recruited through worksites are being randomly assigned to MET or traditional services. For information: Jack Bonina, Worcester Fights Back, 200 Mechanics Bank Tower, Worcester Center, Worcester, MA 01608. (508) 752-0508.

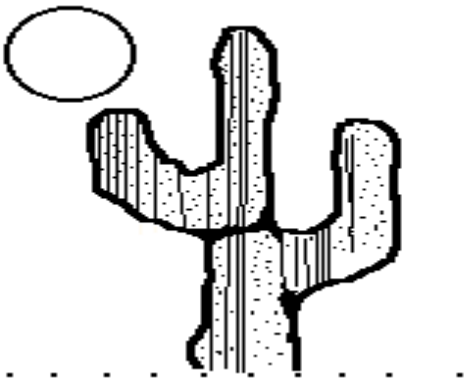
Bob Meyers and I are just beginning a 5-year NIAAA-funded clinical trial of three approaches for counseling significant others of unmotivated problem drinkers. Spouses and other concerned SOs will be recruited through referrals and media announcements, and randomized to: (1) unilateral family therapy based on the community reinforcement approach, (2) Al-Anon facilitation counseling, or (3) a Johnson-Institute-style intervention. Definitive results are expected in 1999.

ICTAB-7

The Seventh International Conference on Treatment of Addictive Behaviors will be held in the Netherlands, May 28 - June 1, 1995. We have reserved a modern conference facility on the west coast of Holland (which isn't very far from the east coast), and a brochure will be mailed in July. The theme is "Changing the Course of Addictive Behaviors." Plans include presentation of results from a number of major ongoing studies, including Project MATCH, and the Study of Treatment and Recovery (an NIAAA three-site replication of Alan Marlatt's relapse taxonomy).

More Assessment Instruments

Our group is just completing the introductory paper on the psychometrics of DrINC - the Drinker Inventory of Negative Consequences - and its short form, the SIP (Short Inventory of Problems). If you're doing Drinker Check-ups, this may be a useful instrument for you. Scoring sheets and profile forms are attached. I recommend using these forms instead of the DrINC you were given at the workshop, which combined Lifetime and Recent problems on the same form. We have found that respondents get confused, and give logically inconsistent responses. Therefore we separated the DrINC into a lifetime consequences form (normally used in initial evaluation) and a recent (past 3 months) form that can be used at baseline and follow-ups.



Thoughts on Training

Doug Vaughn, Seattle, WA

We at BSI have learned a great deal about training MI from our recent experiences. First of all, we continue to learn how important it is to tailor the presentation to the audience. Every group has its own unique population, service and/or approach to its clients. While keeping the spirit of MI, we have tried to tailor the techniques to those different audiences. Second, we have learned the importance of

doing as much role playing as possible. For example, when we cut out a Summarizing role play due to time constraints, we found the listeners less likely and able to use the strategy in the later "Putting it all together" role play.

Diane Bailey, Olympia, WA
What have I learned?

- Public health nurses were hungry to learn a new approach that was client centered.
- In role play, develop a general description of a client. Don't ask learners to role play a clinical situation they have experienced. They will not work on skills or approaches. They are too close to the problem and may have personal attachment to the role-play. (This may be very obvious to those more learned than I. I had to deal with the results in two workshops before I realized what was happening.) [Ed: Is there a story here, Diane?]
- Tap into the learner's right side of the brain! Have symbols available to cue and focus the learners. We used: music (e.g., "Reasons to Quit" by Willie Nelson and Merle Haggard); a wall hanging (e.g., Stages of Change, Reflective listening); a menu box; cartoons (Callahan's); a balance scale. I added as I went along because people forgot and fell into old habits.
- Be rested. It takes a lot of energy to train for two days and deal with resistant behavior, personal examples and being creative. Food, music and laughter helps. I need a lot of light. We did one training in a court room with dark paneling with a learner that thought this was "a bunch of crap". She had been dragged to the workshop. By the end I was exhausted - but she left asking for more.
- One of the greatest challenges is focusing on what the client is concerned about rather than the nurses prioritization of what needs to change first. When presenting MI, resistance may be offered as "but we have to do this...". Role with it. Slow up. Help them focus through summarizing.

Fran Jasiura, Kelowna, B.C.

- I was fortunate to book 2 back-to-back training's. I received much helpful feedback after the first training, & incorporated subtle and not-so-subtle changes into the 2nd training which reflected in improved written evaluations.
- There seemed to be a great disparity in participants' skills and previous training. Many Canadian counsellors have completed the 30-hour **Addictions Research Foundation (ARF) Addictions Counselling Training** course -in fact, in some provinces it's core training--which means they have been exposed to various addiction frameworks, reflective listening training, assessment skills and treatment planning. MI is an excellent adjunct to ACT training and the ACT training can be an excellent prerequisite to MI.
- Some feedback expressed a concern that I had confronted the disease model too heavily (incongruous when confrontation is the goal, and not the style, of MI). Canadians seem not as locked into only the disease model. Subsequently, in the 2nd training, after beginning with the persuasion exercise, I asked a series of questions: Who in the group was not working on some lifestyle change?(no one put up their hand); Did your motivation fluctuate? (a resounding YES); Under what conditions? (i.e., stress, too busy, time of day, time of year, company, pain). Thus, having this list of motivators, I asked the trait or state question, and broke them into small groups to discuss both the assumptions and problems with the trait model. The overheads then reinforced their points, and I summarised that if they believe motivation is a trait (i.e., can't be influenced), they'd have trouble with the MI style and that's OK, ''cuz it's not for everyone. No negative comments on this less confrontational approach.

- Many seem impatient with reflective listening, wanting to move more quickly to strategies for resistant behaviour, SSM, and fishbowl. Yet, the comparison between pre & post workshop questionnaires showed fewer roadblocks, more affirmations, and more simple, amplified, & double-sided reflections after training.
- Showing the first part of the Miller video early in training worked better for both demonstration and summary purpose.
- More humour (let's scan the funnies...see attached. [Ed: Sorry, I couldn't attach the attached but they were funny.])
- While reviewing the 8 motivational models, I asked for practical strategies/tools from the participants to demonstrate these models. I did the same with the Readiness to Change ruler (i.e., specific tools/strategies currently used within Precontemplation). Thus, training specific populations (i.e. Youth counsellors, or Impaired Driver counsellors) allows for validation & motivation of the participants and a sharing of many great ideas.

Editor's Cut

David Rosengren

You know, I have to be honest and say the wages with this position are lousy but the fringe benefits are great. Over the last few months I heard from several of you and it was great. I was energized about MI as I read your letters and talked with you. It was interesting to hear what you've been doing. I am impressed. It also makes me think again about the workshop and things which might be helpful for "the next class".

One thought (I'm only allowed on a week or I get into trouble.) about is the importance of doing these trainings shortly after completing the Training for Trainers Workshop. My guess is there is a range of activity level out there from those who have done several trainings and feel very comfortable doing it now, to others who may have had limited or no opportunities and may feel their skills are rusting. I place myself in that rustoleum category and have been thinking about ways to be more active. It seems awfully important to get out and do a training right after the workshop. I wonder if a helpful element might not be to identify settings that we either will or want to train in and develop a workshop outline accordingly, as part of the formal training process. I know we did a bit of that as an option, but as a neophyte trainer, I think I might have benefitted from some more structure in that regard. Then again, I'm sufficiently obsessive that I always want a little more structure. Still, I think some time set aside for identifying our first training setting and laying the groundwork for it, at the time of the training, may have helped me off the launch pad a wee bit sooner. What do the rest of you think? Other ideas for Bill & Steve now that you've been in the field a bit?

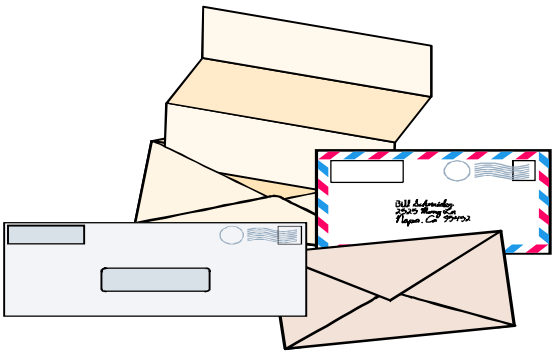
To those of you who submitted pieces, I appreciate your mail. I have tried to put the information you gave me in a format that fit the newsletter and stayed true to what you were saying. I apologize for not including the cartoons but I'm not that High Tech. Now Reid might be able to do something about that. In lieu of cartoons, the following recently arrived on my e-mail. Stealing unashamedly from Letterman, let me list the Top Five List for acceptable excuses for not coming into work:

- My mother-in-law has come back as one of the Undead, and we must track her to her coffin to drive a stake through her heart and give her eternal peace. One day should do it.
- I prefer to remain an enigma
- I can't come in today because I'll be stalking my previous boss who fired me for not showing up. Ok?
- The dog ate my keys. We are going to hitchhike to the vet.

And, the number one reason:

- When I got up this morning I took two Ex-Lax in addition to my Prozac. Now, I can't get off the john, but I feel really good about it. (excerpted from the Sunday Washington Post, 4/14/94).

Just another reminder...



Behavioral Sciences Institute

Doug Vaughn

The lot of us at BSI have been busy over the few months since we were Albuquerque, preparing and putting on Motivational Interviewing training, both internally to our own staff and to outside groups.

Sandy McAuliff, Ann Hendrickson and John Hutchins have been doing on-going MI training for our 6 HOMEBUILDERS offices around Washington state. Doug Vaughn and John Hutchins did two days of MI as part of a larger training for options counseling, a family preservation program in Eugene, OR. Heather Halibisky, Ann Hendrickson and Sandy McAuliff presented a one-day MI training workshop for chemical dependency counselors from around the state of Washington. The Chemical Dependency Training Coalition has certified BSI to provide one-day and two-day MI training for continuing education credits for CD counselors. Doug Vaughn presented a full MI training for a start-up preservation program in Adelaide, South Australia in March (see above article).

News from Trainers

In May, Jan Dyehouse, R.N., Ph.D., University of Cincinnati Medical Center, and Sharon Mudd, M.S., R.N., Alcohol Research Center, University of Michigan, gave a joint presentation on the use of brief interventions in the psychiatric setting for a nursing symposium in Columbus, OH. Included in this presentation was some of the MI work, as well as reports of pilot data from our own settings. Jan and Sharon met at the training workshop in Albuquerque last October and are hopeful of continuing their work together in the future. Sharon also reports that the University of Michigan Alcohol Research Center is developing a brief intervention for use with older adults in primary care settings. Included in this work will be concepts derived from MI.

[Editor's note: Do they allow people from Big Blue into Buckeye Country? Being from Golden Gopher Country I just wondered....]

Diane Bailey, R.N., has been awarded a small grant to teach MI to public health nurses in Washington. She and Kari Merkle, also a public health nurse, have led four 2-day workshops with another scheduled for this Fall. Forty nurses participated in the these training's. She has also given another five presentations (1-3 hours in length) on MI to ≈ 100 nurses and maternity support providers throughout the state. In addition, Diane has been recently employed as an inteviewer for a fetal alcohol syndrome research project funded by the CDC at the U of Washington. Dr. Sterling Clarren is the PI. Diane will be collecting retrospective information on 80 - 120 women who have given birth to FAS children.

Odds - n - Ends

Diane Bailey requests help finding information about the use of the Diagnostic Interview Schedule III-R with women that are problem drinkers or addicted to alcohol.

Fran Jasuira asks:

- Can we measure workshop outcome with the questionnaires provided? How?
- Ongoing creative and fresh approaches to Reflective Listening training will be useful, if not necessary, to hold participants' interest (the *Do you mean exercise* works very well).
- Bill, do you have any recommendations or updates from the DCU overview presented in the manual?

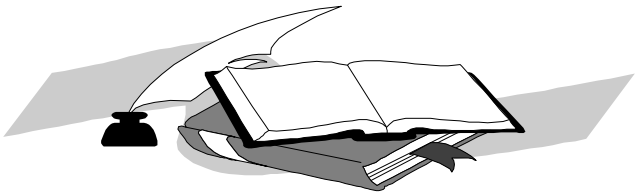
Publications

Some publications from the New Mexico Group.

Agostinelli, G., & Miller, W. R. (1994). Drinking and thinking: How does personal drinking affect judgments of prevalence and riskiness? Journal of Studies on Alcohol, 55, 327-337.

Miller, W. R., & Kurtz, E. (1994). Models of alcoholism used in treatment: Contrasting A.A. and other perspectives with which it is often confused. Journal of Studies on Alcohol, 55, 159-166.

Miller, W. R., & Sanchez, V. C. (1994). Motivating young adults for treatment and lifestyle change. In G. Howard (Ed.), Issues in alcohol use and misuse by young adults (pp. 55-82). Notre Dame, IN: University of Notre Dame Press.



Letters

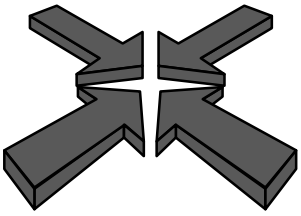
Dear Readers:
I have a problem. I wrote earlier that I am getting energized by this whole MI thing. Its a sign, I know it. Oh, God. I'm a MI groupie! Next thing you know I'll be talking about the Woodstock reunion, looking for tie-dye, and remarking about the good-old days when Steve and Bill were young and good-looking. Then I'll want to write a book about my recovery from doing confrontational therapy and entitle it Adult Counselors of Alcoholics. Can you help me?
The Editor

(The Editor reserves the right to edit all letters to support his point of view).

Training Events

TRAINING FOR TRAINERS SCHEDULED!

The second training-for-trainers workshop is scheduled for October 10-12, 1994 in Santa Fe, New Mexico.



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