Motivational Interviewing Newsletter for Trainers

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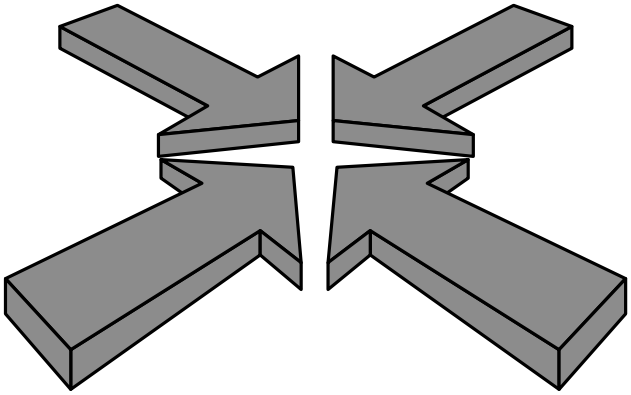


New Perspectives

Point/Counterpoint: Advice-giving by Physicians

Editor's Note: The following are offerings from Geoff Williams and Stephen Rollnick on advice-giving by physicians. Geoff is a MD, PhD from Rochester who attended the Santa Fe Workshop. Stephen forwarded this information to me with the following preface.

Geoff, an MD from the second MINTie workshop, got worked up about my saying that advice-giving was a waste of time! So we corresponded, and offered to have a little debate in public, through the newsletter.

I invite both Stephen and Geoff to submit rebuttals for the next issue, as well as encourage the rest of you to offer your thoughts on this matter. Personally, I can't hear a debate without immediately having the image of Jane Curtain and Dan Aykroid doing Point/Counterpoint on Saturday Night Live.

To Advise or Not to Advise, That is the Question

Geoff Williams

[Ed's note: A portion of Geoff's writing was lost in fax transmittal. I have tried to ferret out that piece as best I can. My apologies to Geoff for errors in interpretation. My words are in italics]

Because physicians have a fundamentally different role than do psychologists, I advise teachers of MI to advise their physician trainees to advise. This role requires that physicians prescribe treatments for patients. Medical patients have no innate understanding or predisposition to pursue these treatments. This is different than the innate tendency that people have to change addictive behaviors. On this basis, I offer four major reasons why I advise physicians to advise their patients.

First, medical science is inexact and advise is based as much on the seasoned clinician's intuition as it is on fact. Therefore, part of what a seasoned clinician has to offer a patient is their experience of applying medical knowledge to other, similar, patients. This information is not available in textbooks or articles about the condition. Even if it was, patient's cannot reasonably be expected to keep up with the medical literature. Patients who are left unadvised by their doctors are not "competent" to reason through the incomplete medical facts themselves, and lack the judgment of the clinician. Second, patients have come to expect that physicians will advise them, thus making it quite likely that patients will perceive non-advice as neglecting them, tacitly approval to avoid

healthy changes and health improving treatments. Third, from a legal perspective, medical care is always compared to a standard of care in the community. There are many juries that would easily be convinced that a physician who didn't give advice was *failing to meet community standards and therefore liable for damages. Fourth, when training a group* of otherwise psychologically naive physicians not to give advice is likely to sacrifice the teacher's credibility, and I fear, undermine the chance to motivate the physicians to adopt a MI approach to patient care.

Please understand, I am all for physicians working explicitly to encourage their patient's active involvement in the decision-making, and for the patient's to take responsibility for their behaviors, but many times this starts by giving advice to otherwise uninformed patients. If the doctor provides this advice in an informational manner, patients can make an informed choice; if they provide the advice in a controlling manner, patients are left to rebel or comply. However, if they don't provide the information, patients can't make any choice at all. Patients have a great capacity to hear physicians' advice as information, and thus have their motivation enhanced. So, my advice to you, is to advise the doctors you teach to advise.

To Advise or Not to Advise? A Reply to Geoff Williams

Stephen Rollnick

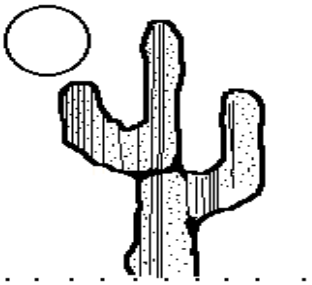
Its nice to argue with MD's. I don't often get the chance. Its a pity that Geoff also has a psychology qualification. I would have preferred you to be a bit more of a pure medic, Geoff! But what wild assertions you nevertheless make. "Patients have a great capacity to hear physicians' advice as information, and thus have their motivation enhanced." Come off it, matey, as they say in Australia. Where do you get this from? The other day I watched a diabetic specialist deliver "dietary advice". The hapless patient's eyes glazed over in a state of passive resignation. She had heard it all before. It was a patronizing diatribe.

I admit this debate has a bit of an oversimplified edge to it. I am probably guilty of contributing to this. Like the debate about, "Is psychotherapy effective?" Inevitably we must ask, "What kind of advice, to what patient, delivered by which physician, in what way?"

Advice giving seems to consist of at least two elements: persuading someone about what to do, and providing information. This corresponds to Geoff's distinction between controlling versus informational consultation styles. The providing of information can be done in a motivation-enhancing way. We have learned this from the Drinker's Check-Up studies. It's the persuasion element that is problematic and which runs against the spirit of MI. I accept that there are situations in which the patient's want to be told what to do, particularly if the problem is serious. There are also some kinds of patients who usually liked to be told what to do. I would restrict my argument to the arena of lifestyle behaviour change. Here I believe physicians too often make mistakes.

In teaching physicians, I make the above distinctions, and then simply suggest they try to be more flexible in how they talk to patients. My message is this: If you are talking about lifestyle change, provide information but be careful with direct persuasion. Watched for glazed eyes and signs of resistance. If you really want to tell clients what you think they should do, always complete the sentence with, "...but what do *you* think?" I then remind them of the song entitled, "Its not what you do, its the way that you do it...". I agree with Geoff that it might be wrong to attack advice-giving in an overgeneralized way. By the same token, it

should not be defended in this way either. If I am guilty of the former, Geoff's last sentence reveals that he might be guilty of the latter?



Notes From the Desert

Bill Miller

Desert Bloom

Greetings from the high desert, which is already in full Spring bloom. Like the sagebrush, the demand for MI continues to grow. We receive at least a request a week here, and respond to virtually all of these by sending out the trainer's list. I know, from your letter's, that at least some of these requests are finding their way to MINTies. Michele Packard sent us a very attractive Sage Institute flier of their MI training calendar. Looks great, Michele!

Just a thought...

Should Canadian trainers band together to form the MINTie Mounties?

MI's version of Family & Friends

Here are some new contacts from recent correspondence:

Miss Cliona Ni-Mhurchu (Department of Nutrition and Dietetics, Royal Bournemouth Hospital, Castle Lane East, Bournemouth BH7 7DW, UK) writes that she is planning to study the effectiveness of MI for patients with hyperlipidaemia (elevated cholesterol levels) to encourage dietary changes.

Eric C. Rubel (Addictions Treatment Foundation, Toronto, Ontario M5S 2S1, Canada) has submitted for publication an article on Effectiveness of a Workshop on Motivational Interviewing with Alcohol Abusers." As far as I know, this is the first empirical evaluation of the efficacy of MI training.

Mark P. Jensen, Ph.D. (Department of Rehabilitation Medicine, University of Washington, Seattle, WA 98195) has in press the first publication on applications of MI with chronic pain patients. The citation: Jensen, M.P. (in press). Enhancing motivation to change in pain treatment. In D.C. Turk & R. J. Gathchel (Eds.), *Psychological treatments for pain: A practitioner's handbook.* New York: Guilford Press.

Robert A. Senft, M.D. (Center for Health Research, Portland, OR 97227-1098) in January submitted the final report of his NIAAA grant R01-AA08976: "Drinking Patterns and Health: A Randomized Trial of Screening and Brief Intervention in a Primary Care Setting." They found a modest but beneficial effect of MI on 6-month drinking behavior in a primary care population screened for heavy drinking. Bob will be presenting his findings at ICTAB-7 in Holland this May.

Peter Monti, Ph.D. (Center for Alcohol and Addiction Studies, Brown University, Box G, Providence, RI 02912) has a grant to conduct MI with teens who were admitted to the emergency room for drinking-related reasons. They are planning a brief assessment and counseling with teens and their parents, and have developed manuals for these interventions. Also at Brown, Damaris Rohsenhow, Ph.D., is testing MI in the treatment of cocaine dependence.

Frederik Spak (Department of Social Medicine, University of Göteborg, Vasa Hospital, S-411 33 Göteborg, Sweden) has translated the short form of SOCRATES into Swedish for use with DWI Offenders. He

plans to conduct several hundred interviews with impaired drivers each year. Meanwhile, MINTie Tore Børtveit (The Bergin Clinics, PO Box 297, N-5001 Bergen, Norway) is developing a Norwegian translation of Socrates and is preparing a Norwegian Drinker's Check-up.

Rivka Applebaum (20 Ha'atzmaut St., Herzlia, Israel 46789) sent the results of an MSW thesis entitled, "Ambivalence of Opiate Addicts Toward Heroin and Withdrawal." A questionnaire to measure ambivalence (Kaplan, 1972) was administered to three samples: 21 clients in methadone maintenance, 19 applicants for detox, and 24 drug-free former drug addicts. Ambivalence towards heroin was significantly higher among those continuing to use heroin.

Dr. R.R. Jacobson (Division of General Psychiatry, St. George's Hospital Medical School, University of London, Cranmer Terrace, London, SW17 ORE, UK) wrote to say that he has included questions about MI in the psychology section of the British Psychiatric qualifying examinations.

Closer to Home

Meanwhile, Rollnick and Miller have submitted for publication an article entitled, "What is Motivational Interviewing?" This grew out of discussions during the second MINTie workshop, in which we were pressed to provide a clear definition of MI and guidelines about what exactly does and does not constitute MI.

The second edition of the Hester and Miller *Handbook of Alcoholism Treatment* was released in March by Allyn & Bacon, and includes updated chapters by Nick Heather on "Brief Intervention Strategies", by Ned Cooney et al., on "Screening for Alcohol Problems and At-Risk Drinking in Health Care Settings", and by myself on "Increasing Motivation to Change". Chapter 2 reports the most recent meta-analysis of the alcohol treatment outcome literature.

Here at the UNM Department of Psychology, Lauren Aubrey has just been awarded a small NIAAA grant to evaluate MI with adolescent substance abusers entering treatment at CASAA. Craig Noonan will also be starting an NIAAA-funded study of the effectiveness of a *group* MI counseling approach at Albuquerque Veteran's Administration Medical Center substance abuse treatment program. These are both firsts in MI as far as I know. I'm developing and testing an MET manual-driven treatment for drug abusers, as part of a NIDA-funded pilot project with Bob Meyers. The first-draft manual is in fairly good shape, and I am willing to provide it to MINTies who are working on this topic.

From Across the Pond

Stephen Rollnick

What is Motivational Interviewing?

When driving back from Santa Fe after the last MINT Workshop, Bill and I decided that we should have included a definition of MI in our 1991 book. So we have written a little paper, called , "What is Motivational Interviewing?" which has the following definition in it: *A directive, client-centered counseling style for eliciting behaviour change by helping clients to explore and resolve ambivalence.*

Recipe from Rollnick
I've got some more recipes, derived from recent teaching experiences, but I have no idea whether these are useful to you? So I shall choose the lazy route, and wait for feedback from you or coercion from the Editor before sending out any more. [Ed.'s note: Steve - Considered yourself coerced.]

European MINTie Workshop
October 9 & 10, 1995. Northern Italy, just outside of Genova, on the Italian Riviera coastline. Bill will have details if you know of anyone who might want to attend.

Controlled Trials & the Expert Trap
I'm working with a family practitioner colleague on a brief negotiation method for use among smokers. Its a controlled trial. We get lots of money to do it. I wrote the section in our grant application on the content of the intervention. When we got the grant, against heavy competition, I felt really expert. I was well-placed to design this intervention with my background in MI, many years working on simplification, a personal history of struggles with nicotine, and so on.

We went to our local pub to celebrate the award, and on the second pint of beer, it suddenly struck me. We were falling into the expert trap. We should really be asking smokers what kind of help they would find most useful. Maybe some of them would love a good finger wag? The outcome has been illuminating, and confusing. Here are some examples. First example: the readiness to change assessment. We draw a line and ask the person to place a cross on it. Many say they could have placed a cross on a wide range on the continuum. I am more than ever convinced that this judgment is a fragile one, vulnerable to the atmosphere between practitioner and patient. The second example: some of them really liked a straightforward, heavy-handed, fear-inducing finger wag! One in particular, who was initially a precontemplator, burst into tears and left the room fully intending to quit. Others got really furious when we tried this. How can we know this beforehand, and tailor the intervention accordingly? In a few months we should know the answer! The third example: variations on a theme. In looking back through these pilot consultations in video, we kept noticing the variations between us in how we deliver finger wagging. Sometimes I am much less confrontational than I thought I had been, and most confusing, sometimes the content is finger waving, but the way it is done appears autonomy enhancing? I keep thinking of that pop song, "Its not what you do, its the way that you do it..."

Editor's Cup

David Rosengren

Limits of MI (or Pizza Anyone?)
One of the things that I have been sorting through in my training and consultations are what are the limitations of this model? Where does the rubber meet the road and the road win?

A personal experience provided one example of the importance of flexibility with any paradigm. My daughter, preparing for Kindergarten this Fall, recently had her physical examination. Booster shots were one element of this exam. Fortunately for us, we were the last appointment of the day so only the clinic staff were left when my child curled up into a ball, sobbing hysterically, and refused to take her shot. After several attempts to gain compliance, the nurse graciously excused herself while I tried to settle Katie. It soon became clear that my training in psychiatric care had ill-prepared

me for this circumstance. No amount of MI was going to get that little arm out. A moments thought led me to a paradigm shift. I needed something more valuable than the shot was painful. A Pizza bribe was born! And so in my best authoritative-Dad voice I said, "Katie, we cannot leave until this shot is done and if you'd like some pizza, you need to stop crying and do the shot now." The arm came out, the shot was done, and later as we ate pizza, Katie commented, "I was pretty brave, wasn't I Dad?" After I quit choking on my pizza, I responded, "Well some people say being brave is doing something even when you are scared, so you were brave today". To myself, I added, "Your Mom is taking you to your next set of shots."

Unique Features

The comment from experienced psychotherapists is often, "So how is this different from good clinical practice?" Bill and others have put together some pieces that contrast MI with Rogerian approaches. This provides some basic insights, but doesn't quite answer the question for me or for my audience members. It seems to me that the model was developed in the addictions treatment environment where "good clinical practice" is not necessarily the norm and so provided a dramatic contrast effect. In the larger mental health field, I think the difference is more fine-grained and therefore our task as trainers more challenging. Steve's points earlier about its not what you say, but how you say it seem apropos. I'd add that its also when you say it. Timing is part of what is unique in this approach. It provides a map for when you do things and stop doing others. The other unique feature of MI, from my perspective, is the conceptualization of client resistance and ambivalence as normal change processes. Obviously, the Stages of Change Model of the Transtheoretical Theory has contributed enormously to this perspective. It seems to me this point provides the foundation from which all the other elements can be built. Then again, I could be wrong.... Perhaps in their upcoming article Steve and Bill have written will address this issue. I look forward to reading it.

To Advise or Not

I read with great interest Steve and Geoff's debate on advice-giving and found myself thinking about my own recent experience with advice-receiving. Though this is not the issue at the heart of this debate, I will share another perspective.

This past Fall I was diagnosed with Diabetes, Type I. The fact that I was squinting my eyes to focus as I made trips every ten minutes to the bathroom should have been a giveaway, but with no family history of diabetes and the absence of other risk factors I ignored the symptoms. I figured the exercise was good, and I'd found a great new diet plan. After the diagnosis was made, medication and dietary changes led to even higher blood glucose levels, so I went on insulin. My medical care was excellent and I read voraciously so I was well-informed. I was a model patient and followed the physician's advice religiously. It was a roller coaster ride getting my glucose levels under control, but I eventually succeeded. Although as I was taking care of all the physical pieces, the emotional pieces weren't quite so easy. This was a big life change and one that despite my best efforts, still confounded my attempts at control on occasion. The thing that kept coming to mind for me in all this is no one, not my physicians, the nurses, or dietitians, ever once said, "Gee, David. These are some pretty big life changes. How are you doing with this stuff?" They were great about offering reassurances. I didn't plan on pouring my heart out, but it would have been nice to have someone on this highly competent health care team (one that was obviously going to play such a large role in my life from now on) acknowledge this point. As I saw it, this emotional piece more than any other was likely to adversely effect diet, exercise, and medication adherence

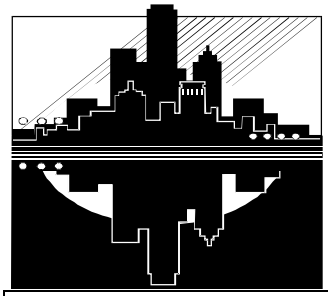
issues for me. As I thought about this, I made a decision to talk with my physician.

I shared, with some trepidation, my disappointment with my physician about this point. He was shocked that he had not asked and apologetic, but also curious about his own process around not asking this question. I believed his assumption was that given my apparent compliance and good response to advice-giving, the need to ask was negated. He confirmed this point and pledged to be more aware of this issue as he talked with his other clients.

The point in all this is that while patient's may or may not have a great capacity to receive advice from their doctors, physicians need to recognize that advice-giving is only one part of their job. They need to be prepared to inquire about the emotional aspects of the health issue in question; we as trainers can help with that. But, failure to understand the problems at issue may render the point of advice-giving moot.

Odds - 'n' - Ends

MINT-3 Scheduled for Italy
The third annual Training for Trainers in MI has been scheduled for October 9-11 at the Hotel Regina Elena in Santa Margherita Ligure, Portofino, Italy. We hope to attract a range of multilingual trainers who can further disseminate MI in Europe. If you know someone who may be interested in attending, contact Delilah Yao at the University of New Mexico: 505-277-2805.



The Big Apple

Nabila El-Bassel

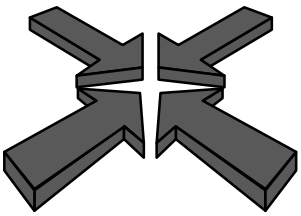
Some good news.
On January 22, 1995 I gave a three-hour training session on MI in Jerusalem at the first International Conference on Social Work in Mental Health (Israel).

On March 5, 1995 I presented a paper on: Motivational Interviewing in Drug Treatment: A Teaching Approach in Social Work Practice.

In January 1995, my colleague Dr. Robert Schilling (PI) and myself (Co-PI) were awarded a grant from NIAAA for one year to test the efficacy of MI in enhancing aftercare treatment among detox patients.

In Spring 1996, I will be teaching a graduate level course on MI at the Columbia University School of Social Work.

(Dr. El-Bassel is an Associate Professor at the Columbia University School of Social Work, 622 West 113th Street, New York, New York 10025).



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