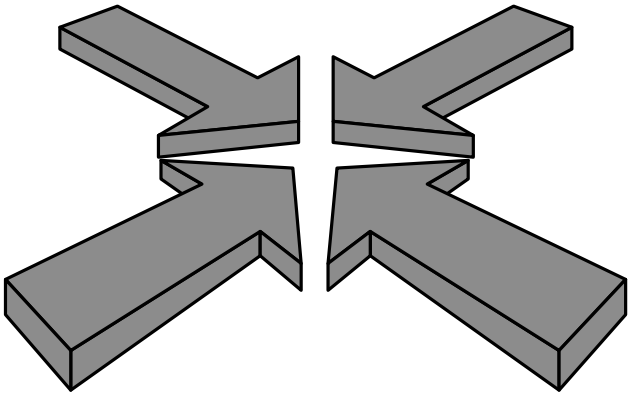
Motivational Interviewing Newsletter for Trainers

September 1, 1995, Volume 2, Issue 3



New Perspectives

From Across the Pond

Stephen Rollnick

A New Paper

We mentioned this in the last newsletter. After the 1994 MINT workshop we decided to write a brief paper (What is Motivational Interviewing, by Rollnick & Miller) which clarifies the definition and spirit of the method. This is now *in press* in Behavioral & Cognitive Psychotherapy and should appear alongside a few other papers on motivational interviewing. It should be useful in training.

Experiments with Smokers: Moving Beyond Readiness to Change

I mentioned this in the last newsletter. We have had fun. We paid smokers to allow us to practice new consulting techniques on them.

We puzzled over the fact that the readiness to change assessment seemed fragile and in the end, not very useful For example, unsure smokers did not always respond to an examination of pros and cons. We needed to approach this problem from a different direction. Se we decided to ask them why they had placed themselves on a particular point on the readiness to continuum, and not somewhere else.

What emerged was the distinction between **motivation** ("Do I want to quit?") and **confidence** ("Can I succeed?"). This corresponds to the distinction between efficacy and outcome expectations in Bandura's theory. We developed a simple brief assessment which involved asking two questions. They turned out to be so useful that we felt there was no need to assess readiness to change. We are now training family physicians to do this. It's a quick assessment (2-3 minutes) of how someone feels about their smoking. And it points to what the practitioner and patient should be focusing on.

Here are the questions. First, "How much do you want to stop smoking (**motivation)** right now. On a scale from 0-10, if 0 is not at all motivated, and 10 is very motivated, what number would you give yourself?" Second, "If you did decide to stop smoking now, how **confident** are you that you would succeed?" On a scale from 0-10...etc." The patterns which emerge are interesting and have immediate clinical relevance. If someone is high in motivation and low in confidence, their needs will be very different to someone who has the reverse pattern. Our general rule is,

if there is a problem with motivation, don't deal with matters of confidence just yet.

We then encourage the physicians to ask simple questions like, "You scored 5 on motivation. Why did you not give yourself a score of 1 or 2?". The answer is a self-motivational statement. Another useful question is, "You scored 4 on confidence, what would help you to get up to 7 or 8? What could I do to help you get there?"

I'd be interested to hear from people who explore this kind of work any further.

The Consultation from Hell

I can't resist returning to the subject of advice-giving raised with Geoff Williams in the last newsletter. Here is an excerpt from a transcription of a consultation with a diabetes sufferer. It's a good example of advice-giving at its worst. I shudder to acknowledge that the practitioner involved had received training from me lasting one hour.

Nurse: (Beginning of consultation) Last time I saw you, you decided you wanted to lose weight, and therefore I gave you some information about how to do this.
Patient: I can't lose weight, so forget that.
Nurse: OK, I'm going to ask you about that in a minute. We have talked about food and healthy eating in the past, and I would say that some of the things like puff pastry is made with a lot of fat, would you be prepared to...
Patient: Ah well, I don't have an awful lot of it.
Nurse: How many would you have in a week?
Patient: About a dozen, but they are only little ones.
Nurse: That's right, but they are still high in fat.

Of course, there are much more fundamental issues than how one deals with behavioral targets. David Rosengren's piece in the last newsletter about his diabetes says it all.

Setting Targets

This seems a lot trickier than I first thought. I was trained as a behavioral psychologist. Looking back, we fell into a crippling expert trap. We knew all the theory. Short-term, specific and manageable goals were the best to aim for. Practice was needed. Self monitoring would be particularly useful. But the patients often never returned with their self monitoring diaries. I shudder to think how many were written off as unmotivated!

In Cardiff, we trained a group of physicians and nurses in the use of target setting among diabetes sufferers. The transcripts of their consultations make compelling reading. The most striking observations were these: Firstly, the delicate balance between eating, exercise, weight and other behaviors and concerns were usually overlooked. Practitioners tend to talk about one behavior as if it occurs in a contextual vacuum. Premature focus is very common. Secondly, when they are setting goals with the patient, they not only make most of the suggestions, but they move from the general to the specific in huge leaps. "Thinking about your diet, have you though about telling the family that you will not cook fried for a few days each week?" This kind of problem is particularly acute with eating behavior, where the options are so numerous. If I choose, to control my weight by aiming to eat less fatty food (and there are numerous other options), this general goal can immediately be broken down into 2-3 smaller goals (e.g., less red meat, less cheesy food). If I choose one of these goals, a number of options open up, until ideally I arrive at a specific target (e.g., no fried food during the week). We need to find ways of helping patients move from the general to the specific in a helpful way.

Editor's Cup

David Rosengren

September Sunrise

I begin by admitting that I was caught off-guard for this column of the MINT. It seems my summer must have been a good one, because the publication date stole-up on me. Before I knew it, Stephen Rollnick's column was on my desk and I was looking at it in the sort befuddled look normally reserved for 3 a.m. questions from my 5 year old daughter. That I-don't-quite-understand-what-this-means-because-you-can't-possibly-be-asking-this-at-this-time look. So, the common sense thing would be to keep this brief; based on how much I've now written, it seems I may be lacking in that regard.

Over the Wire

I have talked to some of you over the past few months for one reason or another. Invariably you are doing something interesting that I would like to include in the newsletter. Unfortunately my memory, as I think we have just aptly demonstrated, is faulty at best. Without something written from you, it becomes lost.

For example, I phoned Kurt Dermen (Buffalo) to inquire about some work he has done with role induction as a precursor to treatment. In the course of that conversation he told me about the comparative trial now underway to test Role Induction vs. MI as a way to increase treatment compliance. We also discussed his ongoing involvement with Project MATCH's long-term follow-up. MET, a manualized variant of MI, was used as one of three interventions within Project MATCH. And Kurt, this is the part I apologize for, I swear you told me about a third project that you are involved with but I am drawing a blank. However, I did remember that Kurt was recently placed on the IR (injured reserve list) for MI trainers. It seems he broke his ankle while sliding into home with the winning run for his local softball team.

Meanwhile, Mary Velasquez has been busy doing presentations in a variety of settings. She and I discussed the relative merits of post-lunch activities versus lectures a while back. Her experience-based discovery was Stages of Change for trainees have mediating influences: time of day and degree of stomach fullness being two of these. I believe her conclusion was the appropriate formula for a presentation-matching strategy is: contemplation + 1 p.m. + full stomach = activity (or die). Unfortunately, I failed to heed that strategy recently myself.

Hello? Is This Thing On?

Well, if we learn as much from our failures as our successes I had a great educational experience a few months back. I was a presenter for one of the many workshops at the Northwest Conference on Addictions, a conference geared towards the practitioner with the majority of its attendees being CCDC and QCDC workers. This was my first time at this conference and, based upon my reception, it may be my last.

I began my post-lunch session with an exercise for the 50 or so attendees. They broke into small groups and answered questions among themselves about what is motivation. A consensus among group members was then reached (or at least attempted) and shared with the larger group. This exercise has worked well in the past and provides a check for the participants about where their thinking is at on these issues. It also provides a gauge for me about how to proceed. At least it usually does.

Now, it may have been a failure to fully appreciate the Velasquez formula for post-lunch presentations. It could also have been a presentation which misjudged its audience. It could have been a lousy delivery. Or it could have been the audience from hell. All I know is that my little shtick, which includes jokes, anecdotes and funny cartoons and that generally gets good reviews, barely got a chuckle. It had 'em in the aisles all right, but they weren't laughing. The funniest thing about the presentation was they all picked up my literature on their way out. Maybe they wanted to be sure they spelled my name right when they complained to the conference organizers.

The tough part was I had another workshop to do 15 minutes later. Still, that did decrease the number of self-deprecating comments I could make. Actually, I went to the bathroom and had a little self-directed pep-talk. I think the guy next to me was concerned about my having stopped my Haldol, but it seemed to help. The upshot is the next presentation went swell. People were engaged in the process. The role-plays were well-received. Heck, they even laughed at my jokes and cartoons. There was one dissenter who informed me that I wasn't a good listener, but I didn't pay any attention to him.

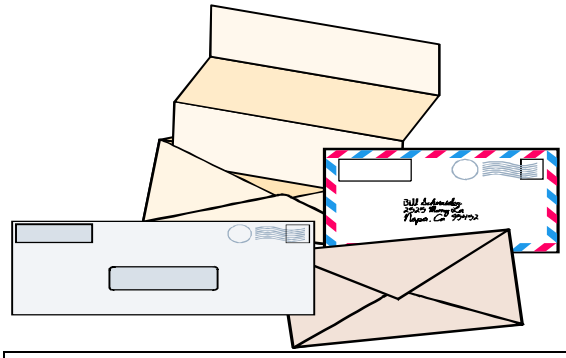
The final analysis was a mixed picture. There were basic strategic errors made that included a failure to accurately identify the audience and therefore not preparing appropriately, as well as not switching strategies soon enough when I encountered resistance. There were other conclusions as well. Use more action and less-talking with a non-academic trained crew. Integration of concepts is helpful, but sometimes more is less. Segues are important to flow and comprehension, particularly from activities to lecture. Four hours is insufficient rest the night before a presentation. Not exactly earth shattering revelations, but one's that I needed to revisit.

On the other hand, now I know why Letterman and Leno keep back-up audiences. To me, this may mean at times "it just ain't happenin". Rolling with resistance is one piece, but also recognize that some audiences, as with clients, are more resistant. Obviously, this does not excuse us from being fearless facers of our own shortcomings, but it also gives the other party the dignity of their own process. It also reminded me of the importance of being confident in your own skills as a therapist and trainer. Failure experiences don't exactly engender confidence, but they are not the end of the world either. At times like this I find the words of Stuart Smalley helpful. "I'm good enough. I'm smart enough. And darn it, people like me." (For those unfamiliar with Stuart, he is a spoof on therapists done by Al Franken.)

Professional embarrassment aside, I would like to invite folks to drop a line to share experiences about when things went less well. Feel free to talk about how you either snatched victory from the jaws of defeat or returned to fight another day. As with supervision, this process is only as helpful as we are willing to be self-revelatory about our less than perfect moments. So, please share the joys of being a trainer.

Mail Call

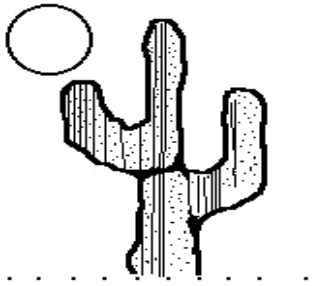
Just another subtle reminder that I'd like to hear from you.



Odds - 'n' - Ends

MINT-3 is still Scheduled for Italy

The third annual Training for Trainers in MI is still scheduled for October 9-11 at the Hotel Regina Elena in Santa Margherita Ligure, Portofino, Italy. There are still openings if you know someone who might be interested. If you know someone who may be interested in attending, contact Delilah Yao at the University of New Mexico: 505-277-2805.



Notes From the Desert

Bill Miller

Editor's note: Bill's column will resume next issue. The Editor was late in sending a reminder and Bill was unable to meet the compressed deadline. My apologies to Bill and to the readers.

Inquiries and submissions for this newsletter should be forwarded to:
David B. Rosengren, Ph.D.
Alcohol & Drug Abuse Institute, University of Washington
3937 - 15th Ave. NE, Seattle, WA 98105
Tel: 206-543-0937 Fax: 206-543-5473
Email: dbr@u.washington.edu

This newsletter is made available through support by the University of New Mexico and the Alcohol & Drug Abuse Institute at the University of Washington.