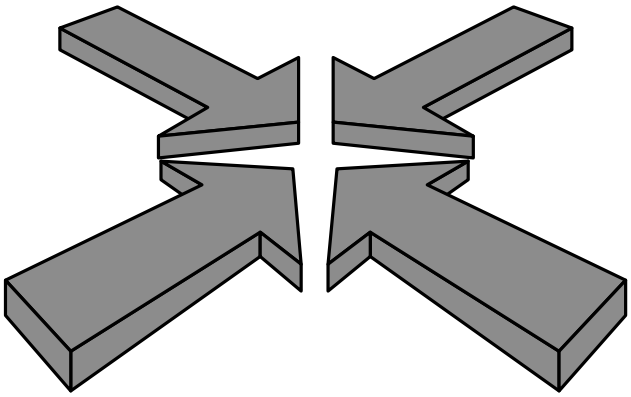
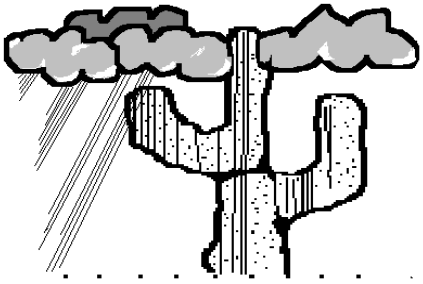
Motivational Interviewing Newsletter for Trainers

September 1, 1998, Volume 5, Issue 3

A Publication of the International Association of Motivational Interviewing Trainers



New Perspectives



Last Installment from the Wetlands

Bill Miller

This time I offer a short note and a longer essay. As I send this to David I am packing up my office for the drive home from sabbatical. We're due back in Albuquerque around the 15th of August, so this will be my last message from the wetlands.

Our outcome study on training motivational interviewing is coming to a close. I have had a great time collaborating on this with MINTies Kathy Mount, Steve Berg-Smith, and Denise Ernst, and other capable Kaiser staff. We have analyzed questionnaires, videotapes, and audiotapes from 20 trainees at the Washington County Community Corrections program. We have a new system for coding tapes that I'll be glad to share with those of you who might want to use it. We found it particularly stimulating to code videotapes and then, in staff meetings, discuss and debate our coding. It gets right inside the process of motivational interviewing, analyzing what is happening (and why) at a verbal exchange level. The full system is far too complex to use in training of groups, but we found it stimulating to use as a clinical research team. I can also imagine this being a useful tool in training and supervising individuals. We have coded some sections of the new training tapes, and will be developing some norms on the scales so that the system can eventually be used to provide personal feedback.

Project COMBINE (Combining Medications and Behavioral Interventions) is proceeding through its design phase. It is NIAAA's new multisite collaborative trial, this time involving 11 U.S. clinical sites. The current plan is to test two medications crossed with two levels of behavioral intervention: (1) medical management that could be done through brief visits in a healthcare setting, and (2) a psychosocial therapy that combines elements of all three Project MATCH treatments: motivational enhancement therapy, cognitive-behavior therapy, and twelve-step facilitation. Meanwhile in the UK, another multisite clinical trial (UKATT) will be comparing brief intervention with a more complex psychosocial therapy for alcohol problems.

Through the reflective time of this sabbatical and a few recent experiences, I've gotten to thinking again! The essay that follows was stimulated when someone asked me about "the motivational model of addiction" that underlies motivational interviewing. I said a few things, and then remembered a story that I once heard poet/singer/writer Rod McKuen tell. He was reading some of his poems in San Francisco, and someone asked him if they were from a collection. "Yes," he said, and was then asked for the name of the book. *Stanyon Street and Other Sorrows*,

he replied. "Then I went home and started writing it."

If you know the history of motivational interviewing, that's how it all started. Here's another rough draft installment.

* * * * * * *

Toward a Motivational Definition and Understanding of Addiction

It has seemed intuitively obvious to me that addiction is fundamentally a motivational problem. I created quite a stir, however, when I uttered those words recently in the midst of an expert panel. I was nearly tarred and feathered for "resurrecting the moral model."

It turns out that the discomfort raised by saying that addiction is essentially a motivational problem has to do, in part, with a simplistic understanding of motivation. It is easily equated with the "Just say no" bootstrapping perspective that one should just, as the Brits say, "pull one's socks up" (I love that) and behave sensibly. That view does, indeed, reduce to blaming people for their problem.

Volitional Control

To say that choice is involved in addictive behavior is not to say that it is *only* a matter of choice. Janice Brown and I have proposed that one could quantify the proportion of variance in a behavior that is amenable to volitional control (Brown, 1998; Miller & Brown, 1991). That volitional quotient would vary within the same person over time, and differ across behaviors for the same person, and across people for the same behavior. Some behaviors, such as speech, are readily controlled by conscious attention (although one thinks immediately of individual variability in this as well). Some, like breathing, are controllable within some clear limits. Other phenomena that are ordinarily beyond volitional control can be brought under partial conscious control through training (such as biofeedback) and practice. The degree of variability among people in the volitional quotient will vary across behaviors. Some people find overeating extremely difficult to control, while others rarely give it a thought. With regard to drug use, a person's volitional quotient may vary widely across classes of drugs.

Within this perspective, addiction can be thought of (at least metaphorically) as a declining volitional quotient for a particular behavior or class of behaviors. The degree to which it can be controlled (stopped or reduced) by conscious intention diminishes over time. Perhaps more accurately, volitional control *varies* more across time and situations, which is consistent with Mark Keller's redefinition of loss of control as unpredictability. The subjective version of this is "using more than I intended." In natural usage, the term "addiction" implies some reduction in volitional control of a behavior.

Yet diminished volitional control of behavior (sometimes termed "diminished capacity" in criminal law) is a necessary but not sufficient condition for what people refer to as addiction. Over time, a person with Parkinson's disease experiences diminishing control over tremors, but no one would call this addiction. The term requires a further judgment that there are conditions under which the person *could* exercise volitional control, which brings us a step closer to natural language usage. Studies in the 1960s clearly demonstrated that even chronically dependent drinkers with access to alcohol could regulate their drinking given sufficient incentives to do so, at least under controlled laboratory conditions (Heather & Robertson, 1983). More recent treatment research using monetary payment for drug-free urines similarly illustrates the ability of chronically dependent users in the community to alter their cocaine and other illicit drug use in response to incentive. Even the most extreme "disease model" programs that profess solely neurochemical origins of addiction ultimately rely upon the client's volitional abstinence (Milam & Ketcham, 1981). Neither intoxication nor substance dependence mitigates responsibility for committed crimes in the minds of most juries. Indeed, a majority of America's 1.6 million prisoners are incarcerated for crimes committed under the influence of alcohol or other drugs. This, too, reflects the public view that addictive behaviors may involve diminished but not abolished self-control and concomitant responsibility. Self-regulation is *retrievable*.

Diminished Deterrence

A diminished but retrievable capacity for self-regulation is still not sufficient to constitute what people mean by addiction. Individuals with

Parkinson's disease can often stop or diminish their tremors by conscious effort, at least until more profound deterioration occurs. A further condition for addiction is that it inflicts apparent risk or harm to oneself and/or others, and yet persists. Abstinence from food yields a withdrawal syndrome (hunger, malnutrition) but eating does not constitute an addiction in public usage. Only overeating does, in that it inflicts risk and harm. Nor does persistence despite harm by itself warrant application of the term "addiction." Criminal behavior often persists despite the fact that it inflicts harm at least on others, yet it is rarely regarded as addiction. It is the *combination* of (1) a behavior persisting despite apparent risk and harm, and (2) diminished but retrievable capacity for self-regulation that constitutes what is meant in social usage of the term addiction, at least in the United States.

It is also what has usually been meant by the term "addictive behavior." These two defining characteristics are not limited to the use of dependence-producing psychoactive drugs. Although the establishment of physiological dependence contributes to diminished capacity for volitional control, some of the most widely abused drugs produce little or no withdrawal syndrome. Further, the same conditions for addiction are met by a variety of "compulsive" behaviors such as pathological gambling, which only by the wildest stretch of imagination can constitute a "brain disease." What does and does not qualify as addictive is determined, at least in natural language, by a very large degree of sociocultural judgment about the above two defining conditions.

The description of a dependence syndrome expanded the diagnostic concept of dependence beyond its prior limits of physiological tolerance and withdrawal. It added a set of behavioral components that can now constitute a dependence diagnosis in themselves, even in the absence of physiological adaptation. Those symptoms boil down to an inordinate priority given to the behavior: increased time spent in the (drug-related) behavior, deferent withdrawal from other activities, decreased variability in the addictive behavior, persistence of the behavior despite risk and harm, avoidance of situations where the behavior is inaccessible, high priority given to the behavior when resumed after abstinence (rapid reinstatement), and subjective sense of diminished ability to restrain the behavior.

Said another way, the two defining conditions of usage for the term "addiction" are:

1. The person is willing to pay a price for the behavior that seems, from a normative social judgment perspective, inordinately high.

2. The person is judged to have diminished ability to regulate the behavior.

It is the latter of these two conditions that brings with it decreased social blame and censure for the harm caused. In criminal law, there are mitigating conditions such as diminished capacity, absence of general and specific intent, and insanity. In society, the imagery of illness is more often used to describe diminished capacity (mental illness, addictive disease). The beneficial sociologic functions of claiming "sick" status have been well described by Talcott Parsons. The assignation of disease or illness provides the individual with access to well-established forgiveness and restoration rituals. There are, however, other routes to compassionate understanding, and the sick role itself has disadvantages. Ironically, those who endorse beliefs consistent with the disease model of alcoholism also tend to endorse moralistic attitudes such as "alcoholics are liars and can't be trusted" (Moyers & Miller, 1993). The disease model, at least in the U.S., has become intertwined with the very moralism it was intended to overcome.

Too High a Price to Pay

Some fascinating current research is exploring why it is that certain harmful drugs (such as tobacco) and behaviors are so powerfully reinforcing. Some drugs, such as cocaine, are so inherently rewarding that laboratory animals will work to the point or exhaustion or starvation in order to continue receiving doses. Other addictive behaviors acquire their reinforcing properties. Gambling is rewarded on a variable ratio reinforcement schedule, one of the most potent schedules known for producing high rates of behavior that are resistant to extinction.

Besides diminished volitional control, what qualifies high-rate behaviors as addicting is that they persist despite harmful consequences. The person is willing to pay what seems too high a price in order to continue them. Said another

way, motivation for the behavior has become more attractive than alternative rewards. Again, it is not the case that the person is *completely* unable to regulate the behavior. Given sufficient incentive - in extreme, a million dollar reward or a gun to the head - self-control is possible. In fact, much smaller rewards have been shown to regulate the use even of highly reinforcing drugs like cocaine and heroin (Higgins et al., 1993; Stitzer & Kirby, 1991) and of alcohol in dependent individuals (Heather & Robertson, 1983).

Competing Motivations

The problem of addiction, then, is one of competing motivations. The term "motivation" here is understood not simplistically as will power, but as involving complex biopsychosocial factors. A classic psychology course in motivation covers a broad range of determinants of behavior including biological drives, learning and conditioning, cognitive processes, emotion, and social influence. A similarly broad perspective is needed to understand the factors that interact to yield the phenomenon of human addiction, where the motivations favoring continuation of the behavior outweigh its harm and the perceived value of available alternatives. It is unsurprising that addictive behaviors seem irrational, because rational cognition is only one of a host of motivational factors.

The route out of addiction involves finding alternatives that are more motivating. Again, the competing motivations may be multiple in number and kind. The suffering associated with an addictive behavior tends to increase over time, shifting the ratio of pros and cons. This is reflected in the concept of "hitting bottom" and having "suffered enough" for change to occur. There is wide recognition of the concept of "high bottom" individuals whose behavior turned around before negative consequences reached dreadful proportions. Decisional balance models and more recent behavioral-economic analyses (Tucker & Vuchinich, 1998) also reflect this perspective of competing motivations.

Sometimes the shift of balance seems utterly external and obvious. A medical professional is caught diverting opiates, and his or her license and livelihood depend on clean urines. A parent is threatened with the loss of marriage and family. A sizeable estate is inherited, with installment payments contingent upon being a non-smoker. An employer gives a worker one more chance to sober up in order to keep a lucrative and rewarding job. In cases such as these it is plain that contingencies have shifted in the social environment. Staying drug-free becomes more reinforcing than continued use, which is now reliably followed by a loss of significant sources of positive reinforcement.

Then there are those one-time occurrences, even "oddly trivial" events, that people often name when asked about why they quit. These events do not in themselves signal an actual change in social reinforcement contingencies. A cocaine user's eyes slightly shift focus, and he sees himself in the mirror behind the line of powder. A smoker's dog dies of lung cancer. A dependent drinker's beloved pastor stops by for a visit while she is at home intoxicated. Or my favorite example: Premack's (1970) smoker who leaves his children standing in the rain in front of the library while he drives away for cigarettes. What is happening here? Premack called it "conscience." Whatever it is, it seems to involve a sudden shift in meaning, in how the person perceives the pros and cons of the behavior. In one sense, it is as though one or more cons have suddenly become dramatically more salient, taking on a higher value weight. In another sense, it is as if the person steps outside the self for a moment, to see himself or herself from another perspective.

I wonder if this points us to some pieces of the puzzle that has been occupying me for some time: Why is it that motivational interviewing works at all? We seem to know the style and strategies, the operations that evoke change. We know (I think) how to teach people to do it. The efficacy of the approach is replicable across cultures. But *why* does it work? How can it be that a person who has been persisting for years in a pattern of dependent drinking or drug use despite clear negative consequences, abruptly shifts that pattern after an hour or two of motivational counseling? How is it that having a single session of motivational interviewing before beginning a course of outpatient or inpatient rehabilitation program can double a person's chances of abstinence three months later? The person has learned no new coping skills or conditioned responses, and there have been no changes in the "actual" external contingencies operating in the person's life. The effect of a single counseling

session ought to be lost, overwhelmed, drowned by the noise of the social environment. Yet it is not. What theory do we have about what is going on here?

I'm not sure that I can do much better than metaphor at this point, but a picture is starting to emerge in the puzzle. It seems to me that without any overt changes in the external environment, the client nevertheless leaves a successful session of motivational interviewing with a new set of contingencies. From Julian Rotter to radical behaviorism, after all, contingencies have been recognized to be *perceived* relationships between behavior and consequences. Rule governed behavior is characterized (and sometimes faulted) for its unresponsiveness to "actual" contingencies in the environment. A cognitive map of how things are overrides how things "really" are. It is the *perception* of consequences, and not only veridical schedules of reinforcement, that shapes behavior. What we are seeing in motivational interviewing may be a sudden shift in how the person perceives the consequences of his or her behavior, and perhaps in the salience of those consequences. It is *as if* the person leaves with a whole new set of contingencies governing (or beginning to govern) the behavior. Some might describe this as a shift in the stimulus equivalence set to which the behavior belongs.

How does this happen? I have placed a good deal of emphasis on eliciting self-motivational statements from the client. This *feels* right to me, and is consistent with Daryl Bem's self-perception theory, but I confess I am not certain that this is how it works. Another possibility that occurs to me is that for a brief time in motivational interviewing, we lend clients another perspective, a mirror, a chance to step safely outside of their own frame of reference and to see themselves with new eyes. This is not done by saying, "Listen to me. Here is how I see you," which places the person in the role of a passive listener. It is done by a temporary kind of merging. From the perspective of the therapist we call it empathy, seeking to see the world through the eyes of the client. In a metaphoric sense, we temporarily step inside the client, or better - become one with the client. Naturally, this improves the therapist's understanding of the client, but I think that it also changes *the client's* perspective. It is as if the client, too, can step into this empathic frame of reference and look back upon himself or herself.

I think that at least two things happen when that is done well. First, I believe that the client is able to see, saliently, some of the consequences of his or her own behavior, as from the perspective of an observer. Call it shame or conscience or hidden observer, there is a conscious process of perceiving in a new way, of seeing, *feeling*, contingencies. Second, I believe that we also lend clients our perspective of hope for them (Yahne & Miller, in press). It is the magic in my favorite Pygmalion study (Leake & King, 1977), and it is the madness of Don Quixote. From the merged perspective of empathy, the person sees that something is *possible,* and the seeing begins to make it possible. It was Fritz Perls' definition of teaching: to show a person that something is possible. We refer to it as supporting self-efficacy, but I think it's more than telling a client, "you can do it." It is somehow helping the client *see* that he or she can do it.

This is quite comprehensible from the perspective of a health belief model and the appraisal theories that have succeeded it, or from self-regulation theory. Protective change occurs when a person sees (1) a serious risk (discrepancy), and (2) the possibility of decreasing it. The four types of self-motivational statements that we have recommended be elicited from clients are statements of perceived problem, concern, intent to change, and ability to change. Turn the model around to promote approach rather than avoidance, and change occurs when a person sees (1) a worthwhile goal (discrepancy), and (2) the possibility of attaining it. The self-motivational statements then become statements of perceived opportunity, value, intent to attain it, and ability to attain it.

How, then, does all this relate to addiction as a phenomenon of natural language? Recall that addiction is perceived by an observer when a behavior appears to be continually pursued at too high a cost, and there is diminished capacity for self-control. When the *client* becomes that observer, liberation from addiction occurs as he or she sees - in this case through the eyes of an empathic merger - that the cost of the behavior is indeed too high, and that he or she does have the means to change it.

According to Rabbi Dr. Abraham Twerski, the capacity to take the perspective of another and to

consider the consequences of one's actions is one of the features that distinguishes human beings from other living things. It is one of those differences between people and animals to which Frank Logan (1993) alluded in saying that we possess good animal models of the acquisition of addiction, but not of recovery. When we temporarily merge with another person empathically, we not only take on that person's perspective but also lend them one. I again raised some eyebrows recently by saying to a scientific audience that this is essentially a form of loving.

In any event, I see an emerging motivational model of addiction. It differs in some ways from, or at least builds upon, the motivational model of behavior change implicit in motivational interviewing. The preceding is a very rough attempt to stimulate some thought (my own, but especially yours) toward a theoretical model that could guide our clinical work through a coherent understanding of the problem we seek to treat. Because the model involves a balance of perceived contingencies, it does not negate and can incorporate a broad range of biopsychosocial motivations that are involved in addictive behaviors. I have illustrated my raw, unpolished thinking process, rambling through studies and stories, law and literature, metaphors and a bit of mysticism. Who has some more pieces to this puzzle?

Bill Miller

References

Brown, J. M. (1998). Self-regulation and the addictive behaviors. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors* (2nd ed., pp. 61-73.

Heather, N., & Robertson, I. (1983). *Controlled drinking*. London: Methuen.

Higgins, S. T., Budney, A. J., Bickel, W. K., Hughes, J. R., Foerg, F. E., & Badger, G. J. (1993). Achieving cocaine abstinence with a behavioral approach. *American Journal of Psychiatry, 150*, 763-769.

Leake, G. J., &King, A. S. (1977). Effect of counselor expectations on alcoholic recovery. *Alcohol Health & Research World, 11*, 16-22.

Logan, F. M. (1993). Animal learning and motivation and addictive drugs. *Psychological Reports, 73*, 291-306.

Milam, J. R., & Ketcham, K. (1981). *Under the influence: A guide to the myths and realities of alcoholism*. Seattle, WA: Madrona.

Miller, W. R., & Brown, J. M. (1991). Self-regulation as a conceptual basis for the prevention and treatment of addictive behaviours (pp. 3-79). In N. Heather, W. R. Miller, & J. Greeley (Eds.), *Self-control and the addictive behaviours*. Sydney: Maxwell Macmillan Publishing Australia.

Moyers, T. B., & Miller, W. R. (1993). Therapists' conceptualizations of alcoholism: Measurement and implications for treatment. *Psychology of Addictive Behaviors, 7,* 238-245.

Premack, D. (1970). Mechanisms of self-control. In W. A. Hunt (Ed.), *Learning mechanisms in smoking* (pp. 107-123). Chicago: Aldine.

Stitzer, M. L., & Kirby, K. C. (1991). Reducing illicit drug use among methadone patients. In R. W. Pickens, C. G. Leukefeld, & C. R. Schuster (Eds.), *Improving drug abuse treatment* (pp. 65-90). Rockville, MD: National Institute on Drug Abuse.

Vuchinich, R. E., & Tucker, J. A. (1998). Choice, behavioral economics, and addictive behavior patterns. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors* (2nd ed., pp. 93-104). New York: Plenum Press.

Yahne, C. E., & Miller, W. R. (in press). Evoking hope. In W. R. Miller (Ed.). *Integrating spirituality in treatment*. Washington, DC: American Psychological Association Books.

Important MINT Dates

Submission	Publication
12/1/98	1/1/99
4/1/99	5/1/99
8/1/99	9/1/99

MINTies (and others interested in MI) are invited to submit pieces for the MINT. Remember, it doesn't have to be perfect. MINTies consistently state that hearing from other trainers is one of their greatest desires for this newsletter. So, send it on in.

Correspondence

Hi David,

A MI work update. I have received a small contract with the Ministry of Human Resources (MHR) in B.C. to investigate the adaptability of MI with the Financial Assistance Workers (FAW's) in Region 5. These are folks who determine eligibility for Income Assistance (i.e. welfare), and then try to motivate their clients to access a variety of programs designed to help them get off assistance and attach to the labour market. This has been driven by economic realities, plus reorganization, new mission statements etc. For the first time the word "help" appears in the MHR mission statement. Their mandate focuses primarily on this attachment to the labour market, "and when necessary income support & related services". This project certainly seems to have challenges & possibilities.

The milieu has the identified ingredients where MI has cut its teeth: large caseloads & tight time restrictions; multiple, enmeshed & difficult behaviour change; an interpersonal context too frequently fraught with historical power & control issues; & serious “nonnegotiables” the legislation isn't going to change. So…we have adapted a motivational approach to the process. I am to write a training manual that adapts MI to this specific target population, with specific case scenarios, tools etc. The steering committee includes the various stakeholders. A questionnaire is going out to the 80 FAW's in the region. We will do a 2 day training in November with 16 self-selected FAW's, followed by a 1 day follow up in December, and then gather feedback about the applicability of MI to this market. I haven't seen any evidence of other work in this area so am interested to hear from all interested parties. Anyway, David, have a great rest-of-the-summer, and see you in the Fall.

Fran Jasiura

Box 43011
Okanagan Centre, B.C. Canada V4V 1Z6
Phone & fax: 1-250-7660229
Email: fjasiura@cablelan.net

Fran plans to attend the IAMIT meeting in Newport and wonders if there is another woman who would be interested in sharing a room. If so, contact her at the listings above.

Editor's Cup

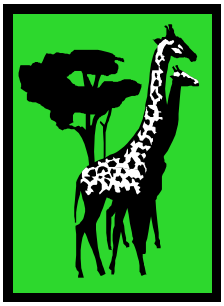
David Rosengren

One of the true joys of my work life is the opportunity to have friendships with people all over the world. A related benefit has been to live vicariously through these friends. In this issue I wanted to share those benefits with you.

Angelica Thevos, a friend and colleague from Project MATCH days, works for the Medical University of South Carolina. She recently journeyed to Zambia to implement a study with a MI component. The challenges of doing a project in this developing country were intriguing to consider. Added to this, was the ability to watch her journey unfold through emails over the Internet. A running travelogue allowed us to track her progress and “talk” as this project progressed. This was truly a fascinating process to behold and I decided that you might enjoy it as well. Therefore, in this issue, you will find a brief description of her study and Part I of her Travelogue. Part II will be included in the next issue.

For privacy reasons and because of space limitations, I have edited Angelica¹s messages. For clarification purposes, you’ll find a few references to Tony (husband) and John Anthony (6-year-old son), but mostly what you’ll discover is a lyrical description of an experience in Africa and the joys and trials of a MI study in a developing country. I also think that Angelica¹s warmth, enthusiasm and passion come shining through.

Angelica will be participating in the upcoming Newport MINT training. If you enjoy her travelogue, I hope you will let her know. Perhaps we can prevail on her to show some pictures...



MI in Zambia

Angelic Thevos

A study funded by the Centers for Disease Control and Prevention represents the first application of Motivational Interviewing (MI) principles using health workers directly from a community in the developing world. The study, conducted from March to June of this year, focused on implementing point-of-use disinfection and safe storage of water practices for the prevention of diarrhea in Zambia, Africa. There were other donors to the project as well, such as the United States Agency for International Development (USAID) and the Tropical Diseases Research Council. The specific site for the intervention was the community of Ipusukilo in the town of Kitwe, which is in the Northwestern part of Zambia. This part of the country is known as the Copperbelt. Zambia is bordered by eight countries, including Angola, Republic of Congo (formerly Zaire), Tanzania, Malawi, Mozambique, Zimbabwe, Botswana, Namibia. It is located north of Zimbabwe in the sub-Saharan, south-central part of the African continent.

Diarrheal disease is a leading cause of morbidity and mortality in children less than 5 years old in Zambia (and most other developing countries). The recurrent outbreaks of cholera are evidence of the persistent problems with water quality and sanitation. The project used a simple, inexpensive, easy-to-disseminate and effective intervention to improve drinking water and hygiene. It has three elements: (1) point-of-use (or household level) disinfection with a sodium hypochlorite solution (the same as weak chlorine or bleach) produced locally with simple technology (using salt, water and electricity); (2) a 20-liter plastic storage vessel with a lid and a spigot; and (3) education about the causes and prevention of diarrhea and proper use of the intervention.

The intervention used MI to promote long term behavior change in safe water handling practices. The idea was to augment the educational component of the project with MI behavioral change methods. The study compared a standard Education Only intervention with a Motivational Interviewing intervention. Local Neighborhood Health Committee members (NHCs) from the community of Ipusukilo were trained in basic MI theory and practice. The focus was to influence the use of chlorine in the treatment and safe storage of household water in the project population.

Zambian Travelogue – Part I

Transmission 1

My first day in the field was the most intense experience of my life, bar none. The poverty of the village (called Ipusukilo) beats anything National Geographic or TV could ever portray. The sights, smells, feelings, and thoughts are almost too much to bear. This place has the depth and complexity that defines a developing country. People live 10 or more to a house with one bedroom and one "living room/kitchen". The houses in the compound are on top of each other. There is no electricity. Food is scarce. Children are sick and some are dying - and they are everywhere! The houses are dark, with only a small opening for a window in order to keep the heat out. Yet the dignity of the place and its people is astounding. The yards are clean with houseplants in any kind of container imaginable. Some can afford to have animals like chickens and ducks so they are living in the mix as well. They do what they can to beautify their yards with stones and plants. And they are always washing clothes and table coverings and leaving them to dry on the bushes. Their daily work to survive is very hard.

The first week we completed the baseline survey and did some focus groups. As soon as we arrive at the houses, the people bring out small handmade "benches" that are only a few inches off the ground and only seat one person. But they offer them with pride and I receive them with deep respect. They try to decorate their homes with whatever they can. There are plywood tables and broken chair seats, but they are adorned with hand crocheted or embroidered coverings whenever possible. The women wear skirts made

of one piece of colorful cloth that is tied around their waists. They carry the smaller children on their backs, wrapped in the same kind of colorful cloth. Packages of all shapes and sizes are carried on their heads, just like we have always seen as stereotypic of Africa. Children of 3 or 4 years old carrying smaller babies on THEIR backs are a common sight. The children are too many and most, if not all, are malnourished. On the second day, I saw two children, one about one year old and another maybe 5 months old who seemed near death. I can not adequately describe the depth of feeling and experience this is. After the first day, I cried.

The study is exciting. And the people are wonderful. The language (Bemba) has a beautiful lilt to it, and most of the people (outside of the village compounds) speak English, which is great and makes things much easier. We are working with people who have a deep commitment to making a change in their lives and in their communities. The nurses and neighborhood health committee workers are beautiful, warm people. The first week, we went into the town of Kitwe to meet with the City Council. That, too, like everything here, was amazing. They are trying to do so much with very little resources and there are some very talented people (along with lots of the same old bureaucratic, negative types too of course). They are textbook examples of new organizations and they have such an incredible agenda! Their problems are of a magnitude that we can only guess at, yet they have the courage, strength, dignity, and fortitude that is indescribable.

This is a very malarious area, particularly in the compounds. Yet I unfortunately got a terrible reaction to meflaquine (Larium) which I was taking as a malaria prophylaxis. The side effects were awful: not sleeping at all for at least 2 weeks, lots of anxiety, visual distortions, tremors, stomach upset, etc. But I endured - not knowing it was the Larium – and continued working throughout. When I look back on it, I am amazed I was able to do that given how horrible I felt. Luckily we were in Lusaka, the capitol, when the effects peaked and I got to the American Embassy Health Clinic for instant diagnosis and some help. Apparently, this is quite common to the point where European docs no longer prescribe it.

We went to Lusaka during my second week here. During this time, we had an intense schedule of meetings. For three solid days we met with: the US Agency for International Development (one of our main sponsors for this study); the Japanese equivalent to USAID, many top government officials including the new Minister of Health; and several of the Heads of Divisions within the Central Board of Health for the Republic of Zambia. Then there was UNICEF, CARE, Rotary Club, the Peace Corps, the Red Cross, Basics, Population Services International, and many other NGOs too many to name. We are trying to find support to bring a mold to make our water vessel here in Zambia, as it is too expensive to import. There was a great deal of enthusiasm and it appears we may be able to secure a tri-continental cooperative effort with Rotary of USA, Japan and Zambia, along with USAID in Zambia and Japan to pay to get the mold and production of the vessels here. The Peace Corps is also very interested in field testing a prototype of a portable chlorine machine that volunteers can carry on bicycles to villages to make enough chlorine to disinfect water for 400 families a week. The Peace Corps Coordinator for all of Zambia stopped by the GuestHouse this morning since they do training for aquacultures nearby and we showed the prototype to him and to several of the volunteers. They are also very excited about investigating the possibilities for incorporating Motivational Interviewing training into their curriculum for new volunteers. Their Director of Training will be meeting with me this week regarding the MI intervention.

It is very hot here during the day. The first week we had magnificent thunderstorms throughout the days and then cooling temps at night. But that abruptly stopped about four days after I arrived. It is still hot, but no rain since. The sky is gorgeous and the clouds change by the minute. The stars are spectacular. Diarrhea and malaria rates are increasing in the compounds, as our weekly diarrhea surveillance data reflect. The village where we work is about a 35-minute walk from where we are staying so we just carry jugs of boiled water with us and move through this work. There are tremendous highs and lows in emotional intensity, which this story only hints at. Tony and JA have not visited the compounds yet, as I am keeping to the plan to break them in slowly. I had a most extreme introduction that was too much, compounded by the Larium

reaction. But it is settling down for me now as I get more adjusted. I have been working on developing the training materials (thanks to Mary Velasquez and Dave Rosengren for their help!) for about 4 of the nurses here, who will in turn train the Neighborhood Health Committee workers in much more simplified techniques. I have devised a second substudy involving only the nurses, as it is clear that the NHCs will not be able to provide "pure" motivational interviewing at their level of skill. The nurses may be able to, though, and that is worth a separate small study (of the t-test variety). The details of all of this are still evolving.

So that is all for now. The length of this message speaks to the amount of time and experience that has elapsed since I arrived. Future dispatches will be much shorter, I imagine, but will follow sooner - barring any more technological glitches. Until next time...Shalenipo oom quai....

Angelica

Transmission 2
Muli Shani.

The intense impressions of Africa continue. There is so much to say, so much that I have not mentioned, so much that I have neglected, and so much that undoubtedly escapes me.... I continue to work hard here, as always. That state is the most comfortable to me, as you all know. It allows me to channel my energy. In typical African style, the meeting was supposed to start at 9 am and end at 10, but began after 10 and continued to at least 12:30 (at which time we respectfully excused ourselves)....

I met with people from the Copperbelt Health Education Program this week as well. We saw their sign (which is right next to one of two places in town that have copy machines and sell copies) so we decided to go there to get some feedback on the drawings that Tony is doing for the educational piece of our project. Drawings are essential, as most of the people in the compounds are illiterate. While at the Health Education offices, I briefly described what I intend to do here and, as I am finding every time I talk about it, they too are very interested in Motivational Interviewing. I hope to talk with someone from their organization that develops training for the health workers working on HIV/AIDs in this area. Africa has 2/3 of the world's AIDS cases but only 1/3 of the world¹s population. Whole villages are wiped out as a result of the epidemic. So the need here is so great, and the people are so eager for new and useful information, that it is overwhelming. At the same time, their eagerness is so refreshing...it beats any graduate student that I have ever met. And it is almost impossible to say no....

I have been walking to the Ipusukilo Health Clinic, where we are based for this project. Walking is easier and cheaper. The roads here are beyond description - potholes are an understatement. These are dirt roads with holes that are enormous. The roads that have been tarred at one point in time have so little tar left that they are indistinguishable from the dirt ones. Cars are in terrible shape - doors don't open, liquid often is leaking out of surprising places, windows that actually work are nonexistent, and I think we have never been in one car that has an intact windshield. Plus there are no speed limits and cars race through at dizzying speeds, dodging the potholes, other cars, and pedestrians like us. Even though people here are supposed to drive on the left side of the road, the entire area is up for grabs so one never knows which way the cars are going to go next. What an experience! We do take "taxis" into town though, because that is a very long walk. The taxis are generally anyone that has a car that is willing to drive you somewhere. Negotiation of the price at the outset, before you set foot in the car, is mandatory.

The women here are so remarkable. They are so strong, contribute enormously (if not completely) to family and community, do most of the work, have tons of babies, are filled with love, and deal daily with deep disappointment and burdens that we can not even imagine. They do all this and more without a whimper of complaint or acknowledgment of suffering. They also are adequately represented at all the committee meetings I have been at so far. And Frederick Chiluba, the President, has appointed the first women to his Cabinet: the Minister of Health and the Minister of Finance.

We met personally with the new Minister of Health while in Lusaka for meetings. She is an ambitious, friendly, bright, and very African woman - with a

Masters in Microbiology, a Ph.D. in the same, a certificate in infectious diseases, and an MD. She was impressive to say the least. As an interesting comment on this culture, we read in the paper this week that she was ousted out of Parliament because her dress was too short (just above the knee!)!!! I am anxious to see how she responds to it. She is not the type to take an incident like that passively. When we visited her, her office was completely filled with flowers (mostly miniature roses which seem to be big here in Zambia) in congratulations for her new appointment. She mentioned that if all the flowers in her office and home were vegetables they would be put to better use, but was also quick to add how much she loves flowers. It was clear that she had many well wishers who care a great deal about her. She has a practice of "adopting" bright children who are doing well in school and finances their education for as far as they can or will go. She told us of a tragic story (there are many) of one of her favorites who had just died the Sunday before our meeting together. The girl was hit by a car (another common occurrence as the above paragraph attests to) and hung on a few days. Dr. Luo missed meetings and attended to the child personally and enlisted the best surgeons she could find but the child did not survive. She had tears in her eyes just relating the story to us. Africa is full of stories like that. And full of compassionate, full people like Prof. Luo. Adversity brings out the best in people and breeds the most courageous and transforming responses.

The children here are also of a whole different nature than our American counterparts. It seems as though the very tiny ones (less than a year old) are the equal, if not more advanced than their American counterparts. Zambian babies go everywhere riding on their Moms[1] backs, strapped in with colorful pieces of cloth. I am still amazed at HOW they manage to stay put. Sometimes they are actually upside down when their Mom[1]s are bending over doing chores and still they stay wrapped in those cloths! The Mom[1]s just pull them from back to front when they need to nurse them. Then, often before they are a year old, they are off their mother[1]s backs to make room for the next baby. That is when they lose developmental ground, I think. The younger children, starting at toddlers, are quiet and almost listless. They just hang around, quietly. Not anything like the kids we know at home. There are no toys. In fact, the older kids play with plastic bags wadded up and tied with string to make a "ball". I also saw one creative 8 or 9 year old who constructed a kite from a plastic bag and sticks. It actually flew a little. Some play with bottle tops in a circle of dirt. Others just roam in groups. All are quiet. But yet they also giggle and run together -especially when they see us Americans. It is unusual to hear a child cry. And, as I think I have mentioned before, children of 3 or 4 years old are carrying younger ones on their backs while they do the business of the household, like laundry and fetching water. I think that the lack of stimulation by their moms contributes to their passivity. Their mothers simply do not have the luxury of time to play, educate, or otherwise stimulate them. So they lose developmental ground. I am still awed at how they all just cluster around their mothers or each other and sit still or merely walk aimlessly around. In spite of this description, they do seem pretty happy though.

I have completed the first phase of the MI training for the nurses. As usual, it started one hour late and we did not get as far as I wanted to. But once more, I have some very willing and enthusiastic learners. We are scheduled to continue the training at the end of this week and finish up early next week, including the design of the training for the Neighborhood Health Committee Workers. I am considering using the new approach of Steve Rollnick[1]s which is tailored to brief interventions but the nurses want it all, and may want to train the NHCs in a lot of mainstream MI. I am not that hopeful that the NHCs can handle the level of skill that is required. One or two are completely illiterate. But I am open to what these nurses want to do. They have the most input since they know the NHCs as well as the community and the culture, of course. They will be doing the NHC training, with my help, since it will have to be conducted in Bemba. All of the handouts and exercises have to be translated and we can not use any of the Miller/Rollnick videotapes (due to the language and technological barriers) but they are confident that they can do it. Given all that they have accomplished so far, I can hardly doubt them. Yet there is the lingering fear of all of us on the team that they may not advance with any of the tools we are giving them after we leave. But we can only do what we can do. The rest is up to them. They often surprise us, but there is tremendous amounts to overcome here, as these stories tell.

That¹s about it for now. Did I say that these Emails would get shorter????? More soon.

Angelica

Transmission 3

The experience here gets richer and richer. The more I learn about Africa, and about Zambia in particular, the more amazed I am. I did not know that Africa is four times the size of the United States and has SEVEN time zones. The diversity on the continent is hard to believe. There are so many countries. It was great to hear what Clinton did and said while here recently. We managed to catch his departing speech at Goree Island on TV (CNN no less) and we were all pretty moved by it. We were very nationalistic about him apologizing for slavery and going to the island where Nelson Mandela (a giant among men) was imprisoned. For all his faults, he is going for the big issues and I am thankful for that. OK, enough American politics.

The impact of the slave trade and colonialism on this continent was more devastating than any of us will ever be able to absorb. Yet, despite years of oppression and exploitation, the Zambians as a people are enormously trusting, open, and friendly. They are all quick to smile their bright smiles with gorgeous, enviable, white teeth. The range of skin color goes the full spectrum of rich, dark, absolutely beautiful tones. High cheekbones, expressive eyes, and strong bodies are everywhere. The women are very attractive. And they seem a very gentle people as well.

I am struck by the difference in affect between the poor here and the poor at home. American poor are filled with seething anger and rage. And racism. At home it is often very difficult for different races to work together, even if towards a common goal. I have found that problem repeatedly in the peace and social justice work I have done over the years, not to mention "just plain" social work. Here, where injustice has had such a profound effect for hundreds of years, the rage is not evident at all. Crime is predominantly petty theft and mostly driven by intense need, actually starvation and desperation. The tenor of society is so much different than our own where mistrust and violence - or simply denial of the problems - prevail. It is a pleasure to work with people who are so friendly, enthusiastic, trusting, and open. There is a British reserve to some, but even then they are quick to smile and help. And whenever we try to speak Bemba they break out in appreciative laughter.

The consciousness of theft and of poverty is impossible to escape. Every house here outside of the shanty villages are all surrounded by high concrete walls, topped with either barbed wire or, more often, sharp and jagged pieces of glass embedded in cement. All have complete security systems and most have guards who work around the clock and stay in empty, small guard shacks next to the entrance gates. Cars that come by must blow the horn for the guards to open the gates, and people who walk up must pound on the gates to announce their presence. Bright outside lights are on all night in the houses that have electricity. Beggars are ubiquitous. There is a national policy of the government not to pay alms (or to tip either which does not lend itself to getting great service). This is hard because there are no social programs to take care of the exceptionally needy or disabled. Small children are frequently seen leading around a blind person, begging for food. Many people tell of their hunger and plead for some money. It is difficult. I have seen several people who probably have had deformities as a result of polio - another preventable disease that many people here suffer from.

In the towns, like Lusaka and Kitwe, the begging is worse. Lusaka is different from Kitwe in that, if you are riding in a car and stop at an intersection, at least 10 people surround the car and try to get you to buy whatever they are selling. And they are selling all kinds of things from peanuts or bananas or other produce to oil paintings, stickers, watches, hats, shirts, or even plastic bags. You just have to keep saying No, thank you, or Awe, Natotola (pronounced Ahhh¹-way which almost sounds affirmative and is quite musical when drawn out they way they do). This happens much less in Kitwe, but it does happen. We have recently had several people coming to our Guest House trying to sell different things like jewelry and other handicrafts. The word is out that the Americans are here....

I am starting to get comfortable with the town of Kitwe - an amazingly vibrant place. It feels like everything here is closer to the human experience

as well as covering a much broader range. It is sometimes a sensual overload, but always enjoyable. The smells, sounds, sights, and feelings are all in the extreme. The market is a center of bustling activity. Stands are everywhere, selling everything, and everyone is negotiating price. The stands themselves are makeshift with pieces of sticks and coverings of plastic if there are coverings at all. Imagine those by the hundreds, or in the case of Lusaka by the thousands, with everyone in town there. Wow.

That is all for now. There is so much more, so expect a new "transmission" soon.

Transmission 4

On Saturday, we brought the Sanilec chlorine machine to the Ipusukilo Health Center. When we got there, the place was busy with activity. Outside the clinic, all of the Neighborhood Health Committee members were cleaning up. Our project "launch" takes place on Tuesday and everyone is preparing. They were sweeping, weeding, planting plants, and even painting the new security door on the room that was designated for the machine. This launch will be a big thing. The mayor of Kitwe is scheduled to come and give a speech, as are members of the Kitwe City Council, and other local dignitaries. The Health Director of USAID-Zambia from Lusaka is flying in with the Director of Population Services International. PSI will be working on the social marketing campaign when this project gets kicked off in the entire Kitwe area, other sites in the country, and then eventually throughout Zambia in a few months. It was a pleasure to see everyone working so hard and getting so excited.

We had to haul the water in buckets from a nearby household well in order to get enough to make up a batch of chlorine for Tuesday. The process is a simple one, involving sending electricity with an electrode through water and salt, making sodium hypochlorite. Rob stayed late with the NHCs and bottled it all up so that we can give it away to the study participants (and sell it to anyone else) on the launch day.

The clinic areas were completely packed with sick people, mostly mothers with children. There were no open places to sit on any of the benches, either in the two rooms inside or outside. Plus there were only two nurses available since the others who were to be on duty were also sick. When Akiko and I learned how short-handed they were, we offered to help however we could. Working in that clinic was a sobering and tragic experience, while at the same time it was very rewarding to be able to so obviously help where the need is so great.

There are no envelopes or bottles (or anything) in which to dispense meds. Neither is there much paper. But they used paper they had – like old, used booklets akin to the "blue books" I took exams in - to ingeniously pack the pills. Akiko and I learned to rip the booklet paper into small squares, roll them into small funnel shapes and then twist the bottom so it became something that could hold meds. We crossed out whatever was written on the paper that was showing and then wrote in the name of the medicine and the dosing regimen, per the nurse¹s instructions. One nurse acted as a triage nurse and diagnosed the children, the other dispensed the meds accordingly. Child after child came in. Most had malaria, which they treat with chloroquine. Some cases were so bad they needed to use injections of chloroquine. There is very little other medicine. Even aspirin is precious.

One mother came in with two children, one a baby of about 6 months and another of about 3 years. The baby was clearly seriously ill. High fever, rigid, and had been convulsing. The baby¹s neck was stiff and at the same time it had the limpness of a very sick child. The other child was walking but also had a rigid neck and high fever. Most probably it was cerebral malaria. They had no Phenobarbital to treat the convulsions but did have a little Valium. Akiko (an internal medicine doc) had to say at least twice that the baby needed to go to the hospital as soon as possible. We were both worried and upset. Margaret, the nurse, finally wrote up a referral to the hospital for both children. Health care for children under 5 is covered in Zambia, otherwise there is no way these children would have been able to receive treatment.

Since their discussion was in Bemba, I asked Margaret to tell me what was happening. She told me that in order for the mother to accomplish getting to the Kitwe hospital, she had to walk back to her house and look for the children¹s grandmother to watch her other kids. Then she had to walk, with the baby on her back and the 3

year old, to the market. That walk is at least 10-15 minutes from the clinic. Once at the market, she would have to wait for a minivan that goes (irregularly) into town. The minivan costs about 400 Kwacha, one way (about 22 cents). I went out to look for the mother and asked her if she had the money to get to town. She understood my English and said yes, but then I think she regretted that since I would have quickly given her the money and she only realized that afterwards. Margaret later told me that she only had enough Kwacha to go one way. She would have to walk back to the compound! About an hour¹s walk, one way. This is a poignant example of life in the compounds here. Akiko and I have been thinking of that ever since. It, along with many other things, has made me so grateful for all we have, and so aware of what we take for granted. It also speaks to the inventiveness and fortitude of these people who live and work in profound poverty.

John-Anthony loves going to the Clinic at the compound, which is wonderful for us all to behold. At least 50 children came around when he was there. They played, sang and laughed together. JA brought a hackey-sack and they devised all kinds of games to play with it. Even Tony got involved and taught everyone a game he called "underleg baseball". They took to it right away. Tony had to ice his swollen knee after all that, in addition to the long walk home, but he feels it was well worth it. One child shared a go cart he constructed out of wood; the wheels were used oil filters. The children took turns riding and pushing it. They taught each other songs and the laughter could have been heard from far away. How beautiful! They had a fantastic time. When do people grow to suspect, fear, and mistrust one another, especially others who are different? To see the innocence, acceptance, and warmth of those little children is on the level of spiritual.

So, it goes on....

Angelica

Editor's note:
Travelogue: Part 2 will appear in the next MINT. It will detail the project launch, successes and failures, and some lessons learned along the way.

A Second Cup, European Blend

Tom Barth, European Co-Editor

Rhoda Emlyn-Jones is one of the experienced Euro-MINTie. In the MINT Trainer forum on Malta last October she expressed a quiet and confident competence which made her an obvious person to MINTerview.

Rhoda is Principal Social Services Officer (Alcohol and Drugs), City of Cardiff Social Services Department and Manager Cardiff Community Alcohol Team and Vale Alcohol and Drug Team

Euro MINTerview

Tom: *You've worked in the alcohol field for a long time, why did MI attract you?*

Rhoda: Working in the alcohol field in the late 1970s, in the context of a developing social learning and client centered approach, we had a sense of what was needed — a belief in people and an understanding of their experiences that went beyond the constraints of the popular thinking of the day.

What we saw in practice was in stark contrast with popular perceptions and current models of intervention.

MI gave us the words and expressions to define the process in a way that fit. The language was respectful, humane and dignified and the approach provided the focus and the structure, as well as clarifying the style and the spirit.

Tom*: What do you feel is the most important difference between MI and other counseling methods?*

Rhoda: The most important element, I feel, is that MI emphasizes the powerful and intensely responsible role of the therapist in assisting people through a process of change. The intensity is focused, structured, non-analytical and non-egotistical.

Tom*: How would you describe what Steve calls "the true spirit of Motivational Interviewing"?*

Rhoda: I have enjoyed the metaphors expressed through this newsletter - "the music not the words" or Jeff's concept of the dance metaphor "Are we dancing or wrestling?"

For me, it is about passion not emotion, not evangelistic persuasion but passionately held beliefs that "move" people. The beliefs are rooted in respect for the individual, their strengths and abilities.

I hope that this transmitted in my interactions with trainees, through commitment to the principles of MI. I start from a position of belief in trainees' ability to embrace the spirit and hear the music.

Tom*: Do you have any comments on the discussion about the balance between teaching the techniques of MI as opposed to the general attitudes, warmth and empathy?*

Rhoda: The techniques are built upon the spirit. The approach is structured but not mechanical. The energy is concentrated on the client's experience. The techniques without energy and commitment to the client cannot be effective. Beliefs and attitudes are crucial — how we think about a problem profoundly affects what we do about it and this affects outcomes.

A shift in approach, beliefs and attitudes will strengthen a trainee's enthusiasm to master the techniques, therefore it has to be a primary goal of training.

Tom: *Some of us wonder whether it is at all helpful to talk about "resistance" to behavior change and think that " resistance" perhaps is the same thing as " motivation" or "ambivalence". What do you think?*

Rhoda: I think this is an interesting and thought provoking debate. My experience in training people in MI, at this point in time, is that resistance is an important concept to explore - for students to become sensitive to expressions of resistance and be in a position to understand them as a normal part of the process.

In my experience we have not moved on far enough from the concept of "denial" to allow us to drop the concept of "resistance" which reframes and normalizes the behavior.

Post MINTerview Comments:
I'm amazed at the strength, and the passion, in your answers, Rhoda. Thanks.

Compared to what I have been thinking about teaching the structure, and the techniques of MI, both you and Gian Paolo (in the last issue) are so clear in saying that beliefs and attitudes must be the primary goal of training.

I have been thinking that all our trainees have the capacity to be empathic , or understanding, or confrontational, or supportive, or blaming, or ---- (you name it) - and when relating to "addiction-clients" all these behaviors can be activated. (And often are, in unpredictable and inefficient ways).

Any systematic or structured approach might improve the quality of their work. As a tool, MI relies on the person's natural ability to be supportive or empathic. It structures, and improves the performance of these " help-giving behaviors". And MI cannot easily be used abusively. Therefore, I have thought, teaching the techniques of MI would probably do no harm, but will reinforce and " give words to " the good sides of trainee behavior, and ignore the not-so-good sides.

Some of our evaluations, however, show that our workshops have more effect on general attitudes than on behavior, so Rhoda and Gian Paolo have some important points…

On the other hand, in resistance terms, people are unlikely to be happy about a workshop designed to " improve your attitudes toward the client group." So I guess what we call it can be different from what it is, and from how it works.

MORE MINTerviews?
Perhaps. We have also talked about exploring some of the basic concepts of MI, like resistance, ambivalence, motivational, etc. Ideas anybody?

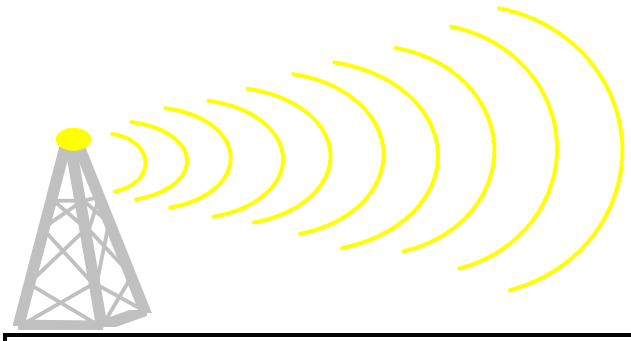
Rhoda's idea that we can move from the concept of denial through "resistance", towards an even more neutral concept, is fascinating. When will we be ready, Rhoda, and what will it be called?

Tom Barth

Contact Information for the Euro-Editors
E-mail addresses:
Peter Prescott petereva@online.no
Tom Barth tfwb@online.no
Tore Børtveit
bente.ubostad@psych.uib.no

Mail address:
Bergensklinikkene
P.O. Box 297
N-5001 Bergen
Norway

Fax +47 55908610
Phone: +47 55908600



From Across the Pond

Stephen Rollnick

Steve has decided to sit this issue out, but he will be back in action for '99.

Inquiries and submissions for this newsletter should be forwarded to:
David B. Rosengren, Ph.D.
International Association of Motivational Interviewing Trainers
3020 Issq.-Pine Lake Rd SE, Suite 72, Issaquah, WA 98029
Tel: 206-543-0937 Fax: 206-543-5473 Email: dbr@u.washington.edu

This newsletter is a free publication made available to members of the International Association of Motivational Interviewing Trainers.