

MI Changes

Allan Zuckoff, PhD

Dear Readers,

This issue of *MITRIP* arrives hard on the heels of an important milestone in the history and development of motivational interviewing: the publication of the third edition of the foundational text on the theory, practice, and implementation of MI, William R. Miller's and Stephen Rollnick's (2013) *Motivational Interviewing*. Now subtitled *Helping People Change*, thus capturing the growth of MI from a narrowly targeted, pre-treatment intervention for alcohol problems to a broadly generalizable approach to counseling people who are considering change of almost any kind, the book is striking in that, 30 years after the first description of MI (Miller, 1983; original manuscript facsimile published as Miller, 2008), it provides a new conceptual framework ("four processes of MI") and a reorganized and expanded description of MI's underlying "spirit" that retain the essence of what came before and yet give a richer and more nuanced account of how MI is actually done.

As I see it, the import of this new development lies not only in what it offers to practitioners who wish to be able to provide MI to the clients they work with, to trainers who seek more effective ways of helping practitioners to learn the approach, and to researchers who strive to determine when and how ("whether" having already been rather convincingly demonstrated) MI "works." It also conveys a profound implicit message: that the work of refining and deepening an approach to counseling does not end even after it has been described, manualized, tested, disseminated, and (in some quarters) acclaimed; that humility and a restless spirit are the wellsprings of creativity and innovation in developing better methods for improving the lives of those who suffer; and that our eyes, as researchers and practitioners both, should always be cast toward (in the words of Miller, 2012) the "far horizon" of what we can achieve in helping people change.

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From the Desert

Confessions of a Recovering Trainer / What about Decisional Balance?

William R. Miller, PhD¹

CONFESSIONS OF A RECOVERING TRAINER

Through 40 years of teaching my emphasis has been on knowledge with a scientific base. In reviewing the outcome literature on treatment for alcohol problems, I have long advocated for the use of evidence-based practice (Miller & Hester, 1980; Miller, Zweben & Johnson, 2005). Yet through most of my career I neglected to apply the same standard to what I spent most of my own time doing: teaching and training.

Like most of the important “aha” experiences of my career, this one began during a sabbatical leave when I had time for reflection. While in Portland, Oregon in 1997, I received a call from the Washington County probation service, asking if I would train their probation officers in MI. My first reaction was to decline and protect my sabbatical time, but then I had an idea. “If we can make it a study, I’ll do it for free.” What I asked for was audiotaped practice samples with actual client-supervisees before and after training. I also wanted taped skill samples with standard-patient actors immediately after training. This was a top-down training, arranged by the director of the probation service who could require compliance, and he agreed to the conditions.

This meant that we also had to come up with a way of coding audiotaped MI practice sessions. Fortunately I had creative colleagues at the Kaiser-Permanente Center for Health Research, including Denise Ernst and Kathy Mount, and together we crafted the original Motivational Interviewing Skill Code (MISC) to quantify both counselor and client behavior (DeJonge, Schippers & Schaap, 2005; Moyers, Martin, Catley, Harris & Ahluwalia, 2003).

So Kathy Jackson and I provided our best 2-day, 16-hour MI workshop, and gave a copy of *Motivational Interviewing* (Miller & Rollnick, 1991) to each of the 22 participants. We also offered six free on-site follow-up consultations to discuss their experience in applying MI. Then 3-5 months after training, 21 of the 22 provided a practice sample.

What we found (Miller & Mount, 2001) changed how I think about training. In retrospect it should not have been surprising, but at the time it stunned me. There were, at best, very modest changes in practice behavior, and MI skills remained far short of what we would regard to be reasonable competence, let alone proficiency. MI-inconsistent responses (such as confrontation and advice without permission) remained at 36%, and from subsequent experience we know that it doesn’t take very many MI-IN responses to spoil the soup. On a 7-point global MI scale (with 5 as a competence threshold), averages went from 3.6 before training to 3.8 after and 3.9 at follow-up. In essence we had succeeded in sprinkling

a few reflections on top of their standard practice without reducing MI inconsistency. Their clients showed no increase in change talk. In other words, we had yielded a little (albeit statistically significant) improvement in practice behavior, but not enough to make any difference to their clients.

On questionnaires, however, the participants rated themselves as markedly improved in their understanding of and proficiency with MI, and said that they were now using it in practice. We also found that we had managed to significantly *decrease* participants’ interest in learning more about MI! Of the six free follow-up consults, half of the participants attended none at all, and the most common number of sessions attended (by 27%) was one. Even at follow-up, only half said that they had read the book. When I went back to present the study results, I asked them about this decreased interest in learning more. “Well, we had already learned it!” was the explanation.

Clearly we were doing something wrong. We had not succeeded in installing skillfulness, and we had inoculated them against further learning! On reflection, our training model looked something like this:



One might call it the IOEAOTE model. No, it’s not Greek: in one ear and out the other.

Like most good research, this study left me with a better question: What does it take to help people learn MI? If it’s a complex skill like playing a musical instrument or flying an airplane, it takes far more than sitting in a classroom absorbing information. One never hires a golf coach and says, “but don’t watch me,” or a piano teacher and says, “but don’t listen to me.” I wouldn’t care to fly with a pilot whose training consisted of a 2-day workshop on the ground.

First of all, learning requires feedback of results. You can take practice tests for years, and without feedback of whether your answers are right or wrong you won’t be learning. Thirty years of archery experience won’t help much if you can’t see the targets. Corrective feedback is essential for learning. Perhaps this explains one of the most robust findings in psychotherapy research: that therapists don’t get any better with practice. Average client outcomes are the same on average for novice therapists and for those with years of experience.

Besides feedback, learning a complex skill usually involves some coaching. Whether it’s chess, tennis, making or playing guitars, it’s common to learn from a master, or at least someone who is better at it than you are.

That led to the EMMEE study (Miller, Yahne, Moyers, Martinez & Pirritano (2004), which might be the first randomized trial of strategies to help people learn a psychotherapy. We recruited 140 licensed

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professionals who treated alcohol/drug problems, and randomly assigned them to one of five learning conditions:

- W: 2-day workshop alone
- WF: Workshop plus mailed feedback on practice audiotapes
- WC: Workshop plus six follow-up 30-minute coaching calls with skill practice
- WFC: Workshop plus feedback plus coaching
- ST: A self-taught comparison group given the MI book and videotapes

As before, we got audiotaped practice samples before training (required to get into the study), and had participants interact with standard-patient actors immediately after the workshop. We planned to get follow-up practice samples at 4, 8, and 12 months after the workshop. That's when we learned that, as Terri Moyers says, "It's easier to get urine samples from crack addicts than to get practice samples from therapists." Even with payment for tapes and persistent pestering, by 12 months adherence was down to half.

Using competence standards for practice that we would expect for therapists delivering MI in a clinical trial (Miller, Moyers, Arciniega, Ernst & Forcehimes, 2005; Miller & Rollnick, 2013), we found that three groups on average reached this level: those who received feedback (WF), coaching (WC), or both (WFC). The self-trained control group and the workshop only group did not. Then we gave the whole package (WFC) to the control group after 4 months, and they came up to competence level.

A different question, though, is whether their clients were behaving any differently. (We couldn't use the actors for this, because they don't respond like real clients.) Only one group was able to significantly and substantially increase their clients' level of change talk: the WFC group. From what we know about the relationship between in-session change talk and behavior change, it would appear that only the WFC group developed their MI skills enough to improve client outcomes. Interestingly, even in the wait-listed ST group that later received WFC, client change talk did not increase.

The real question, I guess, is why we ever thought that just sitting through a one or two day class would have any enduring effect on well-established practice habits. Yet that remains the dominant model for continuing education credits required for renewal of a professional license or certification. This model of training is a clear parallel to the overuse of directing that is so common in clinical practice, to which MI is a contrast: just provide the information and some advice, and people will change their behavior.

What are the implications, then, for workshops? I'm surely not suggesting that we do away with them, any more than one would eliminate music theory for musicians, or the preliminary ground school for airplane pilots. The point is that these are just the beginning of learning a complex skill. Before the Miller & Mount (2001) study I was at least implying (and thinking) in my training that participants would go away skilled. Indeed, our trainees went away believing that they were skilled by virtue of the workshop, and we know that self-perceptions of proficiency without feedback are essentially uncorrelated with actual competence in the practice of MI. Now I say explicitly at the outset that participants are unlikely to leave the workshop skilled in MI, but if I do my job well they will know how to begin learning it.

It is also a fact that for some people a good workshop is enough to get them up to speed with MI. They seem to "get it" intuitively when introduced to it. I remember people in my own workshops who seemed to take to MI like a fish to water. In the EMMEE study we examined the

percentage of trainees who were *newly* competent in MI after training. That is, at baseline they did not meet our standards for competent practice, but afterward they did. In the WFC group, it was 60% (and some of the remaining 40% were *already* competent in MI at baseline, so we don't attribute that to training). In the workshop-only (W) group the comparable figure was 29%. Now, some only had a short distance to go, but nevertheless with nothing more than the workshop (at least nothing more that we offered them), 29% met competence standards after training.

Perhaps it would be better, then, to say "that this workshop may be enough for *some* of you, but not for most of you." A problem here is that self-perceived competence is optimistic at best. Our natural tendency (if we're not depressed) is to believe that we are performing better than we really are, which could send people away with the same mistaken impression that our Portland participants had. I would therefore encourage trainees to at least get some reliable feedback based on observed practice. MI (like chess or a musical instrument) is something you can *keep* getting better at with practice, at least if you have reliable feedback of results.

Another reality of training is that some people have much farther to go than others. For some, the boost of a workshop is enough, but there's no way to know without listening to practice. Who is a reasonably competent flautist after a 2-day workshop? The only way to know is to listen. This means that a standard "dose" of training may be enough for some, depending on their starting point, but for many it will not.

I hasten to add, too, that it's not just a matter of hitting a competence threshold once. Human performance on most any dimension tends to drift over time. We fall back into old habits, often without realizing it. Highly experienced airline pilots nevertheless are required periodically to fly with check pilots beside them.

An advantage that we have with MI is that in-session change talk, sustain talk, and discord are reasonably good proxies of client outcome. They're not perfect by any means, but in general the balance of change talk to sustain talk gives you an indication of how likely change is to happen. As with chess, sport, and music, if you know what to watch and listen for, you have indications of how it's going *while* you're doing it.

We have much more yet to understand about how best to help people learn MI. Feedback and coaching seem to be important, as with most any complex skill. But what aspects of MI are most important in helping clients change? What should we focus on in training people at various levels of skillfulness? Is there an optimal sequence in which to develop skills (Miller & Moyers, 2006)? What about different learning styles or preferences? How about cross-cultural adaptations of MI (Miller, et al., 2008)? What is most important to retain, and what aspects need to be adjusted?

In a way, the challenges in training parallel those in the clinical practice of MI. It is a meeting and blending of the expertise of trainee and trainer. There is no one-way installation of skill. With what we know so far, I think we are one step closer to understanding Monty Roberts' (2001) aphorism that "There is no such thing as teaching—only learning."

WHAT ABOUT DECISIONAL BALANCE?

Just before the MINT Forum this year I completed with Gary Rose an article on decisional balance. In preparing it, we reviewed all research we could find on the efficacy of interventions based on constructing a balance grid of the pros and cons of change, the findings of which were strikingly consistent. Here is a brief summary of what we found, with a focus on implications for MI.

First and foremost, decisional balance is a *measurement* construct. There are various ways to assess it, but basically it is the relative weight of pros and cons at a particular point in time. This construct has been especially important in research on the transtheoretical model (TTM) of change. The balance shifts over time from precontemplation to contemplation to preparation. It seems to be an increase in the *pros* of change that particularly marks the transition to preparation and action. Thus the current balance of pros and cons is a reasonably good marker of readiness for change.

However, “decisional balance” has also come to refer to clinical interventions that thoroughly evoke and explore the pros and cons of two alternatives (such as change or status quo). These date back to Janis and Mann’s 1977 classic, *Decision Making*, where they proposed a 16-cell grid to use when making difficult choices. Their intervention was intended to be nondirective, practiced by a neutral interviewer with what is now termed *equipoise* in health care. The purpose was not to favor a particular decision, but rather to help clients make the choice in a way that would avert post-decisional regret. Somewhere along the line, however, decisional balance interventions were also proposed as a way to help people decide to change. In this regard, decisional balance became confused with MI.

Here, briefly, are four clinical scenarios in which a decisional balance might be used, and what research to date tells us about them.

With Pre-decisional People

Those who are regarded in TTM as being in precontemplation and contemplation stages have not yet made a decision to change. They are either content with the status quo (precontemplation) or ambivalent about change, with counterbalancing pros and cons (contemplation). In this pre-decisional state, it seems the expected outcome of a balanced exploration of pros and cons would be continued ambivalence. Outcome research consistently shows either no benefit or a detrimental (decreased commitment) effect of decisional balance interventions. The only exception is an intervention that explored both pros and cons, and then focused systematically on the pros of change with evocation and reflection. The latter is essentially MI, with a goal of strengthening the pros of change. In other words, it may be possible to undo the damage of a decisional balance by subsequently focusing on the pros, but there is no good theoretical or empirical reason to have done a decisional balance in the first place with pre-decisional people.

With Post-decisional People

A somewhat counter-intuitive finding is that when a decisional balance is done with people who have *already* made the decision to change, it tends to increase commitment to change. An explanation of this finding is that people cognitively defend the decision they have made by emphasizing the pros and thus further strengthening their commitment. However, it is not clear how much outcome difference this makes with people who have already decided, and there would seem to be some risk of undermining change if the person’s decision and commitment to it were tenuous.

When Change Talk is Not Forthcoming

Steve and I are responsible in part for the confusion of MI with decisional balance by suggesting an evocation strategy to use when no change talk seems to be forthcoming. In our third edition (Miller & Rollnick, 2013) we call this procedure “running head start.” It is meant for the situation where one’s best MI efforts are simply not yielding any client change talk. The suggestion is to take a step back, ask about the advantages of the status quo, and then ask about the “less good things.” It is done in this order in hopes that first listening to the pros of status

quo will diminish defensiveness and facilitate discussion of the other side. Note, however, that this assumes there actually is underlying ambivalence. Running head start is not a formal decisional balance. There is no priority on thoroughly exploring all the advantages of status quo and disadvantages of change. The purpose of the procedure is to evoke and then explore change talk. This strategy is based on clinical experience, but I know of no solid scientific evidence that it actually works with clients who initially offer little or no change talk.

In Equipoise

A fourth scenario is when the clinician chooses *not* to favor resolution of ambivalence in a particular direction. There are many such clinical situations where the proper ethical stance is neutrality: for example, a client deciding whether to adopt children, participate in a clinical trial, or donate a kidney. From what we know about MI, change talk, and the interpersonal dynamics of change, we also know better how *not* to tip the balance intentionally or inadvertently. Here is where decisional balance seems most appropriate—to thoroughly and equally explore all the pros and cons without guiding the client toward any particular choice. There is curiously little experimental evidence as to whether such interventions actually do help clients make a choice or decrease post-decisional regret, and how this interacts with the client’s initial balance or pros and cons. Nevertheless, it seems that a decisional balance intervention is ethically appropriate in equipoise, and a good way for clinicians to consciously avoid putting a thumb on the scales.

In sum, there is no theoretical or empirical reason to construct a decisional balance intervention with pre-decisional people when the hope is to facilitate change in a particular direction. It is precisely when the clinician chooses to *avoid* influencing the client’s direction of choice that decisional balance is appropriate.

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Buddy-Motivational Interviewing (buddy-MI) to Increase Physical Activity in Community Settings

Study Protocol for a Pragmatic Randomised Controlled Trial

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Abstract

This article describes the development and evaluation of a novel buddy-motivational interviewing intervention intended to help apparently healthy but relatively sedentary adults to adopt and maintain regular physical activity for health and fitness. Many people experience great difficulty in initiating physical activity (“the getting going problem”) and behavioural regression is common (“the keeping it going problem”). Typically there is a rather large gap between what people know to be healthy and what they actually do. This intervention is an adaptation of motivational interviewing in that it adds client-selected motivational-buddies who can provide *in-session* input as well as ongoing *out-of-session* support focused on strengthening clients’ motivation for and movement toward their physical activity goals. A pragmatic parallel group randomised controlled trial with 12-month follow-up aims to deliver and assess the effectiveness of the intervention in a format that could realistically be implemented within primary care, workplaces, schools or other similar setting. The study is due to report clinical effectiveness findings in 2014.

Keywords

Motivational Interviewing, Social Support, Buddy, Physical Activity

Significant changes in the demographic profile of New Zealand will result in fewer children, more older people and further ageing of the population. Half of New Zealand’s population will be 46 years and older by 2051, compared with a median age of 35 years in 2004 (Statistics New Zealand, 2004). For health services, this is significant in two fundamental ways: first, health service utilisation is greatest in the first few and last few years of life; second, these shifts in the demographic profile will also be reflected across the health workforce, potentially resulting in large unsustainable losses of health care professionals. In short, the increasing demand for resources is likely to significantly outstrip the available capacity in the not too distant future. Compounding these demographic factors, the increasing trend in life expectancy in New Zealand is not paralleled by improvements in morbidity, due largely to the progression of non-communicable (*lifestyle*) diseases, particularly coronary heart disease, obesity and Type 2 diabetes (Ministry of Health, 2001, 2005). Inactive and unfit people have almost double the risk of dying from coronary heart disease compared with more active and fit people (Kohl, Gordon, Villegas, & Blair, 1992; Lee & Skerrett, 2001).

Most New Zealanders are exposed to increasingly obesogenic environments and the adverse effects, the so called *lifestyle diseases*,

are now obvious. However, engaging in regular, moderately vigorous physical activity can go some way towards offsetting these adverse effects, and the health benefits of regular physical activity are well documented for all age groups (Bouchard & Shephard, 1994). Early studies conducted by Jeremy Morris and his colleagues (Morris, Heady, Raffle, Roberts, & Parks, 1953; Morris, Kagan, Pattison, & Gardner, 1966; Paffenbarger & Hale, 1975; Paffenbarger, Wing, & Hyde, 1978) demonstrated the so called *independent protective effect* of moderately vigorous or vigorous exercise via a series of groundbreaking prospective cohort studies. Moderately vigorous physical activity is positively linked via a cause-and-effect relationship with a range of improved health outcomes (Lee & Skerrett, 2001) and this relationship is now widely understood and accepted. However, despite the benefits of being more active, most lay-people, researchers, and health professionals would agree that sustained individual-level behaviour change remains very challenging.

Trends in Physical Activity Promotion

There is growing recognition that health behaviour change is more likely to occur and endure when an individual’s environment is supportive of change (McLeroy, Bibeau, Steckler, & Glanz, 1988). Social-ecological perspectives recognise that society is composed of interconnected elements: individual level, interpersonal, organisational, community, and social, and that these invariably influence one another. Therefore, people who are attempting change are influenced not only by their immediate settings but also by the larger social contexts (both formal and informal) in which these settings are embedded (Bronfenbrenner, 1977). There is a growing recognition that it is not particularly helpful to view health problems as residing solely within individuals and quality contemporary health promotion programmes are tending towards a *systems approach*. A systems approach to physical activity promotion might include

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community-wide campaigns, point-of-decision prompts, school-based programmes, workplace programmes, social support interventions in community settings, enhanced access to places for physical activity, urban design/land-use policies and modification to the built environment (Centers for Disease Control and Prevention, 2008).

Intervention at the population level is important in the overall effort to change sedentary lifestyles. Targeted, well-executed population level campaigns can have small-to-moderate effects not only on health knowledge, beliefs, opinions and attitudes, but also on behaviours as well (Noar 2006). A meta-analysis of health campaign effects on behaviour by Snyder and Hamilton (2002) found effect sizes in the range of 0.17 (SD=0.02) for those using a law enforcement message (e.g., seatbelts) to 0.05 (SD=0.04) for those not using enforcement messages (e.g., fruit and vegetable consumption, exercise and weight). While the effects might be small for these health promoting behaviours, they are not unimportant because they potentially reach a large number of people and cumulatively, they add up (Glasgow, 2002).

At the individual level, education and brief psychosocial/psychological interventions have been shown to be useful in many areas of health behaviour change, including smoking cessation, changes in nutrition, physical activity and compliance with medication protocols (Burke, Dunn, Atkins, & Phelps, 2004; Gonder-Frederick, Cox, & Ritterband, 2002; Pringle, Gilson, Mckenna, & Cooke, 2009). Notwithstanding the successes, neither population level interventions nor individual level interventions guarantee health behaviour change. For a variety of reasons, programmes often struggle to deal adequately with individual differences in readiness and willingness to change, cultural appropriateness, barriers to equitable access, and myriad other socioeconomic, cognitive and psychological factors (Fuchs, 1998; Ministry of Health, 2002). Health behaviour change remains extremely challenging and change is often not maintained much beyond the intervention period, and there is the persistent tendency for behavioural regression and *rebounding* (Gonder-Frederick, et al., 2002; McKinlay, 1993). While it is true that modern medicine has evolved to ameliorate many acute illnesses and injuries, it still performs rather less well when faced with the increasing prevalence of lifestyle diseases (Callahan, 2009; Fuchs, 1993, 1998; McKinlay, 1993) and the multi-faceted determinants of health that lie outside of individuals' human biology (Lorig & Holman, 2003).

Most would agree that a "magic bullet" is unlikely. In attempts to address the particular limitations of both population level and individual level interventions, contemporary perspectives recognise the need for multi-level approaches, sustained over years not months, and the need for multi-sectoral policies to promote physical activity. Such multi-sectoral policies include promoting enabling environments, community involvement, and individual-level intervention (World Health Organization, 2004).

RATIONALE

This current trial acknowledges recent trends in physical activity promotion and aims to bridge between the individual-level and wider social networks (the inter-personal level) by formally invoking social support via the use of self-selected *motivational-buddies*. The proposed head-to-head trial has been designed to test a novel adaptation of motivational interviewing (MI; Miller & Rollnick, 2002) against usual MI in a physical activity counselling intervention potentially feasible for use in primary care and community settings. The primary outcomes of interest are self-reported physical activity, cardiorespiratory fitness, and health-related quality of life (HRQOL). Physical activity reflects the *behavioural* aims of the intervention and cardiorespiratory fitness reflects the downstream *physiological* adaptations that may lead to potentially significant

health benefits. Also important, HRQOL reflects the *psychological* aims of the intervention as the HRQOL construct includes the domains role-emotional, vitality, social function, and mental health. The concept of HRQOL acknowledges that people *rate* their actual situation in relation to their individual expectations.

There is a paucity of evidence for the incremental effectiveness of *buddy* versus *non-buddy* interventions in healthcare and this trial aims to add knowledge in this domain. Given the ever present demand for health services and the complex interactions of demand, access, cost and quality, learning how to maximise efficiency in the use of scarce resources is an important research goal.

Why Motivational Interviewing?

Motivational interviewing (MI) has become a well-recognised style or method of client-centred counselling and the application of MI continues to grow at a rapid pace. Only a brief description of MI is given here as many other sources provide thorough explanations and descriptions of its application in healthcare and other settings (Arkowitz, 2008; Miller & Rollnick, 2002, 2009; Miller & Rose, 2009; Rollnick, Miller, & Butler, 2008) and the experimental intervention used in this trial is described in detail below. A central tenet of MI is that the intervention is collaborative in nature and defined by a partnership between the practitioner and the client. Fundamentally, MI involves the activation of peoples' own motivation for change and MI involves a guiding style with the practitioner actively engaged in eliciting the client's intrinsic motivations for change.

There is now considerable evidence (over 200 randomised trials) for the effectiveness of MI in the treatment of substance abuse as well as a number of other settings and problem areas, including family practice, chronic care, diabetes, cardiac rehabilitation, oral health (emerging) and diet and exercise. Several systematic reviews and meta-analyses of MI have now been published (Burke, Arkowitz, & Menchola, 2003; Hettema, Steele, & Miller, 2005; Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Martins & McNeil, 2009; Vasilaki, Hosier, & Cox, 2006) and these generally report positive small-to-medium but clinically significant effects (Abbott & Freeth, 2008).

A broad range of literature was consulted during the design and refinement of the buddy-MI intervention and in the development of the training resources, including the work of Bandura (1977) on social cognitive theory, Christakis and colleagues (Christakis & Fowler, 2007) on network effects and health outcomes, Magill, et al. (2010) on motivational interviewing with significant other participation, Moyers and colleagues (Moyers, Martin, Manuel, Miller, & Ernst, 2007; Moyers, Martin, Manuel, Miller, & Ernst, 2010) on client language and Miller and Rollnick (2002) and Rollnick et al. (2008) for a general overview of MI and its application in health-care settings.

Why a Buddy Intervention?

The concept of the buddy-system is not new and buddy systems are used formally or informally across a variety of settings ranging from school groups to high hazard workplaces (e.g., search and rescue), the armed forces, business (e.g., mentoring) and healthcare (for example, see May & West, 2000, for a review of buddy-systems in smoking cessation). Buddy systems generally operate so that two people work together and are able to monitor and help each other, usually for the purpose of orientation or providing support, mentoring, enhancing safety, learning, or motivation, or a combination of these (see also Hurdle, 2001, for a review of social support in health promotion).

While there is no standardised functional definition of a *motivational-buddy*, in this trial, the buddy role is described as exerting influence in two separate but related domains: the *in-session* domain,

comprising the structured MI part of the programme and the *out-of-session* domain, which comprises all other buddy-to-client interactions. Within this framework, the support person or motivational-buddy ideally serves the function of a *counselling-buddy* (technically a motivationally consistent buddy within the *spirit* of MI) as well as the more usual emotional/practical support role common to most buddy systems (help with tangible needs, e.g., providing feedback and advice or being an exercise partner or providing other inputs of time and effort or other material resources). Buddies may vary in terms of their enthusiasm, conscientiousness, communication skills, empathy, and availability and generally in the level of support provided. Attempting to positively influence and enhance the supportive relationship between the buddy and the client is therefore another important component of the intervention (see below for more details). However, the goal is not to transform buddies into competent MI therapists, but to guide buddies towards being *motivationally consistent* in their interactions and on the whole adherent to MI fundamentals: to demonstrate the *spirit* of MI.

The buddy-intervention aims to bridge between the individual level of intervention and the wider community. Individual level interventions are often resource-limited in their ability to maintain long-term support and they often don't link-in directly with wider social networks and *whānau* (Māori for "extended family"). The buddy-intervention seeks to address these common limitations by engaging non-health professionals to provide intervention components and ongoing support, with the potential for favourable ripple and inter-personal effects. Consideration has been given to the cultural appropriateness of the intervention, in accordance with the Treaty of Waitangi (New Zealand's founding document) and the focus on *partnership* is viewed as an important strength.

METHODS

Design

Quantitative research methods will be used, based on a pragmatic, parallel group randomised controlled trial (RCT). Blinding the investigator and/or the participants to the treatment received is not possible. Qualitative exit survey data will supplement the findings and provide information on various process outcomes. All procedures were reviewed and approved by the University of Canterbury Human Ethics Committee.

Hypotheses

The study aim is to investigate the relative effectiveness of MI delivered in a buddy-system context as compared to usual one-on-one motivational interviewing. The main hypothesis to be tested is that participants in the experimental group will self-report relatively higher levels of physical activity, cardiovascular fitness and health related quality of life at follow-up as compared with control group participants.

Setting

The study will be conducted in Christchurch, New Zealand, at the University of Canterbury. The University has nearly 19,000 enrolled students, including over 2,000 international students from more than 80 countries and approximately 800 academic staff.

Participants

Volunteer adults ($n = 60$), apparently healthy, relatively physically inactive but able to increase their physical activity. Potential participants will be excluded if in unstable health or if physical activity is contraindicated.

Recruitment and Randomisation

Participants will be recruited via advertising flyers and other opportunistic recruitment. The study is presented as fundamentally a study of MI with a focus on physical activity and both interventions are presented as real and active therapies. A two-step consent/randomisation strategy is intended to reduce rates of non-compliance and drop-out in the control group by reducing the possibility of resentful demoralisation. Block randomisation will be used via the sealed envelope method (Roberts & Torgerson, 1998).

Interventions

Motivational interviewing

MI involves the conscious, disciplined and flexible use of specific communication principles and strategies to evoke a person's own motivations for change. Emphasis is given to the underlying *spirit* of MI which can be summarised as *partnership* (an even power relationship and a joint decision making process), *autonomy* (honouring client autonomy/a detachment from outcome), *compassion* (unconditional positive regard) and *evocation* (the process of bringing to mind and harnessing what people already have) (Miller, 2010; Miller & Rollnick, 2002; Miller & Rose, 2009). MI involves a number of micro-skills including open questions, affirming, reflecting and summarising (OARS) within an overarching process of *engaging*, *focusing*, *evoking* and *planning*- and this process can be tailored depending of the needs of the client and the context (Miller, 2010; Miller & Rollnick, 2002). An MI therapist can also use a range of strategies including agenda-matching, pros and cons, importance and confidence scaling questions, envisioning, rolling with resistance, brainstorming and planning. Another important therapist skill is the ability to resist the *righting reflex*: the impulse to adopt the expert role and forge ahead of the client in an effort to fix the problem (Miller & Rollnick, 2002).

Motivational interviewing differs from traditional biomedical counselling with regard to the *guiding style* of interaction; in addition, the development of discrepancy, supporting self-efficacy, the expression of empathy, empowerment, and encouraging hope and optimism are also components of good MI practice. MI has the potential to facilitate long-term exercise behaviour change and positively influence peoples' health; however as Miller and Rollnick (2009) point out, "*If someone genuinely has no inherent motivation for making a change, MI cannot manufacture it*" (p.131).

Buddy-MI

Motivational Interviewing, as interpreted and adapted here, forms the basis of the proposed buddy-MI intervention model (see Figure 1). In buddy-MI the therapist primarily delivers MI but also works with the participant (client) and his/her motivational-buddy to build a therapeutic relationship in which different basic elements of social exchange such as support, reciprocity, accountability and role-modelling may occur and can potentially be channelled to positive effect. Prior to any *in-session* time, the buddy is provided with background information describing the buddy-role and a range of training resources (as described more fully below). Generally, the focus of the motivational interviewing sessions is on engaging clients and their motivational-buddy in discussions about change, exploring ambivalence about exercise habits, eliciting change talk and commitment language, and planning and discussing how behavioural changes might fit an individual's vision for the future and personal values.

Participants (clients) in the experimental group will be offered face-to-face buddy-MI and follow-up for a period of 12-months and the MI sessions will be conducted with the client's self-selected motivational-buddy participating. The protocol does not set parameters within which the buddy pair is expected to fit and clients are invited to self-recruit their

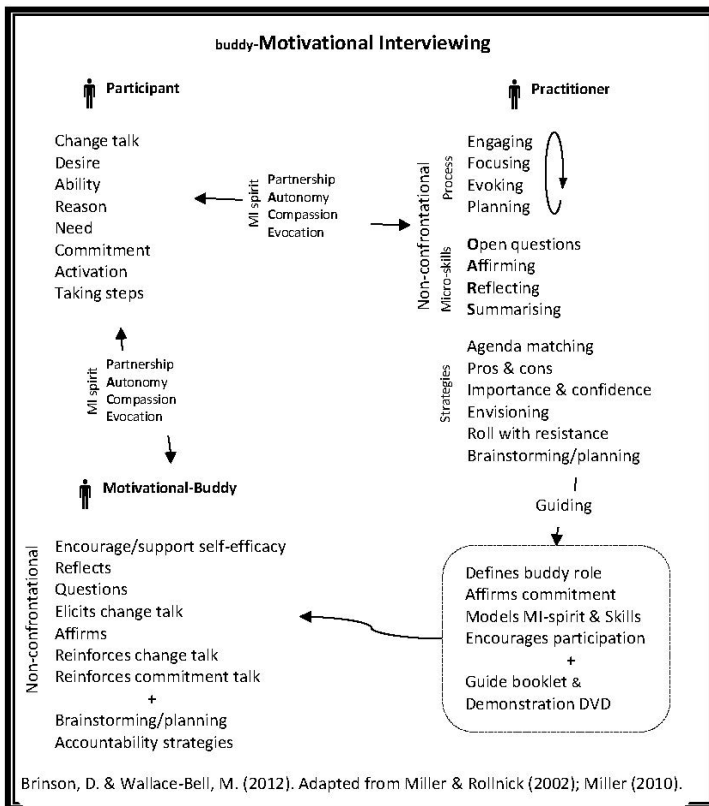


Figure 1

Buddy-MI intervention model.

best choice or *best fit* buddy. The frequency, timing and duration of the treatment will largely be determined by the participants. Ordinarily, within a 50-minute hour format, it is expected that the intervention will fill a minimum of two sessions (<1-2hrs) and a maximum of three to five sessions (2–4 hrs) spread over the 12-month intervention period. For all participants, two initial sessions of MI will be booked approximately a fortnight apart, but beyond this, the participants will be invited to schedule further sessions to suit their individual needs. Follow-up emails are scheduled for one or two days after each session. These follow-up emails take the form of a personalised note thanking the client/buddy for their participation and confirming the next appointment time. Each follow-up note also includes one complex reflection and an affirmation relating to a key point from the previous MI session.

Within buddy-MI sessions, the buddy will be encouraged to adopt a non-confrontational communication style, offer reflections on client or therapist statements, question, affirm, support and reinforce change and commitment statements and/or assist with brainstorming and planning. Instruction and guidance in these skills is provided both in the buddy learning package and via in-session modelling by the therapist. The role of the buddy *outside* of the session time is to be determined entirely by the client-buddy pair (with guidance provided if requested).

The intervention will not follow any specific written therapist manual but as outlined in detail elsewhere (Miller & Rollnick, 2002), MI can involve a range of standard strategies to elicit change talk including importance and confidence scaling, pros and cons, envisioning and planning for change. Buddy-specific adaptations of these standard MI strategies have been tested for feasibility; pilot study video recordings of client/buddy responses were reviewed and coded with the MISO instrument (Apodaca, Manuel, Moyers, & Amrhein, 2007) to guide practitioner training. These adaptations generally take the form of asking the buddy to provide an additional perspective on the client or to relay

their observations of the client's past challenges, efforts or achievements (often buddies provide these unprompted). For example, the adaptation of confidence scaling involves asking the buddy to rate *his or her* perception of the client's ability to take steps towards change (on a scale of 1 to 10). In pilot testing, this more often than not resulted in the buddy scoring the client more highly on the confidence scale and going on to reflect, reinforce, and affirm the client's personal strengths, past achievements and steps already taken towards change. Initial review of pilot session recordings has shown that these buddy-reinforcements and buddy-affirmations commonly elicit client change talk and commitment talk. Eliciting client change talk and commitment talk is generally the objective of using specific strategies in MI, and in the buddy-MI adaptation, an additional opportunity is created to elicit and reinforce desire, ability, reason, and need statements and to introduce and reinforce positive client attributes.

Agreement between the client and buddy to work on a change plan or to develop an exercise schedule was another common outcome during the pilot interviews: this commitment to planning is commonly initiated collaboratively by the client or buddy rather than by the therapist. Brainstorming and elaborating on the types of *out-of-session* interactions and the *style* of communication/accountability that might serve to strengthen the buddy relationship was another common discussion theme. The therapist is thus presented with additional opportunities to reflect, affirm, and selectively reinforce these buddy/client utterances.

Finally, another common theme recorded in the pilot interviews was *accountability*. Accountability is a component of social engagement that has been used to describe any implied or explicit understanding between two people or any rules and expectations that orient the *agent's* behaviour (the client) to the role enacted by the *overseer* (the buddy) (Sharpe, 2000). According to this understanding of accountability, if a client and a buddy establish a relationship based on trust and expected conduct, then a link will be formed between accountability and individual conscience. Client initiated discussions around accountability appear to be common in the buddy-Motivational Interviews and these may exert a motivational influence, although the operationalisation and measurement of accountability and its possible incremental benefits within buddy-MI is beyond the scope of the current research.

Development of buddy-MI training resources

During the preliminary stages of the buddy-MI pilot, post-session feedback was sought from participating buddies. Buddies typically reported that they were unsure of exactly what their role was and what was expected of them. Attempts to briefly coach buddies in their role and in MI spirit and micro skills, prior to sessions, proved unsuccessful due to the lack of time to adequately cover the material. As a result of this feedback it became apparent that a more comprehensive approach was required. Further work focused on producing two resources: a guide-book, *Buddy basics: Information for motivational-buddies*, and a video, *Buddy-basics: an instructional video for motivational- buddies*.

The information booklet includes introduction and background information and describes the rationale for the study. The content also includes an introduction to the concepts of peer-influence and social networks and their possible effects on health outcomes and an outline of desirable buddy-skills/style along with specific practical examples. The booklet was trialled with buddies and feedback was sought on the content. The booklet was also peer-reviewed by the study supervisors and revisions were made to incorporate all the inputs and to simplify and condense the text.

The instructional DVD was developed in two parts. Part one involved developing a voice-over script and a set of slides and graphics to depict a *motivationally adherent communication style*, the fundamentals of behaviour change, and the buddy role. Specifics include

a description of a non-judgmental guiding style, the idea of change vs. status quo, the relevance of personalised goals and values, useful ways to give advice and information (using conditional language) and the importance of avoiding any type of confrontation, directing, arguing or contempt and the importance of being supportive, affirming, and reinforcing of change. The second part of the video involved producing a demonstration role-play of a buddy-MI session. This involved developing a vignette, recruiting actors, recording the session in the studio, audio-visual editing, cover art and post-production. The role-play models some of the different types of positive interactions and *buddy-language* that might occur during a buddy-MI session and on-screen captions are provided to highlight desirable buddy utterances as they occur. The script of the *Buddy basics* DVD was developed with reference to the work of Hettema's (2009) MI training videos, findings by Manuel, Houck, and Moyers (2011) in relation to significant other participation in Project MATCH (Project Match Research Group, 1993), and Apodaca and Longabaugh's (2009) review and preliminary evaluation of the mechanisms of change in motivational interviewing. Attempting to quantitatively evaluate the effectiveness of this buddy-training approach is beyond the scope of the present study; however, feedback from buddies following pilot interviews indicated that the materials are helpful.

The active-control intervention

Because MI *has* been shown to be effective across a range of health promoting behaviours, comparing the experimental buddy-MI to *no-treatment* would not be overly meaningful, notwithstanding the fact that most people who are sedentary are in all likelihood receiving no treatment. Therefore, the control group will receive an active MI intervention. The control group MI intervention differs from the experimental intervention only in that it involves no motivational-buddy.

Treatment delivery

Two related processes, clinical supervision and fidelity monitoring, are required to ensure that quality MI is delivered equivalently to participants in both groups. While related, these two processes are conducted separately as described below.

Therapist skill development / clinical supervision

The therapist/researcher (the first author) holds a Bachelor of Sports Coaching (BSpC) and a Masters degree in Health Sciences (MHealSc) including sports psychology and MI papers, and a three-day training workshop specific to the MITI 3.1.1 instrument (Moyers, et al., 2010). From this baseline, the therapist/researcher received supervision and feedback spanning the pilot period and ongoing into the main study.

During the pilot period, each video recording was first reviewed by the researcher and scored using the MITI 3.1.1 instrument (Moyers, et al., 2010). The MITI scores were entered into a spreadsheet and graphs were generated to map the following dimensions: Global MI Spirit; Reflection: Question ratio (R:Q); percentage of Open Questions (out of all questions; %OC); and the percentage of Complex Reflections (out of all reflections; %CR). In addition, the therapist/researcher carried out self-reflective analysis after selected sessions: writing a reflection (1-2 paragraphs), identifying strengths and less strong characteristics and writing a plan to improve particular aspects of practice as identified.

In addition, the therapist/researcher received fortnightly supervision, feedback and ongoing coaching from a University-based PhD level MI trainer who is a member of the Motivational Interviewing Network of Trainers (MINT) (the second author). Supervision included the review of recordings, coding exercises and calibration of coding, observation and coding of MI sessions in real-time and ongoing reviews of performance, with a focus on continuous skill development. A therapist skill level of competency was achieved consistently across all of the MITI subscales and supervision is scheduled for the duration of the study.

Fidelity monitoring

Ongoing fidelity monitoring will be done via the MITI 3.1.1 instrument (Moyers, et al., 2010) as per the standard recommended protocol for the review of recorded MI sessions. It is important to note that for the purpose of comparable (between-group) fidelity scoring, therapist utterances that reflect buddy utterances are *not* counted even if they are directed back to the client. Total therapist utterances (and behaviour counts) may be reduced depending on the level of contribution made by the buddy but the MITI behaviour count *ratios* hold and the global scores are evaluated using the standard criteria and method. Significant volleys may occur between the buddy and the client but these are not captured by the MITI. Both the Motivational Interviewing Skill Code (MISC) (Miller, Moyers, Ernst, & Amrhein, 2008) and the Motivational Interviewing with Significant Others (MISO) (Apodaca, et al., 2007) could be applied to analyse buddy utterances and provide addition data but this is beyond the scope of the current study.

The fidelity monitoring schedule will be based on retrospective, random, single blinded sampling of 25% of all interviews per quarter. The randomly selected 20 min video clips will be collated onto one DVD for review and rating by the study supervisor. Fidelity data (in particular between-group comparisons) will be analysed and fed back to the therapist during supervision and subsequently used in later data analyses. Table 1 shows the pilot study fidelity scores based on 16 first-session interviews, indicating provision of MI above competency benchmarks. Similar data will be produced for the duration of the main study.

Table 1.

Pilot study fidelity scores via the MITI 3.1.1 instrument, n = 16

Measure	Control group	Experimental group
Global clinician rating	4.45	4.13
Reflection to Question Ratio (R:Q)	2.2	2.1
Percent Open Questions (%OC)	76%	78%
Percent Complex Reflections (%CR)	73%	86%
Percent MI-Adherent (%MIA)	100%	100%

Outcome Measures

Outcome data will be collected in several different ways: self-report via on-line multi-choice questionnaires, objective self-administered fitness tests, coding of video-recorded MI sessions, and free-text exit interview responses. A process evaluation will explore the implementation of the intervention, including number of sessions, treatment fidelity, and participant adherence to the assessment protocol and will include exit survey information describing the participants' own experience of being part of the trial. Data from exit interviews will be analysed for emergent themes using NVIVO™ software. (See Table 2 for detailed information on the study measures.)

Statistical Methods

All statistical analyses will be overseen by the UC Health Sciences statistician/advisor to ensure that appropriate and robust procedures are followed. The SPSS™ software will be used for the analysis. The intention-to-treat principle will be adhered to such that all randomised

Table 2.

Outcome Measures

Outcome measure	Instrument	Explanation	Administered
Primary			
Self-reported physical activity	International Physical Activity Questionnaire (IPAQ) (Craig et al., 2003)	Long form – last 7-days recall, self-administered on-line questionnaire	Baseline, 1, 3 & 12-months
Cardiorespiratory fitness	Cooper 12-minute run test (Cooper, 1968)	Sub-maximal running/walking test to assess aerobic fitness: converted to VO ₂ Max as per Cooper (1968)	Baseline, 1, 3 & 12-months
Health-related quality of life	SF36v2 (Quality Metric, USA)	Self-administered short-form health-related quality of life survey	Baseline, 1, 3 & 12-months
Secondary			
Exercise readiness (stage of change)	Exercise Stages of Change - Short Form (Marcus, Selby, Niaura, & Rossi, 1992)	One item short form exercise readiness questionnaire based on the Transtheoretical Model (Prochaska & DiClemente, 1983)	Baseline, 1, 3 & 12-months
Self-efficacy	Generalised Self-Efficacy scale (GSE) (Schwarzer et al., 1981) with additional Exercise Self-efficacy Scale (ESE) items added (Schwarzer & Renner, 2000)	Self-reported perceived self-efficacy and exercise specific self-efficacy	Baseline, 1, 3 & 12-months
Social support	Norbeck Social Support Questionnaire (NSSQ) (Norbeck, Lindsey, & Carrieri, 1981, 1983)	Measures multiple components of social support including functional properties, network properties, amount of support from specific sources as well descriptive data about recent losses	Baseline & 12-months
Satisfaction with the social relationship (Experimental group only)	Partner Interaction Questionnaire (PIQ-20) (Cohen & Lichtenstein, 1990)	The PIQ-20 modified to change the context from smoking cessation to physical activity	12-months
Motivational-buddy empathy / helping style (experimental group only)	The Helpful Responses Questionnaire (HRQ) (Miller, Hedrick, & Orlofsky, 1991)	A measure of helping-style/ empathy, a brief free-response questionnaire	Baseline
MI outcomes			
Treatment fidelity	Motivational Interviewing Treatment Integrity instrument (MITI 3.1.1) (Moyers, et al., 2010)	Used to code and rate randomly selected interview recordings	25 % random selection of all MI session recordings
Qualitative			
Participant/Buddy exit surveys	A brief six question free-response questionnaire	Analysed using thematic analysis	12-months

participants will be analysed in the groups to which they were originally assigned, regardless of their adherence and the treatment they actually receive and regardless of subsequent dropout or any other deviation from the protocol (Moher, Schulz, & Altman, 2001). If a total of 60 participants enter this two-treatment parallel-design study, the probability

is 80 percent that the study will detect a treatment difference of 0.66 kcal/kg/day (approximately 10 minutes of moderate-intensity physical activity/day) at a two-sided 0.05 significance level. Participants' baseline characteristics will be analysed, intervention dose-by-group will be calculated, and treatment fidelity data will be analysed. Statistical

adjustment will be made in the case of any significant between-group differences.

Between-group changes in means across the primary outcomes will be analysed. Multivariable analysis will be applied to adjust for the possible influence of confounding variables including age, gender and ethnicity. Logistic regression analysis will be used to examine physical activity levels in relation to current recommendations. Cox proportional hazards regression will be used to model participants' progression in relation to the Cooper Institute's fitness categories (Cooper, 1968). Between-group differences in HRQOL will be investigated using analysis of covariance (ANCOVA). Differences in mean scores across the primary outcomes will be compared with previously published estimates of clinically important differences (CIDs) for the primary outcomes.

DISCUSSION

The study, due to report its findings in 2014, aims to test the incremental effectiveness of motivational-buddy support in addition to one-on-one motivational interviewing in people who have expressed an interest in becoming more physically active. It uses a novel intervention design incorporating client-selected motivational-buddies in an effort to mitigate the twin problems of poor adherence and behavioural regression that are commonly associated with physical activity promotion programmes. Strengths of the study include the use of a pragmatic RCT design in a realistic setting, relatively unrestricted entry criteria and analysis of the primary outcomes in accordance with an intention to treat protocol. Together these features will help to provide information about the potential impact of the intervention when introduced into a service, as compared to the efficacy information typically provided by more controlled clinical trials.

As well as the effectiveness data, the study also aims to provide qualitative information on the implementation of the intervention (structure/design/dynamics of the buddy-MI sessions) that may be helpful in the refinement of future buddy-MI iterations. The buddy-MI intervention's therapeutic effectiveness is yet to be demonstrated but the potential implications for the health-care system and the wider community are reduced resource utilisation and healthier lifestyles.

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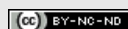
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Motivational Interviewing and Social Justice

William R. Miller, PhD¹

Abstract

This address explores the relationship between motivational interviewing (MI) and six broad humane values: compassion, respect, fairness, human potential, prizing of differences, and collaboration. These values are implicit in the spirit and practice of MI, and have implications far beyond professional practice.

Keywords

Compassion, Motivational Interviewing, Social Justice

One of the few published criticisms of motivational interviewing is that it “ignores the reality of the impact of the social surround” and that “an MI session is a small part of the client’s life.” In voicing this critique, Stanton (2010) was referring to important social determinants of motivation that lie outside the consulting room. Fair enough. We have focused on the dynamics of therapeutic interaction, and have never tried to propose a comprehensive theory of behavior change (Miller & Rose, 2009, 2010). It is important to remember that volition is only one factor in change, albeit a vital one (Miller & Atencio, 2008).

But I want to go Stanton one better. I decided with my plenary this year to go out on a limb, with a call for a consciousness of social justice that is implied by and reaches beyond the spirit of MI. Said another way, I believe that MI is a small part of something much larger, and it is to this larger reality that I want to speak today. Steve Rollnick asked me, “Miller, are you moving the tent pegs of MI again?” I think not. Rather I am reflecting on a much larger field in which we pitched the tent. What I will say here is based on no more than my personal reflections and sensibilities after 30 years of living with MI.

THE DISSEMINATION OF MI: FASCINATIONS

It is, I believe, no accident that motivational interviewing has usually found its home first among some of the most despised, rejected, and marginalized members of society: people with alcoholism, drug addiction, psychoses, HIV and AIDS; the homeless, sex workers, and criminal offenders—those for whom humane treatment is most unexpected, most welcome, and most impactful. Compassionate and respectful treatment of those who are most excluded has been a hallmark of MI from its very beginning—even moreso, perhaps, than was the case for client-centered counseling, which developed within the more

privileged worlds of education and psychotherapy; although in fairness, Rogers did put his therapy to the test at Mendota State Hospital in a controlled trial with schizophrenia (Rogers, Gendlin, Kiesler & Truax, 1967). It fascinates me that MI has been so readily and widely used on behalf of society’s marginalized populations. In her meta-analysis, Jenny Hettema found that MI had twice the effect size when offered to minority populations, compared with White Americans (Hettema, Steele & Miller, 2005).

We are building, of course, upon a strong foundation laid down by Carl Rogers and his students. Later in his life, Rogers (1980) came to understand the person-centered approach as a more general “way of being” with people, and he explored its potential applications in education, management, professions, political discourse, and social change. Now here I am doing the same.

It also fascinates me that so many people seem to be drawn to MI because in some sense they *recognize* it when they meet it—not as something strange that they are encountering for the first time, but as if it were something that they have known deeply and for a long time, like an old friend. To be sure, some professionals now come to MI because of the accumulating evidence base or because they have learned it from the beginning of their training, but I sense that there is something more here. How did MI disseminate so quickly and widely—now in at least 45 languages—with virtually no marketing, and often well in advance of an adequate database? What is it that draws so many caring helpers to MI from so many different professions, nations, and contexts? It is as though we knew it by heart.

HUMANE VALUES

A radical aspect of Carl Rogers’ work is that he placed such emphasis on the mindset and heartset, the spirit with which we work. Here is his own reflection on this:

I was dimly aware—fortunately, only dimly—that I was challenging almost all of the “sacred cows” in the therapeutic world. I was saying in effect, although not very openly, that it wasn’t a question of whether the therapist had been psychoanalyzed, or had a knowledge of personality theory, or possessed expertise in diagnosis, or had a thorough

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acquaintance with therapeutic techniques. Rather, I was saying that the therapist's effectiveness in therapy depended on his or her attitudes. I even had the nerve to define what I thought those attitudes were (Rogers, 1980, p. 270).

What he saw over time was that the attitudes implicit in person-centered counseling (and dare I say, those we have made explicit in the spirit of MI) have implications far beyond professional helping relationships. They are a way of seeing, a way of being in the world. So what are these broader attitudes, these tendencies or dispositions?

C.S. Lewis (1944), among others, maintained that there are certain values that we innately share as human beings – that “certain attitudes are really true and others really false.” We recognize and honor them, if not universally, at least widely. These have come to be called humane or humanistic values. They are shared with and advocated by, but not limited to the world's great religions. “Humanistic” is also the name commonly given to the third wave in psychotherapy – the human potential tradition championed by Rogers and Maslow, in response to its reductionist and mechanistic predecessors of psychoanalysis and behaviorism.

More recently, Karen Armstrong (2010) has advocated for commitment to compassion as a broad umbrella for humane values. Her on-line “Charter for Compassion” states that:

The principle of compassion lies at the heart of all religious, ethical and spiritual traditions, calling us always to treat all others as we wish to be treated ourselves. Compassion impels us to work tirelessly to alleviate the suffering of our fellow creatures, to dethrone ourselves from the centre of our world and put another there, and to honour the inviolable sanctity of every single human being, treating everybody, without exception, with absolute justice, equity and respect (www.charterforcompassion.org).

So what are these humane values? There are many descriptions. I will highlight a list of six core humane values. The first three are set forth as foundational ethical principles in the 1978 Belmont Report on the protection of human subjects that was a response to research atrocities in Nazi concentration camps and subsequently in the United States and other nations. These became the foundation for the protection of human participants in research.

Compassion

The first is called *compassion* by Armstrong (2010) and the Dalai Lama (2001). In ethics it is often called *beneficence*. Compassion in this sense is not an emotion but an intention, a predisposition to act in a benevolent and generous manner to alleviate suffering and promote the welfare of others. Its opposite, maleficence, is to harm others, or at least to act in one's own interest without regard to effects on others.

Respect for Persons

A corollary is an inherent *respect for all persons*. Every human person is of inherent worth and deserves to be treated with respect regardless of income, beliefs, or demographics. Rogers called this *unconditional positive regard*, which includes respect for autonomy and self-determination.

Justice

The third Belmont principle is *justice*—a fundamental humane value for fairness and equity. Each individual is part of a larger community and deserves to be treated equally under the law and in opportunity. Many societies extend this to fairness in the distribution of

resources as well—to see that no one goes without basic human needs for food, clothing, shelter, safety, and healthcare.

Human Potential

Maslow and Rogers added a belief in *human potential* that can be realized, actualized. Given the right conditions, we can trust people to grow naturally in a positive direction. It is a hopeful, optimistic view of human nature, in contrast to the dark impulses of psychoanalysis or the blank slate of behaviorism. Every person has a *telos*, a healthy mature state toward which they will naturally develop if their growth is not distorted.

Acceptance

Fifth, there is *acceptance*, the prizing of differences—the attitude that variety is healthy and valuable in human nature as in biodiversity. This is more than toleration—putting up with differences. It is acceptance, and beyond that curiosity, and beneath that the valuing of differences.

Collaboration

Finally, there is a humane value of *collaboration*, of working together in partnership across differences toward common ends. Its opposite is coercion, the use of power differential to determine whose interests will be served. A lesson of history is that ultimately oppression is doomed—humans cast it off. Coercion by power sooner or later implodes.

I believe that at least these six humane values are in our best interest as a community, as a nation, as a species. The book *The Spirit Level* (Wilkinson & Pickett, 2009) offers overwhelming evidence that a wide array of human miseries are directly related to the degree of wealth inequality in a nation, even in states within the United States: the greater the gap between rich and poor, the greater the suffering of both rich and poor. On average, as a people we are (regardless of income) less healthy, more obese, more depressed and anxious, take more psychiatric medications, have more teen pregnancies and infant mortality, more violence and homicide, more prisons, more alcohol/drug problems, and die younger, in direct proportion to the size of the gap between rich and poor. Living in an unjust society is bad for us all.

The truth and power of these humane attitudes are not unique or limited to counseling relationships. In studying the basic facilitative conditions of a person-centered approach in education, Rogers concluded that “Students of ‘high level’ teachers (those high in facilitative conditions) tended to show the greatest gains in learning. A sobering finding was that students of ‘low level’ teachers may actually be retarded in their learning by their teachers’ deficiencies” (Rogers, 1980, p. 308). It is a striking parallel to what we have found in psychotherapy research, that high empathy facilitates change, and low empathy can be toxic (Moyers & Miller, in press).

But I am saying that these humane values have a claim on us well beyond the testimony of scientific evidence. With Karen Armstrong, C.S. Lewis, the Dalai Lama and the great world religions, I believe that these attitudes, these humane values are simply *true* in an absolute sense. We intuitively recognize and honor them. They are also self-fulfilling prophecies—they are realized as we practice them. They are habits of consciousness that tend to emerge with the extended practice of mindfulness meditation or centering prayer (Keating, 1994). I was also struck, in our study of quantum change (Miller & C’de Baca, 2001), that these people we interviewed, who like Ebenezer Scrooge had been hit by psychospiritual lightning, came to rather similar attitudes despite their huge diversity prior to these experiences. Among their realizations were that:

material reality is a small part of all that is

the nature of God is a love and acceptance so profound that we cannot comprehend it

love is the essence of what we are, and are meant to be

shortcomings should be met with compassion and forgiveness

truth is not to be imposed

all people are profoundly linked.

I wondered whether these are “messages to humankind” trying to get through to us, and these transformed people just happened to be contemporary recipients. I go so far as to believe that these are things we are meant to be.

HUMANE VALUES AND MOTIVATIONAL INTERVIEWING

So what does all this have to do with motivational interviewing? We are, I believe, manifesting these same fundamental humane values in the practice of MI, one person at a time. We embrace collaborative partnership and eschew coercion. We honor and respect the autonomy of each person. We value fairness, generosity, and equal regard for all. We believe that each person has wisdom, strengths, and motivation, and we seek to evoke them. We are interested in, curious about, and prize the differences among people, and we work hard to understand how the world looks from their perspective. We try to keep as our prime directive the other person’s best interests, and to do no harm. These are explicit humane values in MI, attitudes of mind and heart to which we aspire in our practice.

But to practice where? Just within the confines of our consulting rooms? Only inside the MI tent? Those of you sitting here in this MINT Forum are involved in an astonishing array of efforts to live out these humane values well beyond professional practice. For the most part you say little or nothing about it; you just do it. Since Steve Rollnick is not here, I can point without embarrassing him to his volunteer efforts on behalf of children and to reduce suffering related to HIV/AIDS throughout Africa. I have seen inspiring efforts by you to change not only individuals, but whole schools, prisons, and service systems. Why do you do these things? It is related, I think, to why you are here, and why you were drawn to motivational interviewing in the first place.

So lacking data this time, let me tell you a story. In the church that I attend, we began packing and providing sack lunches on weekdays for homeless people in the park across the street. About two years ago, one of these men named Chris showed up on a Sunday morning for worship. He was dressed in street clothes, with disheveled hair, and somewhat intoxicated, but he sat attentively through the service adding an “Amen” or two to which we staid Presbyterians are not accustomed. He was welcomed. People talked to him, encouraged him to come back, and he did. We remembered his name, asked him how he was, asked what he needed, listened to him, and helped with a few basic needs. One Sunday morning, with a little more than usual alcohol on board, he stood up toward the end of the service and loudly proclaimed: “Pastor, I don’t mean to kiss your butt, but you’re the best damned preacher I ever heard!”

He began inviting his friends, and they, too, were welcomed. They invited their friends. After a few months, when someone asked for a sack lunch on Sunday, it occurred to us that these people were hungry on the weekend as well. So we began preparing a simple hot lunch for our park friends. Nobody is required to come to worship in order to be fed, but many of them do. We now have about ten park friends with us on any

given Sunday morning, and it’s clear that the respect, compassion, curiosity, conversations, and belief in their value and potential are far more important than the food. The first of them just got into his own apartment, is stabilized, looks unbelievably better, and now pitches in to help with serving lunch for his friends. Another has put together four months of sobriety for the first time in years. Two who were initially “unmotivated” to get off the street now are taking steps in that direction. Several have become a regular part of the community of St. Andrew church, and we miss them when they’re not there.

Carl Rogers was right, that *attitude* is so important in healing. And it is not limited at all to professional helping relationships. The attitudes of compassion, respect, fairness, human potential, prizing of differences, and collaboration are indeed powerful in healing of individuals and communities. It is such a joy to see those values lived out in the community of MINT.

In my faith tradition we say that it is our task to comfort the afflicted and to afflict the comfortable. How might we practice these values with the privileged on behalf of social justice, with those who have power to change the future? American politics have degenerated into the precise opposite of these values, pursuing change through coercion, shame, blame, demand, and threat. Collaboration is seen as betrayal, compassion as weakness, truth and fairness as optional. What instead would be a nonviolent, evocative response to power? It is what Gandhi and Martin Luther King showed us. Could you sit in a politician’s office and instead of arguing or trying to persuade, ask evocative open questions and reflect? Could you listen empathically to someone who seems to disagree with you dramatically, and seek points of agreement and collaboration? Could you evoke the compassion that is hard-wired and natural in us when we’re not angry or afraid, and strengthen commitment to it?

It is natural to strive to be better. To do that, we must first recognize that we are less than we could be—to develop discrepancy, if you will. A conceptual problem that I have had with Rogers’s personality theory, as I understand it, is his idea that to be mentally healthy is to have concordance between actual and ideal self. Is it really “fully functioning” to have no discrepancy between self-perception and ideal, or is that a personality disorder? It is healthy instead, I believe, to move toward a distant horizon, one that we might never reach individually, but that we can approach. It was Martin Luther King’s unquenchable hope that “I may not get there with you, but we as a people will get there.” My favorite Robert Frost poem, *Take Something Like a Star*, ends:

It asks of us a certain height

So when at times the mob is swayed

To carry praise or blame too far

We may take something like a star

To stay our minds on, and be staid.

These six humane values are a constellation of stars toward which to move, in our practice, in our training, and in all our affairs.

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Welcome Back to *Features and Communications*

Claire Lane

Hello Readers,

Welcome once again to the Features & Communications section. How have you all enjoyed *MITRIP* so far? If you have any comments on the articles you have read, we would love to hear them, so please feel free to send us letters to the editor sharing your thoughts.

We have some tasty treats for you to devour in this section. In *The Office*, we have some helpful reviews of MI books on the common topic of working with children and young people. Additionally, hot off the press, we bring you a review of a recently released MI training DVD set. In *The Lounge*, you will be pleased to hear that our resident agony aunt Iris has been busy coming up with creative resolutions to all your MI related dilemmas. Please keep these coming in, as Iris thrives on a heavy post bag!

I would also like to take the opportunity here to pay tribute to Dr. Guy Azoulaï, a much loved member of MINT, who sadly passed away in July, 2012. I was honoured to get to know Guy a little at the MINT Forum in Sitges (2009). He told me a story about his love of swimming in the sea. In the midst of suffering with chronic back pain, Guy had a dream about swimming butterfly in the sea for miles without needing to stop. He felt this was a sign that swimming may be the solution to his suffering. He told me in great depth about how he braved the waves for the first time after that dream, and managed just a few strokes. He persisted regardless, until he was able to swim at length without needing to stop. He attributed the eventual easing of his back pain to his swimming, and developed a real love for swimming in the sea.

Back in 2009, when the *MITRIP* editorial team were simply a group of volunteers who expressed an interest in being involved, I was delighted when Guy and I were selected as co-editors of the Features & Communications section. We Skyped together, and had great fun thrashing out ideas of what the section could become, expressing our hopes and dreams for this part of the journal to be a melting pot of “informality and topicality.” I referred to him as my “number one co-editor,” and I laughed with affection when he began referring to me as his “glamorous editor lady-in-charge.” However, Guy’s other commitments and increasing health problems meant that he was unable to take an active role in putting the section together. I had fully intended to approach another co-editor to fulfil this role, but have not yet done so. In hindsight, I think I was hoping deep down that perhaps after the first issue of *MITRIP* came out, Guy may have had more capacity to be able to step back into his co-editor role. Sadly, it seems that this dream was simply not meant to be. However, now I have another dream. It is a dream that Guy is at peace, a free spirit swimming in the ocean, looking down on us all with a fond smile.

Until next issue,

Claire Lane
Section Editor

Motivational Interviewing with Adolescents and Young Adults

Sylvie Naar-King and Mariann Suarez

Guilford Press

US \$35.00

Review by Rachel Johnson, DClinPsych¹

As a chartered clinical psychologist working in independent practice in the UK, my clinical time is increasingly filled with families and young people who have found that they simply do not seem to 'fit' the mainstream, often CBT-based, approaches offered within their local mental health services. Families tell me that although they see the value of what was offered, ultimately the input provided has failed to understand or address the complexity of their individual experiences.

With no group of clients is this more prominent than those between the ages of 13 and 21; parents approach me citing discharge letters stating that "poor engagement" or "lack of insight" has affected their teen's ability to benefit from the intervention.

It is perhaps unsurprising, therefore, that I have found myself increasingly drawn towards MI as an approach to help address these issues. MI seems to provide a missing link for clients who find themselves ambivalent not only in relation to the therapeutic input offered, but also about the adult world that offers it, and their own changing role within that world.

Divided into three logical sections, this book sets out to provide a comprehensive introduction to the use of MI with adolescents and young adults, exploring how the core principles of MI can be applied to this age group and some of the common difficulties with which they present. Writing in a clear and pragmatic style, Sylvie Naar-King and Mariann Suarez achieve just that, and the resulting book proved to be easy to read, as well as being a useful and informative clinical guide.

Part 1 presents a guide to the history and central principles of MI with young people; after orienting the reader to the structure of the book, the authors provide a brief, but undeniably valuable, review of some central theories in social, biological and cognitive development in adolescence. Having provided this context, the guide then runs smoothly and coherently through the principles and style of MI interactions; with a clear visual aid to guide the uninitiated from spirit to person-centred skills, through resistance and change talk to plans and commitment towards positive change. Providing tips, examples and summary boxes throughout, this section certainly achieves what it sets out to do, namely providing a sound introduction to the development and rationale of MI, alongside a practical guide to integrating this theory into everyday practice.

Part 2 comprises twelve sections, each focusing on the use of MI with young people on specific behavioural change issues. With sections covering smoking, alcohol and substance misuse, youth offending, psychiatric disorders, eating disorders, obesity and chronic medical

conditions, as well as the application of MI in schools as a family-based intervention, the range of topics is varied without feeling disjointed. A common format for these chapters helps readers draw their own parallels between the areas. Written by an impressive team of over thirty clinicians and researchers specialising in the areas they discuss, each section provides:

- An introduction to the scope of the problem
- An overview of why MI constitutes a useful approach in the area
- A guide to the application of MI spirit and strategies in the area
- Research implications

Part 3 goes on to provide a brief outline of the challenges that might be faced by clinicians looking to integrate MI into their own practice. The first half of this section considers the ethical considerations inherent in balancing the views and goals of client, family, and practitioners, utilising a small range of examples to illustrate four primary ethical guidelines laid out by Miller and Rollnick (2002) for behavioural change. Finally, having made a brief but considered analysis of these, discussion then turns to the process of developing proficiency in MI, from first consideration to the establishment of a MI peer learning group and access of training offered by members of MINT.

This final section offers just a taste of some of the considerations of power, interest, and development that are likely to arise in a journey towards proficiency in MI. However, this is perhaps as it should be. Whilst those already familiar with and utilising MI within their everyday practice will certainly find this book to be a useful resource to revisit skills and principles, perhaps adapting these for use with a different age group, it will be perhaps of most interest to those new to the area. Clinicians from a variety of professional backgrounds who are new to the theory of MI and are seeking different ways to engage adolescents and young people in therapeutic settings will find this to be an accessible guide. The clarity of structure and helpful chapter summaries make the book easy to pick up, even in the midst of a busy clinic.

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The author reports no conflict of interest.

Motivational Interviewing for Effective Classroom Management

Wendy M. Reinke, Keith C. Herman, and Randy Sprick
Guilford Press
US \$35.00

Review by Karen Marsh, BSc, PGDipCouns, PGCE ¹

I have spent twenty years in the motivational interviewing field, and for the past seven years, I have been working in education. Qualified in counselling and teaching, I have a keen interest in the application of MI in schools and how it fits within a school culture. This book was therefore of particular interest to me as, due to its focus on the application of MI in the classroom.

Essentially this book aims to equip classroom consultants with the skills to enable them to assess and coach teachers to improve their classroom management (with a view to improving pupils' experience of education and achieving better grades). The book combines two main ingredients: the tenets of the MI approach and the classroom check-up model (a consultation process with teachers about methods of teaching, focusing specifically on classroom management).

Sufficient theoretical detail is provided to enable the reader to understand the basic foundation and skills of the MI approach. Additionally a wide variety of examples make the approach come alive. The explanations and sample dialogue extracts give a good sense of the approach that could help a reader feel confident enough to try out the basic skills. The main chunk of the book is devoted to the classroom check-up model and its application. Many practical examples are provided, which again enable the reader to confidently use it.

The book succeeds in meeting the essence of its title. At the end of the text, the reader will likely have a full understanding of the MI approach, the classroom check up model, and how these relate to classroom management. In addition to the plentiful examples which bring the approach and the model to life, there are many photocopiable resources to equip the reader in the application to their work.

It could potentially be quite a challenge to combine the conversational style of the MI approach with a model that is very statistically weighted (not only does the consultation method involve lots of paperwork, the feedback to teachers is presented with numerous percentages and graphs). However, if consultants have the spirit of motivational interviewing as the foundation to their communication, the more statistical aspects of the model could nonetheless be integrated.


I feel that this book is very useful for teachers at differing stages in their career. It could be a useful tool alongside teacher training, and has the potential to be integrated into teacher training programmes. From my own experience of UK postgraduate teacher training, I remember that there was little focus on communication and issues of classroom management. This book could support a worthwhile unit of learning on teacher training to that end.



This book could be beneficial to newly qualified teachers. As in driving (in that one only learns to drive independently after passing the driving test), teaching has a similar nature. Once newly qualified teachers have had chance to settle into their role, the model presented in this book could certainly prove valuable. Teachers who have previously been trained in punitive disciplinary methods may also welcome these alternative ideas to encouraging improved pupil focus and behaviour at school. It may be less beneficial to those who do not work well with figures, given the statistical nature of the feedback. The model is fairly formulaic and may not suit professionals who prefer other methods of assessment.

Overall, I think this book is well presented, easy to understand and has a useful application in education.

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Motivational Interviewing

Theory, Practice, and Applications with Children and Young People

Eddie McNamara (Ed.)
Positive Behaviour Management
£25.99

Review by David S. Prescott, LICSW ¹

Those working directly with children and adolescents are aware that the first minutes of any interaction can be vital to the success of treatment. Having used motivational interviewing with this population for the past decade, I was relieved to hear of this book (as well as others about using MI with this age group), and I became immediately interested in reviewing it. Like the book's editor, I am interested in motivational interviewing in contexts involving large treatment teams, whether in schools or inpatient treatment situations.

Recent discussions among members of the Motivational Interviewing Network of Trainers (MINT) have centered on the nature and limits of MI, particularly when the third edition of Miller & Rollnick's defining text has become available. Prominent members, including Bill Miller, have compared MI to a tent, and wondered whether changes in MI result in ever-changing placement of MI's conceptual tent stakes. In between the second and third editions, Miller and Rollnick's important 2009 article on "ten things that MI is not" followed Miller and Moyer's 2006 article proposing eight steps that people take in learning MI. Most recently, at his plenary address at the 2012 MINT Forum, Bill Miller invited attendees to "go outside of the tent" every once in a while.

Into this period of transition comes Eddie McNamara's book. Its target audience includes counselors and teachers, and to that end presents itself as friendly, sympathetic to professionals and young people alike, and easily accessible. Published in 2009, it pre-dates some of the recent evolution of MI. Just the same, many readers will find sections and passages that are well outside of the MI tent.

McNamara has assembled a group of authors who are no strangers to the front lines of MI in schools and counseling situations. The first section of the book focuses on theory and practice of motivational interviewing, with one chapter providing a general overview and an entire chapter devoted to "rolling with resistance", a concept deconstructed (into "sustain talk" and "dissonance" or "discord") in the current iteration of MI. Herein lies the dilemma. On one hand, teachers can benefit from the information contained in this book. Rolling with resistance is better than the aggressive alternatives in place in many schools. On the other hand, the book does not reflect the collective ambivalence experienced by many MI practitioners, as well as Miller and Rollnick themselves, regarding the concept of resistance.

Part Two of the book focuses on applications of MI with children, adolescents, their teachers, and families. These chapters are helpful, and focus on specialty areas of interest to many in the professional trenches. There is a chapter on educational settings generally, hard-to-

reach parents, and combining solution-focused approaches with MI. Part Three addresses systems-level intervention, and includes chapters on the stages of change model (which is not a part of MI, despite their close historical interactions) in facilitating change at the level of an entire school, and incorporating MI strategies into a consultation model for use within school-based behavior-management teams.

Overall, the book emphasizes the stages of change model. It focuses much less on the importance and elicitation of change talk than one might expect, given the attention this aspect has received since Amrhein's important research from 2003. Not surprisingly, there is a strong emphasis on Gordon's roadblocks model, which—like the stages of change model—is often-mentioned in MI trainings but is not actually MI. In some cases, the use of sections and sub-sections can be confusing. For example, in Chapter 9, one might come away believing that the OARS micro-skills are connected solely to the principle of supporting self-efficacy. Likewise, Chapter 2 lists some, but not all, of the OARS skills (reflective statements) and includes them with other strategies, such as coming alongside and reframing, which are specific to responding to discord or resistance. Chapter 1, however, states clearly that the goals of motivational interviewing include increasing knowledge and concern and promoting self-efficacy, internal attribution, and self-esteem (p. 17). Strikingly absent is the elicitation of the client's own goals or values. This kind of inaccuracy casts a shadow over the entire book. In fact, the book asserts that two of these purported goals are aimed at facilitating movement through the precontemplative and contemplative stages of change. While there is reference to MI spirit, it is woven in throughout the text rather than appearing for discussion in its own right.

Ultimately, MITI coders, and MI purists will have reason to take exception to much of the material in the book, even though it will doubtless be helpful to researchers. To some degree this book also suffers inadvertently from poor timing in that it was published three years prior to the most recent definitive MI text. McNamara's text, however, does offer helpful case examples and suggestions (such as understanding how the stages of change model can be useful in understanding parents' motivations and a potentially useful card sort for assessing some aspects of adolescent motivation that could be one alternative for challenging situation) of use to professionals, making it a worthwhile addition to a school's resource library. It would have been more helpful if it was packaged as a combination of motivational approaches alongside helpful models, such as Gordon's roadblocks and the stages of change. Although it was not intended as a definitive text, it is not without merit. It is, however, outside the MI tent.

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The author reports no conflicts of interest.



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Motivational Interviewing Step By Step

Four DVDs

Available at www.psychotherapy.net

US \$199.00 (individual license)

US \$599.00 (group license + instructor's manual)

Review by Julie A. Schumacher, PhD¹

As a clinical psychologist and associate professor, who has been actively involved in MI training and research for the past 8 years, I was interested to review the four-part DVD series, *Motivational Interviewing Step By Step*. Cathy Cole, LCSW, shines as the star of this series. Her expertise as both a practitioner and trainer of MI are evident throughout each DVD. The information provided in the series incorporates several updates to MI terminology and concepts introduced over the past decade. Thus the series is valuable both to the MI novice and the experienced MI practitioner/trainer interested in a “refresher course.” Cole’s warm and casual presentation style is complemented by series moderator Victor Yalom, Ph.D. Yalom engages Cole in discussions about core concepts of MI, as well as the MI sessions depicted on each DVD. While seemingly unscripted and casual, these lively discussions provide the viewer with a clear, logical, and linear explanation of MI concepts. Yalom’s curiosity about MI and how it differs from other approaches guide him to ask Cole probing questions that deepen the discussion of MI and further clarify concepts for viewers.

The DVDs are titled “Core Concepts,” “Increasing Importance,” “Resolving Ambivalence,” and “Increasing Confidence.” The “Core Concepts” DVD is largely didactic, and contains small segments of MI sessions conducted by Dr. Bill Miller to illustrate or reinforce specific MI concepts as they are discussed, as well a series of interactive practice exercises based on MI session segments conducted by Cole or Miller. The remaining three DVDs each contain a brief didactic introduction followed by 3 full-length MI sessions conducted by Cole to illustrate MI concepts. Each MI session includes an introductory discussion by Yalom and Cole, periodic pauses in which Cole provides a brief commentary that allows the viewer to better understand which MI concepts or techniques are being illustrated at various points during the session, and a debriefing discussion by Yalom and Cole.

As implied by the title, in the “Core Concepts” DVD, key elements of MI are reviewed, including: definition, spirit, applications, change talk, phases, and core techniques. During the practice exercises at the end of this DVD, Cole provides viewers with a valuable opportunity to generate MI responses in real time as they observe an MI session. For each exercise, Cole first reviews the core concept viewers will draw on to generate their response, then presents a brief segment of an MI session, and finally instructs viewers to pause the DVD and generate a particular type of response. The exercises seem like a great, non-threatening way for MI novices to build skill, because the only task for the viewer is to generate a particular response, without the added burden of having to first determine what type of response might be best at that point in the

session. I used these exercises in a recent MI training for medical students, and the response from the students was overwhelmingly positive. Although the training group was very new to MI and had only participated in about 5 hours of training at the time I introduced these practice exercises, they felt confident shouting out responses each time the video was paused. In addition, these exercises appeared to deepen their understanding of MI concepts and techniques.

The DVD entitled “Increasing Importance” opens with a discussion of the progression from sustain talk to change talk during an MI session. This DVD includes three very different MI sessions in which the client is uncertain about the need for change: a mandated college student drinker, a mother who is defensive about her pediatrician’s assertion that her daughter is overweight, and a high school senior who is considering dropping out. These sessions provide opportunities for Cole to demonstrate how providers in various roles (i.e., college counselor, health educator, and high school counselor) can use various techniques for increasing importance, such as feedback and envisioning. These sessions, particularly the second session, in which Cole acts as a health educator, also demonstrate the importance of resisting the righting reflex with clients who are uncertain about the need for change.

The DVD entitled “Exploring Ambivalence” includes three MI sessions in which Cole acts as a counselor in an employee assistance program and a health educator. At the outset of this video, Cole and Yalom engage in a discussion about ambivalence and the sources of ambivalence. This DVD provides a valuable opportunity for Cole to discuss and demonstrate the importance of adopting an equipoise stance when working with clients who are considering changes that are neither objectively “good” nor objectively “bad.” This stance is demonstrated in sessions in which an EAP provider is assisting a client in deciding whether to take a promotion or keep his current job and a health educator is assisting a mother in deciding whether to continue to breastfeed her one year old child. This equipoise stance is contrasted to an approach in which a health educator strategically reinforces and focuses on change talk during a discussion of smoking cessation. I also showed the smoking cessation session during the recent training I offered for medical students, and the students’ responses were uniformly positive. Although they were most struck by how good Cathy Cole is at MI, and how powerfully beneficial MI can be for patients approaching difficult behavior changes, they also discussed the ways in which the commentary before, during, and after the session helped increase their understanding of MI.

The final DVD, entitled “Increasing Confidence,” opens with a discussion about how and why confidence is essential for behavior change as well as strategies for increasing confidence. In the three MI sessions included on this DVD, Cole acts twice as a health educator and once as a counselor. Clients in these sessions are a single mother who



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is uncertain about how to incorporate more exercise into her busy life, a teenager who would like to change her diet, and a man who would like to make more progress toward financial security. In these sessions Cole demonstrates how developing a plan, eliciting past successes, and affirming strengths, among other strategies, can be used to enhance client confidence about change. During the second session, the teenager with whom Cole is working is very loquacious. Thus, this session provides Cole with the opportunity to demonstrate not only how to change-plan and increase confidence, but also how guide a session back to the agreed upon focus in a manner consistent with the spirit of MI.

In sum, this DVD series provides a review of the core concepts of MI including updates over the past decade, a set of interactive practice exercises, and nine full-length MI sessions depicting how providers from various professional backgrounds working in diverse settings might use MI to help clients make a variety of important life changes. The discussion and commentary that accompany each MI session allow viewers an invaluable window into Cole's thinking as she conducts an MI session. Thus, these sessions allow viewers to observe how MI sessions unfold from engagement, to focus, to evocation, to planning, and to understand the provider metacognitive processes that underlie this unfolding. Although the "Core Concepts" DVD is a valuable stand-alone training resource that would a worthwhile addition to any MI library, the subsequent DVDs in the series add great richness to the understanding of MI. Each of the subsequent DVDs can also be used as a stand-alone training resource, as each begins with a brief review of core MI concepts. However, these DVDs are likely to be most valuable if viewed after the "Core Concepts" DVD.

As noted previously, this series would likely be a valuable learning tool for both novice and experienced motivational interviewers. For the latter, this series would be valuable as a refresher course. For the former, this series would be a valuable adjunct to formal training and coaching. The series could easily be incorporated into formal training (using the instructor's manuals that accompany the Institutional / Instructor's Version as a source of valuable tips for how to use the DVDs as part of a formal training) or could be viewed before or after formal training to reinforce concepts and enhance learning. Many learners at all levels will likely appreciate the availability of CE credits from psychotherapy.net for this video series.

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Dear Iris

Dear Iris,

I have an embarrassing problem. I hope you might be able to help.

The problem is that I can't stop reflecting. Reflection was a skill that I struggled with initially, so I decided that I would try to practice reflections at every opportunity. Gradually, I found myself more able to stop asking questions, and became addicted to the depth of responses that I got not just from my clients, but from all those around me.

Initially, this meant that discussion at the dinner table was a little more plentiful at home, which was great for the entire family. However, it has escalated to the point where I am bringing queues to a standstill as the shop assistants tell me the story of their lives. Dinner at home now takes a minimum of three hours, and the kids have no time to do their homework so they are getting into trouble at school. People who stop me to ask for directions often end up having lengthy chats over a cup of coffee, rather than getting where they need to be.

I am ironically on the verge of social exclusion due to my ability to empathise and listen to others. I have tried not to reflect in public, but everything I've tried instead hasn't worked. My friends and family have started calling me the 'talking mirror'. I feel so ridiculed, but helpless to stop reflecting. How can I give up something that makes life so interesting?

Yours in desperation,

A super-complex reflection

Dear Iris,

As a trainer with several years experience, I have to say that I am dismayed by the fact that a new MI book has come out. New terminology, new spirit component, no more principles? Some of my best training exercises are about MI principles! They worked really well too!

Do the authors not appreciate that I am going to have to spend hours redesigning my PowerPoint slides, thinking up new exercises and restructuring well developed training plans? Do they not care about how good my trainings were? Little by little is one thing, but they have turned this into a major training material overhaul.

Why are they doing this to me?

Yours disgruntled,

Resistant to change

Dear Resistant,

I can see you are a very dedicated trainer, who integrates new material into trainings to remain contemporary and up to date. You clearly care about your trainees and endeavour to do the best that you can to deliver effective training.

I can see that you feel put upon. It feels almost like your autonomy as a trainer has been violated by these authors, by them taking a description of MI that you were happy with and changing it, without you having any say over the kinds of changes that they made. Now, you feel you are being forced to change against your own will.

It seems to me that you have three options, rather than just one. The first is to stay the same and not change your materials. Alternatively, you have the option to change some things, but keep the others that you were happy with. The final option is to change everything in line with the contents of the new book. There are pros and cons to each of these options, and you are best versed to weigh up what those might be for you personally. If you decide to make changes to your trainings, remember that you are more likely to succeed if you aim to make small changes over a period of time, rather than trying to change everything immediately. There is an entire MINT community out there to support you working through these dilemmas, if you would like this assistance.

Alternatively, you could buy up all the copies of the new book and burn them, so that the information does not get out. Then you can remain up to date without having to change your materials. In fact, you could find other like-minded trainers and have burning parties where you toast marshmallows and devour them slowly as you watch the new texts go up in flames. This of course, would be a more costly option, but could potentially be a lot of fun.

I wish you the best of luck with whichever path you choose.

Yours affectionately,

Iris xx

Dear Super-Complex,

It certainly seems like developing your reflection skills was very important to you. You managed to embrace reflections to the point that they became instinctive. That must have taken real determination.

However, you seem to have reached a point where reflections are starting to stand in the way of your daily functioning, and that of others. You say that reflections make your life interesting. I wonder how ready you might be to change this.

I also wonder if perhaps you may need to give due consideration to some of the other OARS. If you only use one oar, you just end up going round in circles. Additionally, you may wish to think about direction in your reflections. Where do the people you are speaking to want to get to, within the context of what they are doing at that moment? Evidence is suggesting that it is important for us to help clients find direction towards their goals, rather than becoming distracted from this.

Failing that, I've heard that a well known stationery chain has heavy duty parcel tape on special offer at the moment. I'd invest in some, and place it firmly over your mouth, for the sake of your own wellbeing and that of wider society.

Yours affectionately,

Iris xx



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