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Motivational Interviewing in Groups

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ABSTRACT. Motivational Interviewing (MI) is a counseling approach that has strong empirical support in individual interventions. There is emerging evidence that MI can be adapted, with a few critical modifications, to a group therapy format. Few published reports, however, have addressed the process of using MI in groups. We detail a number of recently developed strategies for adapting MI to groups and use transcripts from a cocaine abuse study to illustrate the application of MI to the group setting. We also present coding results from the group sessions using the Motivational Interviewing Treatment Integrity (MITI) scale to assess MI treatment fidelity. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com>*

KEYWORDS. Motivational Interviewing, group therapy, group treatment, transtheoretical model, stages of change

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Group therapy is one of the most widely used modalities for both inpatient and outpatient substance abuse treatment. A number of factors contribute to the popularity of group therapy. The cost effectiveness of group treatment likely accounts for its widespread utilization in most community-based treatment settings (Miller & Hester, 1980). Additional benefits of group therapy for substance abusers are: (1) a group format can provide safe opportunities to remediate interpersonal deficits that are common in substance abusers; (2) peer feedback and modeling may have more impact than counselor-generated information; (3) interactions with peers may also help members generalize their new change efforts to the "real world"; (4) the realization that others share similar problems and the opportunity to impart information and help others may enhance feelings of self-worth; and (5) groups can provide a meaningful social support system (Connors, Donovan, & DiClemente, 2001).

Individual and group interventions typically focus on promoting positive change. Motivational Interviewing (MI; Miller & Rollnick, 1991, 2002), an evidence-based approach that makes this focus explicit, has been widely utilized in individual interventions (Burke, Arkowitz, & Menchola, 2003; Dunn, Deroo, & Rivara, 2002; Hettema, Steele, & Miller 2005), and there is emerging evidence that MI can be adapted, with a few critical modifications, to a group therapy format (Foote et al., 1999; Ingersoll, Wagner, & Gharib, 2000; Lincourt, Kuettel, & Bombardier, 2000; Sobell et al; Van Horn & Bux, 2001). The efficacy of an MI group approach, however, is still unknown, as only a few published reports to date have addressed the impact of group MI. Sobell et al. (1995) compared an individual "Guided Self Change" (GSC) intervention to GSC delivered in the group setting. GSC is a brief cognitive behavioral self-management treatment designed as a motivational intervention to help mildly dependent alcohol and drug abusers formulate and implement their own treatment plans. Treatment provided in the group format produced similar outcomes for both alcohol and drug abusers as the same treatment provided individually. Bailey, Baker, Webster, and Lewin (2004) found that a group intervention with MI and cognitive behavioral elements improved knowledge and attitudes about drinking among at-risk adolescents, and the MI-CBT group reported reduced frequency of drinking compared to a control group. Among heavy drinking college students, a group intervention including MI components was not more effective than mailed feedback, possibly due to social comparison effects that increased group members' perceptions about normative alcohol consumption (Walters, Bennett, & Miller,

2000). Among alcohol dependent adults undergoing detoxification, group and individual interventions based on MI yielded similar abstinence outcomes, though the MI group had a higher rate of participation in self-help groups six months after treatment (John, Veltrup, Driessen, Wetterling, & Dilling, 2003). Unfortunately, as none of these studies employed MI groups without other treatment components, further studies are needed to determine the clinical efficacy of group MI.

Despite the popularity of MI in individual substance abuse counseling and the appeal of adapting MI for use in group substance abuse treatment, information on *how* to apply MI in groups has not been widely disseminated. In this paper, after a brief review of MI philosophy, principles, and methods, we will discuss issues involved in adapting MI to group and present case examples from an MI group treatment for cocaine abuse.

MI AND STAGES OF CHANGE

The stages of change (SOC), first identified by Prochaska and DiClemente (1982), are the temporal, motivational aspects of the change process. According to this model, individuals often enter the change process in the Precontemplation stage as they are unconvinced that they have a problem or are unwilling to consider change. Individuals who then move to the Contemplation stage begin to consider making changes in the distant future. In the Preparation stage, individuals have more proximal goals to change and begin to make commitments and develop plans to change. The Action stage is characterized by individuals' changing the target behavior and adopting strategies to prevent relapse. And in the Maintenance stage, individuals solidify their change and integrate it into their lifestyle.

MI is especially useful in the earlier stages of change as it promotes the exploration and resolution of ambivalence about change by highlighting and increasing an individual's perceived discrepancy between current behavior and personal goals and values (Miller & Rollnick, 1991, 2002). Thus in MI, ambivalence, which is common in the earlier stages of change, becomes a tool to enhance intrinsic motivation to begin to initiate and maintain behavior change efforts. MI is also an important element to incorporate in later more action-oriented stages as client change processes are promoted in the context of an empathic, supportive counseling relationship that promotes self-efficacy and rein-

forces accomplishments that occur in the action and maintenance stages of change (DiClemente & Velasquez, 2001).

The MI approach begins with the assumption that the agency for change is within the client, so the counselor's task is to assume a collaborative and encouraging role and create a set of conditions that will enhance the client's motivation for and commitment to change. The MI counselor expresses empathy, manages resistance, and supports the individual's self-efficacy by using counseling techniques such as open-ended questioning, reflective listening, summarizing, and affirming (Miller & Rollnick, 2002).

Many traditional substance abuse treatment approaches that are highly confrontational often actually *promote* client resistance. In contrast, an essential principle of MI is to reduce resistance and elicit the client's own concerns about a problem behavior because when the client (rather than the counselor) articulates the reasons for change, the client's internal motivation becomes the active ingredient in the change process.

Miller and Rollnick (2001) have described four principles and five counseling strategies that are key to the MI approach. These MI elements will be discussed in terms of their application to substance abuse interventions.

MOTIVATIONAL INTERVIEWING PRINCIPLES

Develop Discrepancy

To highlight and amplify discrepancies, as perceived by the client, between his/her substance use and personal values and future goals, the consequences of continued substance use are explored, often by looking at the advantages of changing and the disadvantages of not changing. As the client becomes more aware of the discrepancies, the client–rather than the counselor–may begin to generate rationales or arguments for needing to make a change.

Roll with Resistance

When the counselor senses resistance, it is time to change the approach. This is an important principle because a client's energy that could be directed toward positive change is diverted instead into defensive maneuvers, which usually result in an escalation of resistance.

When resistance is detected (e.g., client's interrupting, changing the subject, denying, challenging), instead of ignoring or "fighting" it, the counselor "uses" the client's resistance by employing one or more MI strategies such as simply reflecting the client's concern or reframing the issue so the client does not feel defeated, anxious, or angry about sharing his/her concerns.

Express Empathy

In MI, the counselor actively listens to the client without being judgmental, critical, or blaming in order to better understand the client's situation and perspective. Because the counselor understands that a client who is in an earlier stage of change may not be ready to give up substance use, the initial focus is on building therapeutic rapport and supporting the client, rather than on directly promoting change.

Support Self-Efficacy

The counselor supports and builds the client's confidence in having the ability to change in a variety of ways. For example, self-efficacy is enhanced by a positive counselor-client relationship in which the client feels understood and supported. Other approaches are presenting the client with examples of positive changes he/she has made in the past and highlighting the importance of the client's courage in considering choices and taking responsibility.

MI COUNSELING STRATEGIES

Miller and Rollnick (2001) identify four specific clinical strategies that form the fabric of MI. These techniques are summarized by the acronym OARS: Open questions, Affirmations, Reflections, and Summaries. Open questions, as opposed to closed ones, promote discussion and exploration. Affirmations convey respect and appreciation and highlight client successes. Reflections, which are used selectively to convey an understanding of the client's perspectives and reinforce motivation, can be of several types including simple, amplified, double-sided, and reframes. While these four clinical skills are fundamental to good counseling, what differentiates MI from purely client-centered counseling is the strategic, directive use of these techniques to help clients explore their ambivalence and clarify their reasons for change. Once good rapport has been estab-

lished and ambivalence has been explored, a fifth type of strategy, Eliciting Change Talk, can be utilized to begin to shift the client's ambivalence in favor of change. One way a counselor can promote Change Talk is to help the client explore the costs and benefits (or "pros" and "cons") of making a change and to think about his/her level of readiness for change.

It is important for an MI counselor to be able to recognize Change Talk as it can be a sort of "homing beacon" that provides immediate feedback indicating that the counselor is headed in the right direction (Miller, 2001). One type of Change Talk is an expression of longing or DESIRE to make a change, such as "I want things to be different–I want to have drugs out of my life once and for all." A second type of Change Talk involves statements that indicate the client feels that they have the skills and resources to make a change–in other words, they feel they have the ABILITY to change. An example of this type of Change Talk is, "I stopped using once before, so I know I can stop again." An example of a third category of Change Talk, the expression of a NEED to change, is "I've got to get off drugs in order to get my life and self-respect back." The fourth kind of Change Talk is client statements about REASONS for making change, such as "I worry about how cocaine has hurt my health and drained my pocketbook." While none of these four types of Change Talk independently predict outcome, they all predict an increasing Commitment to Change, which in turn is strongly related to positive outcomes (Amrhein et al., 2003). These synergistic processes can be represented as:

> Desire + Ability + Need + Reasons -> Commitment to Change -> Positive Change Outcome.

In sum, the task of the MI counselor is to help the client resolve ambivalence for change by "tipping the balance" in favor of change by reinforcing client responses that indicate desire, ability, need, and reasons for change. In other words, the counselor's strategy is to elicit and selectively reflect Change Talk whenever possible. As the client's motivation and commitment to change increase, the MI counselor shifts from focusing on motivational enhancement strategies to using techniques to further support commitment for change such as helping the client set goals and develop a specific change plan.

ADAPTING MI TO GROUPS

A significant strength of the MI approach is that it is a counseling style that can augment other treatment components. For example, research has shown that MI can be effective on its own as a treatment or as a prelude to other, more traditional substance abuse treatments (Burke, Arkowitz, & Menchola, 2003). However, adding MI groups to the continuum of care for substance abusers can present some challenges. One consideration is the philosophy of the treatment program that is seeking to add an MI component. A philosophy that includes assumptions that individuals are powerless to make change and that immediate abstinence is essential may seem inconsistent with MI tenets that emphasize personal choice and agency and support successive approximations towards a goal as a means of building self-efficacy. Because differing philosophies can be confusing for clients and staff alike, if MI clinicians find that MI principles present philosophical challenges within the context of a particular treatment program, they are advised to seek open dialogue with peers and supervisors about ways to resolve seemingly contradictory beliefs about treatment and the nature of change. A more detailed discussion of implementation issues in group MI can be found in Ingersoll, Wagner, and Gharib (2000).

Beyond philosophical issues, there are also challenges that stem from adapting a highly individualized approach such as MI for a group. The MI spirit focuses on three MI aspects: collaboration, evocation (i.e., elicitation of client concerns), and conveying empathy and respect for the client's autonomy. In individual interventions, the MI counselor seeks to understand the client's perspective and to draw out the client's "arguments" for and commitment to change, rather than inserting the counselor's opinions and biases. In a group format, all members of the group are encouraged to share views and experiences as a means of providing learning opportunities for the group. If, however, member feedback comes across as judgmental, critical, or self-interested–rather than empathic–it can engender resistance. To counter this possibility, the counselor works to create an atmosphere of mutual respect and collaboration, models positive ways of providing feedback, and gently redirects less helpful comments and responses. Another issue to be considered is that because the group is seen as the "client," MI counselors must continually attend to group processes rather than slip into a mode of conducting individual therapy within the group. At the same time, focusing primarily on group process may limit a counselor's ability to elicit each member's concerns and perspectives. Moreover, be-

cause group members are often quite diverse in terms of their target behaviors, stages of change, and reasons for change, the MI process of understanding and eliciting reasons for change for each group member might serve to emphasize the group's heterogeneity rather than its universality which is one factor believed to be curative about the group therapy process (Yalom, 1995). This concern may be ameliorated, however, by the counselor's continual fostering of the MI encompassing precept of affirmation and respect for different experiences and perspectives.

It is clear from this brief discussion that the counselor employing MI in a group setting should ideally be highly skilled and experienced both in MI and in group therapy processes. The effectiveness of MI in group-based treatments is likely to be maximized by incorporating some of the following provisions.

Present the Style and Spirit of MI When Opening the Group

Before providing standard group-type introductions and agreeing on group "rules" (e.g., not interrupting, avoiding monopolizing, arriving on time), present an overview of how the group will be conducted. Begin by telling the members that you are here to help them learn more about themselves and whether there are any changes they would like to make. Assure them that while you have some knowledge and the skills that may be helpful, *if there is any changing to be done, they will be the ones to do it.* This means that the responsibility for change is up to them, and you will not coerce or try to force them to change in any way. Tell members that although you are the group facilitator, they each play an important role in helping other group members. Explain that the group will use the motivational approach, meaning that members will help facilitate change in one another through supportive interactions. *Emphasize that unlike some models of substance abuse treatment, this approach explicitly avoids confrontation.* Clarify that the group attitude will be one of empathy, acceptance, and respect for individual differences, and you may want to note that research shows that a supportive, empathic manner is much more effective than a confrontational one. Since this type of group may be a new experience for some clients, set aside a few minutes for them to talk about their reactions to this approach. Keep in mind that norms are established early in the course of a group and are not easily changed (Yalom, 1995). Thus, the ground rules of the group should be made explicit at the beginning of each session. Tactfully informing members at the outset that hostile or dominating speech is not part of

this group's "style" will help discourage disruptions and the possibility of one person's dominating the group.

Some counselors find it helpful to use the acronym "OPEN" in starting the group.

*O*pen with group purpose: to learn more about members' thoughts, concerns, and choices
*P*ersonal choice is emphasized
*E*nvironment is one of respect and encouragement for all members
*N*on-confrontational nature of the group

The following sequence of the opening of an actual first session illustrates the introduction to group MI as well as the counselor's use of empathy, open questions, reflective listening, and affirmation. This group was conducted as part of a project funded by the National Institute on Drug Abuse (RO1 DAO15453) to study the effects of a stage-based group treatment for cocaine abusers. The intervention is based on the group sessions detailed in "Group Treatment for Substance Abuse: A Stages of Change Therapy Manual" (Velasquez, Maurer, Crouch, & DiClemente, 2001).

COUNSELOR: This is likely to be kind of a different group from some of the other groups you've been in. This group uses the motivational approach. It's not a confrontational kind of group. It's a group where we are more interested in supporting each other, in helping you find out some things about yourself, if you want to make any changes. So it is not a group that is confrontational. We're a group that looks to work with respect and empathy and acceptance. Acceptance really means our hearing what the other person has to say–we don't have to approve of what they say or not, just hearing what the person is saying. So this is not where we want to get in each other's face. Any questions about that? Is that good for everyone?

Client A: Yeah, this is like a peer group. A peer group really is like where we all try to find a problem and a solution so we can help each other out, some might have a thought or somebody else might have a suggestion, that's what it is.

COUNSELOR: [*affirmation*] Uh huh. You got it exactly right. We're here sort of as a support group. We're interested in learning about your situation, where you may or may not want to make changes. But, importantly, remember in this group our roles are not to tell anybody what not to do, that doesn't seem to work very well. So we are here to find out

what you want to do. It will be your choice. Why don't we start with CA? CA, tell some things you hope to get out of our group.

CA: It's been 15 years that I relapsed. I stayed clean for about a year and a half, and then I relapsed again, and when I relapsed, I stayed in the mode of relapse for years. I'm tired of this. I want to go back and improve. So for me, what's going on with me, I have just stayed like in the mode until I really, really get sick and tired all over again.

COUNSELOR: So one of your goals . . .

CA: Well, I'm tired.

COUNSELOR: [*empathy, selective reflection emphasizing momentum*] You're tired. . . you want to get something to help you move on. . . I think what you are saying is really going to tie in with what we are going to do in our meeting. It makes a lot of sense, kind of wanting to move from being tired. What about you, CB?

CB: Two and half years ago, I relapsed. I started smoking (crack). I got myself out of the penitentiary, and I stayed clean for some time, but by 1992. . . I don't know, but I've been trying. I'm working with myself at times, kept it at a limit to where I don't overdo it, and I've been trying not to do it to a point where I don't want to do it no more, and I still can't find the way out, you know so I'm just basically looking for a way out.

COUNSELOR: Looking for a direction.

CB: Yeah

COUNSELOR: Yeah . . . you're trying to find a point where you can get a new direction. Okay, thank you.

CB: (nodding) You're welcome.

COUNSELOR: [*open question, facilitating participation by other members*] And how about what you (another group member) hope to get out of this group?

CC: Well, I been drinking really since I was 14. I mean I gotta say I haven't ever relapsed, cause I ain't ever stopped, so hopefully, just hopefully, maybe, maybe I will find something or see something or hear something that maybe will change me to the right direction.

COUNSELOR: [*reflection that emphasizes common ground with other group member*] You are looking for something, too, to change the direction.

CC: I love drinking, I love to drink, but I hate doing it, you know–the blackouts. I hate doing it. The stupidity that goes with it, but hell, I love it.

COUNSELOR: So you never tried to quit before.

CC: Oh, no!

COUNSELOR: [*double sided reflection showing both reasons to keep using and reasons to quit*] And part of you really likes the drinking,

and there are things about that you don't like, like the blackouts . . . the craziness you don't like.

CC: Well, no. I've been with my spouse, roommate, or whatever you want to call it, for 18 years, and it has not been a problem with the children, with the wife, or with my brothers, or going to family functions. But there are some times when it just–it gets out of hand. So basically what I want to get out of this program, or this group, is maybe I will hear something or maybe I see something, just something. . .

COUNSELOR: [*reflection*] You don't know for sure what's going to come out of this.

CC: Yeah, I don't. . . I don't know.

COUNSELOR: Okay.

CC: But, I'm going with an open mind. I'm not going to tell you when I leave here that I'm not going to drink, but hopefully as time progresses, maybe I will not drink.

COUNSELOR: [*reframe*] So you're at a turning point–you don't know which side you're at.

CC: Yeah.

COUNSELOR: How about you, CD? . . . What you hope to get from the group?

CD: Umm. . .To stop using cocaine. The main thing is to be able to take control of my nerves. I started getting high when I was 15. I'm 48 now. . . . I get nervous in crowds or when I have to confront people or things like that. When I worked or had something to do I was okay, but on a social interaction level that was my main thing. My social skills are lacking because I go to parties and will not really socialize with people because I'll be so high, so drunk, or whatever, and I . . .

COUNSELOR: Sort of interferes with your learning social skills.

CD: Yeah. . .yeah. . .and I had a lot of opportunities, and I've blown them, and I've been given a lot of chances, like I just take two or three hits of weed on the way to work, I say why do I want to do this, when I know I can't, but I need something to calm me down, and uhm. . .that's my main thing, is my nerves.

COUNSELOR: The first thing you said you want to get out of this group is to stop using cocaine.

CD: Oh yeah, sure. . . definitively.

COUNSELOR: And to help with nerves.

CE: Yeah, I think the main reason why I use is something to quick temporarily calm my nerves. It's gotten really worst since my father died, and he left me a couple of houses. I got rent, I got people paying me rent, so for like the past year, I've been sitting inside in my bedroom

just getting high, just like sitting and watching TV and getting high. At first it is neat, it seems great, but after a while it's like there's life out there, you know.

COUNSELOR: [*selective reflection helps focus a client with tendency to digress*] You're tired of missing out.

CE: Yeah. . . I'm sick and tired of missing life.

CE: Yeah, I'm here to kind of get some help from all these other guys to see if we can put something together, something positive, and then see if I can get off cause it's been a long time.

COUNSELOR: [*selective reflection and reframe*] You've been a long time in this, and it's time for something new.

CB: My main thing is I worry that I don't want to get caught and go to prison, lose everything I had, my house, my business, everything. I don't want to do that.

COUNSELOR #2: Part of you is afraid that you have some things that you may lose.

CB: Right, and I'm going to lose everything I have, lose everything I have if I keep this up. That's the main reason.

COUNSELOR #2: So you're little bit afraid that maybe it is starting to get–

CB: Out of hand.

COUNSELOR #2: Out of hand.

CB: Yes.

Focus on Collaboration and Creating an Atmosphere of Partnership

Consistent with MI approach, avoid the "expert" trap by focusing on collaboration and creating a "partnership" atmosphere. Arrange chairs in a circle whenever possible. In the case of groups with two facilitators, avoid having both facilitators sit side-by-side as this creates an "expert" segment of the circle. Introduce discussions with collaborative language (e.g., "Today, your experiences will be really useful in helping us begin to explore some of the ways drug use can sometimes affect others in ours lives. Would that be okay?" or "We have some information that others have found helpful. It may or may not apply to your situation, but would it be all right if we took a few minutes to look at it?"). During and following the presentation of information, use open-ended questions or statements designed to elicit members' thoughts about the issue/information (e.g., "Tell me what stands out most for you in that information." "What do you make of that?" "Tell me what fits most for you about . . .").

Use Selective Reflective Listening to Build Motivation and Reinforce Change Talk

As with MI in an individual format, judicious reflections are the heart of MI group work. Reflections can help establish rapport, express empathy, decrease resistance, selectively highlight responses that are most relevant to the change process, support autonomy, and promote Change Talk. Simple reflections repeat or paraphrase the meaning of a statement, while more complex reflections amplify the meaning or give voice to feelings that underlie a statement. In groups comprised of members in different stages of change, reflections are powerful tools for responding to an individual and applying the individual's response to the benefit of the group. While reflective listening can be challenging in a group format, it is still possible. When two counselors facilitate the group, one may focus on reflecting and the other on the group process.

In the following transcript, the counselors model empathy and affirmation (rather than confrontation) by selectively using reflections to reframe a client's relapse as a learning experience.

CH: I had totally blocked the drugs out of my system. . . I had to move from New York down to Texas. I was trying to add a relationship, concentrating on my goal of what I needed to do. So when I start achieving all of that, then what happens, when I felt lonely, the first thing I did was got me a six pack. . .

COUNSELOR #2: [*simple reflection*] You had things going pretty good, you were starting to feel better.

CH: You know, loneliness sets in.

COUNSELOR: [*reflection of feeling and meaning*] Loneliness is a trigger for you.

COUNSELOR #2: [*reframe of relapse event as normative, not shameful*] It is very common when we are making changes that sometimes there are slips, and this is often called a relapse–not a fatal error. A relapse, a slip. That's common.

CH: I've been there . . .

COUNSELOR: [*providing information designed to reframe client's perspective from failure to opportunity*] Well, research is showing more and more that's often a normal part of change, it's not that you slipped out and became a failure and . . .you're not changing. What can happen with relapse is that you can recycle back in this cycle of change.

CE: I see what you're saying. Like my dad told me, you don't wake up, and say I'm gonna quit smoking. You say I'm going to try to quit smoking.

COUNSELOR: [*affirmation*] You got it!

CE: Because then if you say that, you say I'm gonna quit smoking (but haven't), you're a failure, but if you say I'm gonna try to quit . . .

COUNSELOR: [*repeated affirmation*] You got it!

CE: [*member modeling MI approach of affirmation and empathy*] You're coping with a more realistic thing saying I can either go this way or that way.

COUNSELOR: [*summarizing, providing information*] It's not an either "I am or not." Some people, after a relapse or slip, will cycle back into preparation, some enter back in action . . . A lot of times a relapse can give you information that is really important, such as what were the triggers. What did I do differently to keep the relapse from happening as quickly as it had before?

Use MI Methods for Handling Resistance

MI methods that diffuse resistance in individual counseling also work very well in the group setting. In addition, they can serve as a model for how group members can relate to each other. Group leaders use methods such as empathic reflecting, asking for elaboration on statements that are consistent with the direction of the group, and validating personal choice and responsibility. If a negative, hostile comment by one member does occur, selectively emphasize the most positive part of the comment, reframe the comment, and/or affirm the member (e.g., for his/her concern, experience, energy, passion, pain). At times, the reframe or affirmation may be followed by a diplomatic, empathic reminder about the policies of the group (e.g., "Some of you have been through so much, have so much hard-earned experience that it's probably hard at times to remember that in this special kind of group we try to not tell someone else what to do because we know it is a matter of a personal choice–we each are the experts on our own life. But I appreciate how much we want to pass on some of our hard lessons."). Also, "differential reinforcement" can be used by attending to positive, non-argumentative, or Change Talk responses. These selective reflections allow individuals to be heard and reinforced for their constructive comments.

A group decisional balance exercise that can be used to defuse resistance may be conducted in a straightforward manner or presented in a playful style. Ask group members to first brainstorm a list of reasons for not making a change (i.e., the "good things" about their drug use) and then to list reasons for making a change (i.e., the "not so good things"

about their drug use). A playful twist is for one facilitator to use the group's list to argue against change and invite the rest of the group to take up counterarguments about why change would be a good thing. The second facilitator can record the group's reasons, reinforcing comments and encouraging group members to argue their points even more forcefully. In this way, the resistance is voiced and then channeled into Change Talk. When the debate is over, the first facilitator can summarize the group's main arguments for change, and then specific members can be asked to elaborate on their expressed reasons. This process reinforces the Change Talk that was generated by group members (Walters, Ogle, & Martin, 2002).

Another approach for managing the issue of resistance within the group is teaching reflective listening skills (in their simplest form) to the group members (Ingersoll, Wagner, & Gharib, 2000). Using this strategy, the counselor asks for a volunteer from the group to offer a statement such as "something I feel two ways about is. . . ." After modeling a reflection of the client's statement, the counselor coaches group members to how to make reflective statements consisting of simple rephrases, which are described to the group as "mirror" statements. The counselor should point out that members can use mirror statements to check out their understanding of another member's statement. While group members are not expected to become experts at reflective listening, teaching basic reflective listening skills can help group members avoid using confrontational or persuasion tactics, be appropriately disengaged from the decisions others make, and feel safe to receive feedback from others about their personal decisions.

The following transcript illustrates the use of selective reflections and defusing resistance. You will notice that the counselor's first reflection may have engendered resistance, but as the counselor "rolled with resistance" by carefully reflecting the client's desire to control his life, the client was able to express his feelings of ambivalence and concern, resulting in Change Talk.

CB: I always thought I could control it, you know. I'd been working for myself, I was in the military. I owned my own business. But now it is just that I am more depressed. It is like I can control it, but I can't. The urges–I just want to control it, control what I do, but it is kind of getting out of hand.

COUNSELOR: It's beginning to control you. [*Note: an alternative, more understated, reflection that would reduce the likelihood of resistance responses could be "you worry some that it may be beginning, at times, to control you."*]

CB: It's not *really* controlling me. I take care of my business, my kids–I got seven kids. My bills. I take care of all that. But I do a lot of drugs, I don't know why. My family doesn't know it . . . I just want to be able to control this–to stop it.

COUNSELOR: [*reflecting, emphasizing desire for personal choice and control*] Be in charge of your life.

CB: Yeah, because it's like when I get money in my hands . . .my extra money that I used to take to go to the movies or go here and there, we don't go anymore, we don't go out to eat.

COUNSELOR: [*simple reflection*] The money is gone for something else.

CB: I don't hang out with my brother no more or my sister. I know something is wrong. This isn't me.

COUNSELOR: [*amplified reflection*] You know, what I am hearing is this is not the way you want to be, this is not the real . . . (you).

CB: No, this is not me.

COUNSELOR: [*reflection of meaning*] And you want that real you back.

CB: This is not me.

COUNSELOR: [*affirmation*] I'm glad you're here.

CB: Me, too.

Discuss Stages of Change and Encourage Members to Identify Their Own Stage

Many counselors consider the stages of change to be a useful model for conceptualizing clients' readiness to change and for tailoring interventions. We have also found it useful to educate group members about the stages. Begin the session with a discussion of the various stages, and then present vignettes for a variety of behaviors to allow clients to identify the stage of change for each scenario.

Many clients in the Precontemplation or Contemplation stages may be participating in the program as the result of pressure from others, so it will be important to recognize and acknowledge that they may be resistant to the idea of changing their substance use. There are several ways in which clients may demonstrate this resistance. They may be openly hostile, refuse to engage in conversation about substance use, or appear to be participating while inwardly feeling passive and resentful. As seen in the previous transcript, the way to defuse resistance is to "roll" with it by using motivational strategies. One example would be to acknowledge that many of the group members might feel pressured to be there

and to point out that these feelings are completely normal. Assure them that most members are probably feeling the same way and that the group will give them a chance to explore their own feelings about their substance use with others in similar situations. Others may feel demoralized because they have attempted to change many times. Providing them with information about the stages of change and the number of change attempts that often occur before lasting change is secured can remove some of their shame and instill hope.

The next excerpt describes a discussion of the stages of change model, which promotes insight, exploring ambivalence, and discussing triggers for cocaine use. This transcript also demonstrates how two counselors can work collaboratively.

COUNSELOR: [*providing information*] The idea is to look at this handout and these guides, and see where you think you fit. If it's not cocaine use maybe it's another behavior like changing your diet or losing weight.

CC: I will say I'm in Action. I quit using. I have two different sets of friends–my negative and my positive friends. I just want to leave my negative ones and try to fix it with my positives.

COUNSELOR: [*simple reflection, emphasizing universality*] Kind of like the fellow that we talked about (in the exercise and discussion). You've taken some action. Who else?

CF: Can you be at two (stages) at one time?

COUNSELOR: [*open question*] Tell me about it.

CF: Contemplation and Preparation? Thinking of quitting, wondering how it affects others, maybe trying small changes. Kind of in that stage . . . where, okay, let's not drink a 12 pack a day, let's just see if you can drink socially. I want to drink, but I don't want to smoke (crack). You also are wondering how it affects others. You're trying to lead a double life. You got your friends that smoke, and you got your church buddies who have no idea, no clue (that you smoke). I want to quit. Like I say, I'm in the Preparation stage for cocaine. I want to quit cocaine, I want to quit crack, I want to quit snorting or whatever, but I don't want to cut back (on drinking), so I'm in Contemplation for my drinking.

COUNSELOR: [*affirmation, providing information*]. . .Thank you for that example. Just like we were saying with CH, you can be in a different stage of change with two different behaviors. We can be in Preparation and Contemplation, or you can be in Contemplation and Preparation, depending on the behaviors.

CF: Well, would it be also Precontemplation? Cause I'm thinking it's okay to drink, but I know it's not okay . . . I really deep down I know I

shouldn't because if I do I know it's going to lead to something. So in my mind . . . I'm telling myself, I really don't have an alcoholic problem, I only have a cocaine problem, but you see. . . .

COUNSELOR: [*providing information, summarizing*] The word that describes what you're talking about is 'ambivalence'. . . . and ambivalence is so common in the early stages where you think 'I know that *this* part is okay, but I'm not sure if *this* part is okay. I know I want to change this, and I'm not sure I want to change that.' That sort of confusion.

CF: Oh yeah! . . . confusion–

(General laugh)

COUNSELOR: CE, did you see your place in the stages of change?

CE: Contemplation.

COUNSELOR: [*simple reflection to elicit more detail*] Contemplation.

CE: Yes, cause I'm thinking of quitting, wondering how it affects others, how they look at me, how they respect me, you know. Maybe try some small changes. I cut down, instead of everyday, now I've been sober for a couple of days this week and last week . . . So, that's where I'm at. Contemplation. I don't want to quit, but I do. I'll be honest; I plan to use this weekend probably.

COUNSELOR: [*double sided reflection, emphasizing universality again*] That ambivalence is so common–that part of you wants to quit, you're thinking about making some changes, but not sure you're there yet. How about you, CA? Where are you? [*Notice that the therapist chose not to reflect CA's comment about using this weekend. This exemplifies selective reflection.*]

CA: I'm starting to avoid the triggers with friends.

COUNSELOR: Good for you.

CA: There's so many triggers, like smelling the air. There's so many different triggers that you can't control, from that old crowd or even from driving by that neighborhood where you did it.

COUNSELOR #2: [*reflection*] You're kind of more aware of the things in your environment that are triggers for you.

Next, the counselor continues the discussion on stages of change, using open questions, reflections leading to change talk.

COUNSELOR: Who else?

CG: . . . I try to keep, keep my mind in another stage. I grab some food, and all of a sudden here's this trigger come to the door (and) . . . you just drop everything that you're doing, just follow that trigger. But I try to deal with that trigger because it's easy to just run out and go to it (the trigger). . .

COUNSELOR: [*key open questions to elicit change talk*] What makes it important to you to avoid that trigger? What is the most important reason for you to try to avoid that trigger?

CG: Just to try and just not do it. Just not do it–it's very important.

COUNSELOR: [*reflection*] That's very important!

CG: Oh, is very hard, is very important, I think once you get past one (temptation/trigger), once you try to bypass those triggers, you get more stronger.

COUNSELOR: [*reflection of feeling and meaning*] Each time you get stronger.

CG: Yeah, each time you get a little stronger, yeah.

Group Summaries

Use group summaries to selectively emphasize the most relevant comments and to reinforce Change Talk. Summaries can be utilized strategically to review and highlight relevant information provided by the group, relate a response by one member to an earlier comment from another member, and transition the group discussion to another area of focus (Miller & Rollnick, 2002).

This transcript contains examples of one type of Change Talk (i.e., reasons for wanting to change) which is subsequently repeated in a group summary.

CB: Yeah, because it's like when I get money in my hands . . . my extra money that I used to take to go to the movies or go here and there, we don't go anymore, we don't go out to eat.

COUNSELOR: [*simple reflection*] The money is gone for something else.

CB: I don't hang out with my brother no more or my sister. I know something is wrong. This isn't me.

[*see previous transcript for intervening reflections by counselor*]

CA: I just went through a lot of hell in my relationships and with financial problems, and I did lose my job a while back. I used to have money, plus I had a decent job, finally a little money in the bank, and was more or less a more normal, regular person, you know paying my bills. But my loony side came out. I've never done anything illegal, but you know, it was bad enough, I did a lot of things I never imagine I would do.

COUNSELOR: [*summarizing common elements among group members*] You know, there's a real commonality here about losses and

pain–about hurting your self-image, losing self-esteem, and certainly losing money.

CB: It kind of feels bad when the folks, the people you love, see you. . .

CD: Yeah, when they see you, you feel guilty.

COUNSELOR: [*reflecting feeling*] You feel ashamed.

CB: I let them down.

Brief Written Feedback

Most studies of MI have actually been adaptations of MI that include providing personalized feedback (Burke, Arkowitz, & Menchola, 2003; Dunn, Deroo, & Rivara, 2002). Personalized feedback is norm-based feedback that helps the client understand how his or her behavior compares to a larger group. This feedback is generally used to create discrepancy by increasing the likelihood that the client will perceive their previously accepted behavior as potentially problematic. Whenever possible, use brief written exercises that will provide "personalized feedback" to members. For example, have group members take the Alcohol Use Disorders Inventory Test (AUDIT) and then walk them through the scoring. The group facilitator can describe what each range of scores means and ask group members if they would like to share their scores or their reactions. Typically, some group members share their scores and this leads to a lively discussion and change talk. Those members who are quieter and do not share still have the benefit of the personalized feedback from their own assessment. Affirm members for sharing their scores and selectively reinforce any change talk generated by the feedback.

Eliciting Change Talk Around a Group Theme

Although it is common for members to have differing concerns, it is also common for themes to emerge that are important to the majority of the members of the group. When this occurs, the counselor has an opportunity to elicit Change Talk related to this theme. An example follows.

COUNSELOR: [*open question eliciting buy-in to the common theme that is developing*] Anybody else? . . . Do you have other ways that people have expressed concern? . . . (like some of you said) walking out of your life, nagging you, like CF talking about his mother's having hopes (for him). Anybody else have other people in your lives that have some concerns?

CF: I have my common-law wife. . . her unconditional love for me . . . but you know, if you abuse this drug, you're gonna hurt somebody.

CF: . . . if there's anybody out there, anybody that cares a whole bunch about you, they don't want to see you go down, and that's exactly what you're gonna do if you abuse this drug . . . ain't no question about it.

COUNSELOR: [*reflection*] That's what CB was describing, "you're going down. . ."

CB: If I could turn back time, you know. I feel like a lot of things would've been different.

CC: . . . but I really don't like to turn back time because that's made me who I am. I really don't think I'll ever do coke again. I really don't think I ever, ever, ever, will do coke again. . . but look where you are now. . .

COUNSELOR: [*open question eliciting Change Talk*] If you had to choose the most important reason for what you've said, "I don't think I'll ever use coke again," what would be your most important reason?

CC: My most important reason will probably be me. I mean I want to do it for everybody else, but it was (for) me. I wanted to quit. I missed a lot. I can't explain how much I missed. Everything was on *my* time. I'm gonna do what I want to do. I just had that attitude. I missed so much. So it would be for me and my future. . . .

COUNSELOR #2: [*reflection of meaning*] So you're feeling like this time you really want to do it for you. . . you feel like this is for you, you were missing out on life when you were using cocaine.

ASSESSING GROUP MI TREATMENT FIDELITY

The incorporation of MI into groups using the strategies detailed above appears promising. Because group MI is relatively new to the field, however, we wanted to learn how this delivery of MI in a group format would fare when scrutinized by an expert coder. Videotapes of three group sessions, conducted by two experienced MI counselors, were sent to a coder trained in the use of the Motivational Interviewing Treatment Integrity (MITI) behavioral coding system (Moyers et al., 2005). The MITI assesses treatment quality by coding two global MI concepts, Empathy (the extent to which the therapist understands and/or makes an effort to grasp the clients' perspective), and MI Spirit (collaboration, evocation, and support of autonomy). Several counselor behavioral counts are utilized in assessing the global concepts, such as using

closed or open questions, making simple and complex reflections, and using MI Adherent (e.g., affirming, asking permission to give information or advice, expressing support) or MI-Non-Adherent strategies (e.g., advising without permission, confronting, arguing). The MITI global scores are rated using a 1-7 point Likert scale, with 1 being least MI adherent and 7 being most MI adherent. Although the MITI has heretofore been used to code individual MI sessions, it was applied to the cocaine treatment groups through use of the videotaped sessions. The coder was from the University of New Mexico, trained by Dr. Moyers. Results from this first coding review of MI groups indicated that the intervention met very high standards in terms of conforming to MI principles and strategies (see Table 1). These results are encouraging in that they suggest that MI can be effectively incorporated in group interventions.

CONCLUSION

The use of MI in groups has a number of practical implications, yet further research is needed to study MI in the group setting and to identify both its limitations and strengths. To date we know that MI is a substance abuse treatment with strong empirical support, and it has been widely adopted in a number of countries and in many different cultures (Miller & Rollnick, 2001). Because of its broad appeal and evidence-base, a growing number of providers are being trained in MI and many of them wish to use their skills in the group setting. This manuscript provides substance abuse professionals with practical strategies for adapting MI to groups and offers examples of the use of these strategies in an actual substance abuse group setting. Further research is needed to identify the most important characteristics of effective group MI. In the meantime, clinical innovation is needed. We encourage providers to be creative in adapting their MI skills to groups.

TABLE 1. Motivational Interviewing Treatment Integrity Scale Scores*

	Empathy	Spirit
Group 1	7	6
Group 2	7	6
Group 3	7	5

*Scores range from 1-7.

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