



August 2004

v19 n7

FOCUS

A Guide to AIDS Research and Counseling

Applying Motivational Enhancement Therapy to HIV Prevention and Care

Denise Walker, PhD and Roger Roffman, DSW

HIV service providers commonly see clients who are ambivalent about consistently adopting risk reduction behaviors or consistently adhering to medical regimens. When the client's motivation is mixed, ambivalence is often voiced through the expression of both the positive and negative aspects of the behavior, for example "I know using condoms is safer, but it's hard to do in the heat of the moment," or "I understand that I'm supposed to take my medications, but the schedule is confusing and I get discouraged."

Motivational interviewing is a client-centered, directive style of counseling designed to assist individuals in resolving ambivalence and increasing their commitment for change.¹ Motivational interviewing strategies are intended to prompt clients to explore and better understand their attitudes both favoring and opposing change, with the hope that this understanding will help "tip the scales" toward a commitment to change. Motivational enhancement therapy is a brief intervention modality developed using motivational interviewing concepts and style. Generally one to four sessions, it includes an assessment interview, personal feedback of assessment results, and an exploration of the problems a client has experienced and his or her attitudes about behavior change.

First used with problem drinkers who were neither in treatment nor self-initiating change, motivational enhancement therapy was designed as a brief pre-treatment intervention intended to elicit the problem drinker's voluntary participation in a process of "taking stock." Surprisingly, research has demonstrated motivational enhancement therapy can be effective as a stand-alone intervention to reduce drinking and

related problems as well as a catalyst for seeking formal help.² Researchers have since developed, with varying degrees of success, motivational enhancement therapy interventions for a variety of behaviors including smoking and drug use, exercise, eating disorders, and diabetes management.

Similar to these other health behaviors, risk perception and social norms are aspects of motivation that are linked with HIV risk reduction. Risk of HIV infection is often found to be greatly underestimated by those who engage in behaviors that put them at greatest risk for contracting HIV. Motivational enhancement therapy, designed to provide accurate feedback about risk behavior as one way to motivate change, is ideally suited to respond to this situation.

Principles of Motivational Enhancement Therapy

Three essential principles guide the practice of motivational enhancement therapy. First and foremost, this approach is collaborative. The client and clinician become partners in the client's health care. Clinicians view themselves as having expertise and knowledge about HIV, while viewing their clients as being the experts on their own lives who know if and how change will work for them and the best methods for achieving their personal goals. The client and clinician work together to explore the client's behavior and risk, motivation to change these behaviors, and options for risk reduction.

Second, motivational enhancement therapy is evocative. It views clients as possessing the necessary capacities to alter behavior. The clinician's role is to elicit the client's ideas, evoke confidence, and draw out the client's own internal reasons for change. Open-ended questions and reflective listening facilitate this process. The intention is that the client, rather than the clinician, will generate his or her own arguments for change.

The final principle of motivational enhancement therapy is respect for the client's autonomy. The clinician acknowledges that the decision to change lies within

Editorial: Protected by Ambivalence

Robert Marks, Editor

One of the challenges for counselors working with HIV—whether in the context of prevention or care—has always been balancing the goals of maximizing healthy client behavior and remaining client centered. How does counseling move toward reducing a client's risk of HIV infection or increasing his or her adherence to HIV medications if the client does not prioritize these goals?

A variety of tools have emerged, been refined, or been combined in new ways over the past 20 years. Chief among these have been harm reduction theories, which have legitimized measured steps toward reducing, rather than eliminating, harm; the Stages of Change, which has clarified the phases through which people travel toward any type of behavior change; and concepts such as self-efficacy and

mastery, which have focused on key psychological traits that correlate to achieving desired change.

Many of these tools were transferred from substance use (including cigarette smoking) treatment. This issue of *FOCUS* looks at motivational interviewing, another tool that was developed in this way. In their overview of the concept, Denise Walker and Roger Roffman define the concept, in particular, its emphasis on helping clients resolve their ambivalence about change. Donald McVinney's article on using motivational interviewing within psychotherapy suggests that this tool may have value in longer term counseling.

Since it emphasizes specific desired changes, motivational interviewing tends to be more directive than other approaches—a characteristic that could threaten client-

centered counseling. The recognition that ambivalence is a normal response to change, however, may not only enhance counseling and behavior change, it may also protect the client-centered nature of the counseling relationship.

The focus on ambivalence protects the client from committing to a change that is not right for him or her; change can go forward only after resolving this psychological barrier. Likewise, this focus protects the counselor from imposing change, that is, from becoming counselor-centered. While change may be the goal of both counselor and client, ambivalence belongs to the client alone. The counselor can help point out ambivalent feelings and ally with the part of the client that wants to be different, but resolving ambivalence can be accomplished only by the client.

This capacity to mine ambivalence for psychological treasure may make motivational interviewing particularly suited to working with the issues raised by HIV.

the client's control. Emphasizing client autonomy can paradoxically stimulate an individual's willingness to consider change.

Motivational Interviewing Skills

Motivational interviewing draws on the work of Carl Rogers; it emphasizes the need to create a therapeutic relationship conducive to change. An essential element of this relationship is empathy expressed through skillful reflective listening. The clinician demonstrates his or her understanding of the client's perspective through reflection, with the assumption that listening in a non-judgmental and accepting way facilitates relationship-building and, ultimately, change. Unlike Rogers's approach, however, motivational interviewing focuses heavily on the exploration of ambivalence concerning behavior change. Reflective listening facilitates the client's understanding of his or her ambivalent attitudes, with the expectation that this greater understanding will lead to increased motivation for change.

A basic premise of motivational interviewing is that ambivalence is normal—not a character flaw—when a person is considering changing a behavior that is problematic but has been strongly reinforced.

Based on this premise, the clinician helps the client to consider the ways in which a behavior might be discrepant with the client's goals or values. For example, a clinician working with an HIV-positive mother who has trouble complying with her medication regimen may reflect, "You want to be a good parent and a consistent presence in your baby's life, yet it is difficult for you to regularly take your HIV medications. How is your approach to taking medications related to your goal of staying healthy so you can take care of your child?"

In the face of ambivalence, resistance is likely. When the clinician reacts to resistance with confrontation or persuasion, the client is likely to continue arguing against change. In contrast, a client's resistance is likely to dissipate when the clinician accurately acknowledges and understands it. Consider the following exchange:

Client: You say that to be safer, I need to use condoms with my partner even though he is only going to the baths every couple months? That doesn't make any sense. He's been doing that for years and he's still negative, and he has cut way down. He used to go out every night!

References

1. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York: Guilford Press, 1991.
2. Dunn C, DeRoo L, Rivara FP. *The use of brief interventions adapted from motivational interviewing across behavioral domains: A systematic review*. *Addiction*. 2001; 96(12): 1725-1742.
3. Picciano JF, Roffman RA, Kalichman SC, et al. *A telephone-based brief intervention using motivational enhancement to facilitate HIV risk reduction among MSM: A pilot study*. *AIDS and Behavior*. 2001; 5(3): 251-262.

Genuine affirmation is crucial when discussing highly stigmatized behaviors.

4. Carey MP, Maisto SA, Kalichman SC, et al. *Enhancing motivation to reduce the risk of HIV infection for economically disadvantaged urban women.* Journal of Consulting and Clinical Psychology. 1997; 65(4): 531-541.

5. Carey MP, Braaten LS, Maisto SA, et al. *Using information, motivational enhancement, and skills training to reduce the risk of HIV infection for low-income urban women: A second randomized clinical trial.* Health Psychology. 2000; 19(1): 3-11.

6. Belcher L, Kalichman S, Topping M, et al. *A randomized trial of a brief HIV risk reduction counseling intervention for women.* Journal of Consulting and Clinical Psychology. 1998; 66(5): 856-861.

7. Baker A, Heather N, Wodak A, et al. *Evaluation of a cognitive-behavioural intervention for HIV prevention among injecting drug users.* AIDS. 1993; 7(2): 247-256.

8. Baker A, Kochan N, Dixon J, et al. *Controlled evaluation of a brief intervention for HIV prevention among injecting drug users not in treatment.* AIDS Care. 1994; 6(5): 559-570.

Counselor: Your perception is that your partner is not at risk for HIV because he has not gotten infected even with pretty risky behavior. It doesn't make any sense to you to use condoms in this circumstance."

Finally, self-efficacy is a relatively good predictor of behavior change. Actively supporting the client's own belief in his or her ability to alter a behavior is intended to increase the likelihood that the client will change the behavior. Clinicians also model self-efficacy with their own optimistic views concerning their client's abilities, for example: "I can see that you have a lot of inner strength which

has helped you overcome some major struggles in your life. You've made significant changes in your drinking, and that wasn't easy. I can see that having done this gives you confidence in your ability to better communicate with your casual partners about using condoms." The counselor actively looks for and reinforces the strengths of a client.

These examples of counselor responses highlight four key motivational interviewing counseling skills: asking open-ended questions; using reflective listening; offering affirmations; and eliciting "change talk."

Open-ended questions evoke the client's thoughts and perspectives on their behaviors. Skillful motivational interviewing enables the client to do most of the talking, as the counselor uses open-ended questions to provide a structure and framework for the discussion and directs discussion around resolving ambivalence.

Reflective listening facilitates the process of understanding the client's experience for both the counselor and the client. Clinicians often use reflections in a directive way to capture speech related to change.

The genuine affirmation of positive characteristics and behaviors is particularly important when discussing highly stigmatized behaviors such as barebacking or having unprotected sex with an HIV-positive partner. By acknowledging a client's strengths, clinicians are able to develop rapport and trust, and facilitate an objective and honest discussion of behavior by easing a client's fear of being judged or criticized.

Eliciting change talk is a key example of motivational interviewing's directive nature, which distinguishes it from other forms of empathic counseling. Change talk involves statements made by clients that express need ("I need to take my medications on schedule"), desire ("I want to be

assured that I am healthy"), reasons ("I care about the health of my community"), ability ("I know I can do this"), or commitment to change ("I will use condoms with my casual partners"). When the clinician hears a manifestation of change talk, he or she reflects it back to the client. For example, "You're concerned that your methamphetamine use is getting in the way of you using condoms."

Asking for elaboration also serves to reinforce change talk. For example, "You're tired of worrying if you've been infected after you have unprotected sex. Tell me about a time when that occurred."

The clinician specifically elicits change talk through queries. For example, "What are some reasons why you have considered always carrying condoms with you?" "What concerns you about not always taking your medications the way your doctor instructed?" "What successes have you had previously that make you think this change might be possible?" "What's making you so committed to using clean needles?"

Research on Preventing HIV

Motivational enhancement therapy has been used to promote both HIV risk reduction and HIV antiviral treatment adherence. Despite the infancy of the research literature, a handful of studies have evaluated HIV prevention motivational enhancement interventions for three groups of clients: men who have sex with men, low-income urban Black women, and injection drug users.

Men Who Have Sex with Men. The "Sex Check-Up," a 90-minute telephone-based, motivational enhancement therapy approach offers promise for reaching high-risk men who have sex with men.³ A randomized trial (motivational enhancement therapy versus a control group) of the Sex Check-Up in Seattle targeted men who have sex with men and who had concerns about their sexual behavior or were interested in obtaining objective, non-judgmental, and confidential information. Emphasizing that the services were an opportunity for individuals to assess their HIV risks, the study demonstrated the feasibility of reaching individuals at risk of HIV infection who were neither seeking HIV prevention services nor indicating a commitment to behavior change. At the three-month follow-up, White participants reduced their risk regardless of whether they were in the treatment group (assessment plus feedback) or the control group (assessment only), suggesting the likelihood of a risk reduction effect of the baseline assessment itself. In contrast, Black and Latino participants were more likely to reduce their risk if they were part of the treatment group rather than the control group.

9. DiLorio C, Resnicow K, McDonnell M, et al. Using motivational interviewing to promote adherence to antiretroviral medications: A pilot study. *Journal of the Association of Nurses in AIDS Care*. 2003; 14(2): 52–62.

10. Safren SA, Otto MW, Worth JL, et al. Two strategies to increase adherence to HIV antiretroviral medication: Life-Steps and medication monitoring. *Behaviour Research and Therapy*. 2001; 39(10): 1151–1162.

Authors

Denise Walker, PhD, is Research Assistant Professor of Social Work at the University of Washington, the Clinical Director of the Innovative Programs Research Group, and part of the Motivational Interviewing Network of Trainers. For 11 years, she has conducted research on substance abuse and treatment outcomes with an emphasis on motivational interviewing. She serves as the clinical director for an ongoing HIV prevention study evaluating the efficacy of motivational enhancement therapy with men who have sex with men.

Roger Roffman, DSW, is Professor of Social Work at the University of Washington and Director of the Innovative Programs Research Group. He has developed multiple motivational enhancement therapies for HIV prevention and marijuana disorders.

Low-Income Urban Black Women. Three studies have evaluated HIV prevention programs incorporating motivational enhancement therapy for low-income urban African American women. In the first, researchers randomly assigned 102 women to either a wait-list control group or a four-session group intervention combined with motivational enhancement therapy, education, and skills training.⁴ Exposure to the intervention resulted in increased perceptions of risk, safer behavioral intentions, increased communication with sexual partners, decreased use of substances before sex, and less unprotected vaginal intercourse compared to the control group. A second study replicated these findings.⁵ Neither of these studies was able to clarify what aspect of the intervention was responsible for risk reduction.

A brief, one-session individual motivational enhancement therapy intervention also demonstrated success with this population.⁶ Compared with an educational comparison approach, women receiving motivational enhancement therapy reported increased condom use during vaginal sex and engaged in less unprotected vaginal intercourse.

Injection Drug Users. Two studies have demonstrated little support for motivational enhancement therapy to decrease HIV risk behavior (sexual risk or injecting or needle sharing risk) among methadone-maintained and untreated injection drug users.^{7,8} While, in both studies, participants were able to reduce injection-related risk, neither study was able to reduce sexual risk nor find that increased risk reduction was more likely for subjects in the motivational enhancement groups versus in the studies' control groups.

Research on Improving Medication Adherence

Strict adherence to difficult treatment regimens is crucial to HIV antiviral treatment success. Two studies have tested motivational enhancement to support adherence.

Researchers tested a nurse-delivered, three-session, motivational enhancement intervention that combined motivational interviewing counseling with educational materials.⁹ Researchers randomized 22 participants beginning or changing regimens into either a motivational enhancement therapy group or a standard educational care group. Compared to those who received educational care, patients in the motivational enhancement therapy group reported missing fewer doses of medication and taking medications according to their doctor's recommendations a higher percentage of the time. About half of the participants in the motivational enhancement therapy group who completed a process evaluation indicated that talking about motivation, confidence, and values was helpful. Further, participants felt encouraged to generate their own solutions to taking medications as scheduled.

A similar study of 49 individuals with a history of nonadherence to HIV antiviral medications¹⁰ found that compared to self-monitoring, one session of motivational enhancement therapy combined with self-monitoring and cognitive behavioral skills-training resulted in greater adherence even after three months. In particular, motivational enhancement therapy appeared to be more effective than self-monitoring alone for depressed patients.

Conclusion

While further research is necessary to elucidate the independent effects of motivational enhancement therapy, it is clear that the great strength of this approach is its respect of individual autonomy and its emphasis on validating rather than pathologizing ambivalent attitudes. These attributes are likely to be particularly potent for individuals who are marginalized as a consequence of their race, ethnicity, or sexual orientation or who expect to be scolded for "failing" to achieve risk reduction or adherence goals.

Clearinghouse: Motivational Interviewing

References

Baker A, Lewin T, Reichler H, et al. Evaluation of a motivational interview for substance use within psychiatric in-patient services. *Addiction*. 2002; 97(10): 1329–1337.

Burke BL, Arkowitz H, Menchola M. The efficacy of motivational interviewing: A

meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology*. 2003; 71(5): 843–861.

Carroll KM, Libby B, Sheehan J, et al. Motivational interviewing to enhance treatment initiation in substance abusers: An effectiveness study. *The American Journal of Addictions*. 2001; 10(4): 335–339.

Emmons KM, Rollnick S. Motivational interviewing in health care settings. Opportunities and limitations. *American Journal of Preventive Medicine*. 2001; 20(1): 68–74.

McCambridge J, Strang J. The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: Results from a multi-site cluster randomized trial. *Addiction*. 2004; 99(1): 39–52.

Motivational Interviewing and Psychotherapy

Donald McVinney, MSSW, ACSW, MPhil

In 1991, William Miller and Stephen Rollnick published the book *Motivational Interviewing*, which immediately shifted the paradigm for intervening with substance users from what had become a standardized confrontational approach to a more empathic one.¹ In the second edition of the book, subtitled *Preparing People for Change*, Miller and Rollnick broadened the scope beyond addictive behaviors.² Many of the more common applications for motivational interviewing are related to traditionally short-term interventions such as substance use counseling, compulsive behavioral counseling, and medication adherence. But motivational interviewing may be applied to long-term psychotherapy.

Behavior Change and Motivation

Miller and Rollnick's conceptualization of motivational interviewing is based on several theories of human behavior change, notably Albert Bandura's social learning perspective, which embodies the concept of self-efficacy. Self-efficacy represents a person's belief that he or she can carry out, and succeed at, a specific change strategy.³

Miller and Rollnick also rely heavily on the work of James Prochaska and Carlo DiClemente, who conceptualized the Transtheoretical Model.^{4,5} The "Stages of Change" theory, as it is more commonly known, posits that individuals are likely to change behavior incrementally, moving back and forth through stages, rather than radically. Incremental change is precisely what takes place in long-term psychotherapy where HIV-related issues may emerge.

In addition, the desire for change is an often-stated goal of clients seeking long-term psychotherapy. This desire may relate to changing behaviors that the client

deems, or which others deem, to be problematic. It may also be related to changing patterns of communication with others, changing one's role within a family system, or changing one's affect, for example, the desire to be less depressed or anxious.

According to Miller and Rollnick, motivation is defined as a state of readiness or willingness to change, the point at which the client is considering the possibility of changing, although not necessarily the moment when the client has actively undertaken change. HIV-related psychotherapy can apply this approach in two ways. First, for clients who present with concerns about sexual risk, therapists can question their clients' perceptions of risk and help clients scrutinize their behaviors, which are often influenced by unconscious dynamics. Second, long-term psychotherapy offers a unique opportunity in which to address ambivalence about other HIV-related issues, for example, testing or medication adherence. Motivational interviewing tools such as cost-benefit analysis and "change plans"—by which clients who have resolved ambivalence can map out a realistic approach to implementing change—are especially useful in these contexts.

The Role of the Therapist

The therapist who has integrated motivational interviewing into his or her practice exercises a sensitivity to what enhances motivation rather than applying a more undifferentiated confrontational approach. Further, since change occurs in stages, the therapist identifies interventions that are consistent with a client's stage. To suggest that a client "take action" (the fourth stage), asserting for example that a client "must take medication," while he or she is in a stage of "contemplation" (the second stage) is likely to create resistance rather than strengthen a therapeutic alliance.

Therapists using motivational interviewing also seek to remove significant barriers to change in practical ways. This may involve strategizing about child care

Miller WR, Yahne CE, Tonigan JS. Motivational interviewing in drug abuse services: A randomized trial. *Journal of Consulting and Clinical Psychology*. 2003; 71(4): 754-763.

Stein MD, Charuvastra A, Maksad J, et al. A randomized trial of a brief alcohol intervention for needle exchangers (BRAINE). *Addiction*. 2002; 97(6): 691-700.

Stotts AL, Schmitz JM, Rhoades HM, et al. Motivational interviewing with

cocaine-dependent patients: A pilot study. *Journal of Consulting and Clinical Psychology*. 2001; 69(5): 858-862.

Suarez T, Miller J. Negotiating risks in context: A perspective on unprotected anal intercourse and barebacking among men who have sex with men—where do we go from here? *Archives of Sexual Behavior*. 2001; 30(3): 287-300.

Contacts

Denise Walker, PhD, University of Wash-

ington, School of Social Work, 909 NE 43rd Street, Suite 304, Seattle, WA 98105-6020, 206-543-7511, ddwalker@u.washington.edu (e-mail).

Donald McVinney, MSSW, ACSW, MPhil, Harm Reduction Coalition, 22 West 27th Street, 5th Floor, New York, NY 10001, 212-683-2334, ext. 14, mcvinney@harm-reduction.org (e-mail).

See also references cited in articles in this issue.

arrangements, financial issues, or cultural factors. Therapists usually work with clients to develop a menu of choices tailored to that client. They discuss the costs and benefits of change. They may seek to incorporate significant others into treatment or identify other methods of acquiring feedback.

Finally, therapists actively attend to their clients' motivation. If a client misses an appointment, for example, a therapist will pursue the client, rather than waiting for the client to assume responsibility for rescheduling. While different from more traditional approaches to psychotherapy, recent advances in interpersonal and relational treatment similarly emphasize the importance of engaging with clients to facilitate mutual involvement in change strategies.

References

1. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York: Guilford Press, 1991.
2. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People for Change*, 2nd ed. New York: Guilford Press, 2002.
3. Bandura A. *Self-Efficacy: The Exercise of Control*. New York: Freeman, 1997.
4. Prochaska JO, DiClemente CC. *Stages and processes of self-change of smoking: Toward an integrated model of change*. *Journal of Consulting and Clinical Psychology*. 1983; 51: 390-395.
5. Prochaska JO, DiClemente CC, Norcross JC. *In search of how people change: Applications to the addictive behaviors*. *American Psychologist*. 1992; 47(9): 1102-1114.

Author

Donald McVinney, MSSW, ACSW, MPhil is the National Director of Education and Training at the Harm Reduction Coalition in New York and Adjunct Lecturer of Social Work at Columbia University. He is also a Credentialed Alcoholism and Substance Abuse Counselor.

ing this process of exploration and, in turn, engaging in a similar exploration, the client may achieve insight into the client-therapist relationship and the process of change.

The therapist also supports the client's self-development by promoting self-efficacy in the context of identified goals. When change feels impossible and when the process seems endless, the therapist seeks to encourage and support the client. In such cases, the therapist empathically communicates an appreciation for how difficult change can be, helps the client reframe "challenges" as "possibilities," and encourages the client to view each day as a new opportunity to transform life.

While acknowledging the strengths that a client possesses, including the desire to change, a crucial function of long-term psychotherapy is to analyze underlying psychopathology that interferes with change. Since clients often have no internalized models for self-care, therapists can provide these by challenging distorted cognitions. For example, clients may believe themselves to be "failures" or "bad people" or "weak" or "too old to change." The therapist might respond directly, for instance, by saying: "Your history has made change difficult, but I believe in you, even if your parents did not"; or indirectly, by emphasizing client strengths and successes. The therapist and client can also explore and deconstruct parental and socio-cultural messages and personal beliefs that interfere with behavior change.

Conclusion

Motivational interviewing has gained acceptance in long-term psychotherapy because the primacy of the established therapeutic relationship provides a good foundation for change. In particular, motivational interviewing offers the opportunity to help clients move through stages of change, facilitates an internalized locus of control, and provides empathic and non-judgmental interventions if change is undermined.

Comments and Submissions

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rmarks@itsa.ucsf.edu or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

Recent Reports

Adherence and Motivational Intervention

Konkle-Parker D. A motivational intervention to improve adherence to treatment of chronic disease. *Journal of the American Academy of Nurse Practitioners*. 2001; 13(2): 61–68. (University of Mississippi.)

Personalized interventions using motivational interviewing and the transtheoretical model of change may be useful in facilitating greater medication adherence for people with chronic illness including HIV disease, according to a review of the literature.

“Decisional balance”—the review of the pros and cons of behavior change for each individual—is an important technique, because it pushes individuals to understand the “costs” of current behaviors. Once convinced that change is necessary to maximize the benefits and reduce the costs, people must still achieve the belief that change is within their power. Motivational interviewing can help clients become more confident and progress toward change by helping them recall past successes, by creating situations through which clients can witness the success of other people in similar situations, and by offering verbal support and persuasion.

Motivational interviewing takes advantage of two types of “processes of change”: behavioral processes and experiential ones. Two studies suggest that experiential processes are more appropriately used earlier in the process of change, while behavioral processes should be used later.

Behavioral processes focus on skills building and creating an environment for change, for example, substituting a new behavior for a “problem” behavior, learning to trust others, and using the help of others to support change. Experiential processes target the cognitive and emotional aspects of

change, for instance, awareness of the problem, expressing feelings about the problem behavior, and decisional balancing.

Dual Diagnosis Motivational Interviewing

Martino S, Carroll K, Kostas D, et al. Dual diagnosis motivational interviewing: A modification of motivational interviewing for substance-abusing patients with psychotic disorders. *Journal of Substance Abuse Treatment*. 2002; 23(4): 297–308. (Yale University; and VA Connecticut Healthcare System.)

A motivational interviewing model shows promise for working with substance-using clients who are severely mentally ill, an important finding because such dually diagnosed patients are frequently demoralized by treatment failures and have difficulty mustering motivation to manage their disorders. The approach attempts to mitigate the effects of clinical characteristics such as psychotic symptoms and disordered thinking that may render traditional motivational interviewing ineffective with this population.

Researchers developed and tested a motivational interviewing model in three different groups: an original comparison of 23 subjects; a group of 12 subjects from this original study who provided further clinical experience that was used to improve the model; and a group of seven new subjects who received the improved two-session intervention. Researchers videotaped sessions and used subject feedback to modify their approach.

Subjects from all groups had co-occurring psychotic or mood disorders, and alcohol or drug dependence. Across all three groups, subjects typically were in the 25- to 45-year-old age range, single, unemployed, and using alcohol, cocaine, or marijuana. The original 23-patient study was the only one to compare groups and report results. It found that compared to clients in a standard pre-admission interview, clients in the group receiving a 45- to 60-minute motivational interviewing intervention had better partial hospitalization program attendance patterns than other clients and “lower substance abuse indices.”

The intervention employs typical motivational interviewing techniques such as eliciting self-motivational statements, giving feedback, and helping patients complete an inventory of the pros and cons of behavior change. Further, it integrates a dual diagnosis interview approach, for example, by asking how substance use affects a client’s mental health symptoms.

In order to address the needs of patients with information processing difficulties, the intervention uses repetition, offers concrete verbal and visual materials, and includes breaks in the session. The intervention avoids an emphasis on heavily emotional material or psychotic belief systems. Other intervention strategies include: reflecting often, using metaphors, using summaries to organize patient statements, allowing patients adequate time to respond, and not focusing too much on patient statements regarding despair or negative life events. Even with these modifications,

A pilot study of a motivational interviewing intervention was associated with large reductions in frequency of drug use and sex work.

**Executive Editor; Director,
AIDS Health Project**
James W. Dilley, MD

Editor
Robert Marks

Recent Reports
Michelle Cataldo, LCSW

Founding Editor; Advisor
Michael Helquist

Medical Advisor
Stephen Follansbee, MD

Design
Saul Rosenfield

Production
Suzy Brady
Carrel Crawford
Jennifer Jones
Lisa Roth

Circulation
Jennifer Jones

FOCUS, published 10 times a year, is a publication of the AIDS Health Project, affiliated with the University of California San Francisco.

Ten issues of *FOCUS* cost: **Individual:** Paper—\$48; Paper Outside U.S.—\$60; Electronic—\$36 (inside and outside U.S.); Both Formats—\$58; Both Formats Outside U.S.—\$70; Limited Income—\$24 for either format and \$30 for both formats.

Institutional: Paper—\$105; Paper Outside U.S.—\$125; Electronic—\$90 (inside and outside U.S.); Both Formats—\$120; Both Formats Outside the U.S.—\$140. **Make checks** payable to "UC Regents." Address subscription requests and correspondence to: *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884. For a list of **back issues** and information about cost, write to the above address, call (415) 502-4930, or e-mail jejjones@itsa.ucsf.edu.

To ensure uninterrupted delivery, send new address four weeks before you move.

Printed on recycled paper.

©2004 UC Regents.
All rights reserved.

ISSN 1047-0719



patients must possess enough psychiatric stability to benefit from verbal persuasion and logical reasoning.

Motivational Outreach to Sex Workers

Yahne CE, Miller WR, Irvin-Vitela L, et al. Magdalena pilot project: Motivational outreach to substance-abusing women street sex workers. *Journal of Substance Abuse Treatment*. 2002; 23(1): 49–53. (University of New Mexico, Albuquerque.)

A motivational interviewing intervention was associated with large reductions in frequency of drug use and sex work, and an increase in days of lawful employment, according to a small pilot study of women sex workers in New Mexico. The intervention, however, did not significantly alter behaviors such as condom use and was limited by its size and lack of control group.

Researchers recruited 25 female sex workers from a health care center for homeless people. For 59 percent of the sample, heroin was the drug of choice. Fifty-two percent of the subjects were Hispanic, 30 percent were White, and 15 percent were Native American.

Researchers conducted a baseline interview, followed immediately by a motivational interviewing intervention and an assessment interview four months later. In the motivational intervention, interviewers used subjects' reasons for considering change to develop a "change plan worksheet," outlining specific obstacles and supports for the change. Using a "readiness ruler," each subject then rated the personal importance of changing the behavior, how confident she felt about making the change, and how ready she felt to undertake the change. In order to enhance commitment, interviewers prompted subjects through open-ended questions to explain motivation for change.

Drug-abstinent days increased from 15 percent at intake to 51 percent at the four-month follow-up. Similarly, days of sex work declined from 59 percent to 17 percent, and days of lawful employment increased from 10 percent to 27 percent. At follow-up, condom use with non-paying sexual partners, with whom they also tended to share drugs, did not increase.

Motivational Interviewing in Public Sex Sites

Harding R, Dockrell MJ, Dockrell J, et al. Motivational interviewing for HIV risk reduction among gay men in commercial and public sex settings. *AIDS Care*. 2001; 13(4): 493–501. (University College and Royal Free Medical School, London; Gay Men Fighting AIDS; and Institute of Education.)

A British study found that an intervention combining motivational interviewing

with cognitive approaches may be effective in delivering risk reduction messages to gay men in commercial and public sex settings.

Forty volunteers conducted approximately 900 interviews with gay men at public sex sites and bars throughout London. Interviewers gave subjects a brief questionnaire to complete, followed by the "conversational intervention," lasting up to one hour.

The intervention is grounded in prior studies on cognitive interventions to help gay men identify and critique the self-justifications that they use "in the heat of the moment" to justify unprotected sex. Interviewers used open-ended questions to explore three major areas: client "strategy" for safer sex, their "slip ups" or relapse, and their "status," that is, their perception of themselves as HIV-positive or HIV-negative. Volunteers then asked each client to talk about his personal safer sex strategy and encouraged the client to acknowledge any ways he may have strayed from the strategy.

In response, the client identified the self-talk "in the heat of the moment" that allowed him to deviate from his strategy, as well as the number of times in the last year he had done so. Finally, clients and volunteers engaged in open-ended conversation about risk taking and options for making change. While the strategy has potential, it was difficult for interviewers to engage with subjects in the face of distractions and for clients to remember prior risky situations.

Next Issue

Over the past several years, the Centers for Disease Control and Prevention and organizations such as the UCSF AIDS Health Project have explored the development of prevention interventions that work for people with HIV as well as people without HIV. AHP was one of the first organizations to create a "prevention with positives" training program for HIV providers. In the September issue of *FOCUS*, AHP trainer **Kim Gilgenberg-Castillo, LCSW** describes this process and the evolution of the training to include the process of supporting the sexual health and sexual activity of people with HIV as a way of empowering, among other things, HIV prevention.

Also in the September issue, **Douglas Hudson, MA**, Director of Bay Area Young Positives, talks about some of the issues that face providers doing prevention work with people with HIV.

FREE searchable archive

DID YOU KNOW?

You can access a FREE searchable archive of back issues of this publication online! Visit

<http://www.ucsf-ahp.org/HTML2/archivesearch.html>.

You can also receive this and other AHP journals FREE, at the moment of publication, by becoming an e-subscriber. Visit http://ucsf-ahp.org/epubs_registration.php for more information and to register!



ABOUT UCSF AIDS HEALTH PROJECT PUBLICATIONS

The AIDS Health Project produces periodicals and books that blend research and practice to help front-line mental health and health care providers deliver the highest quality HIV-related counseling and mental health care. For more information about this program, visit http://ucsf-ahp.org/HTML2/services_providers_publications.html.

