

From the Desert

Confessions of a Recovering Trainer / What about Decisional Balance?

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CONFESSIONS OF A RECOVERING TRAINER

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WHAT ABOUT DECISIONAL BALANCE?

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

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

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

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

With Pre-decisional People

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

With Post-decisional People

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

When Change Talk is Not Forthcoming

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

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

In Equipoise

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

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

REFERENCES

- DeJonge, J. J. M., Schippers, G. M., & Schaap, C. P. D. R. (2005). The Motivational Interviewing Skill Code: Reliability and a critical appraisal. *Behavioural & Cognitive Psychotherapy*, 33, 1-14.
- Janis, I.L. & Mann, L. (1977). *Decision making: A psychological analysis of conflict, choice, and commitment*. New York: Free Press.
- Miller, W. R., Hendrickson, S. M. L., Venner, K., Bisonó, A., Daugherty, M., & Yahne, C. E. (2008). Cross-cultural training in motivational interviewing. *Journal of Teaching in the Addictions*, 7, 4-15.
- Miller, W. R., & Hester, R. K. (1980). Treating the problem drinker: Modern approaches. In W. R. Miller (Ed.), *The addictive behaviors: Treatment of alcoholism, drug abuse, smoking and obesity* (pp. 11-141). Oxford: Pergamon Press.
- Miller, W. R., & Mount, K. A. (2001). A small study of training in motivational interviewing: Does one workshop change clinician and client behavior? *Behavioural and Cognitive Psychotherapy*, 29, 457-471.
- Miller, W. R., & Moyers, T. B. (2006). Eight stages in learning motivational interviewing. *Journal of Teaching in the Addictions*, 5, 3-17.
- Miller, W. R., Moyers, T. B., Arciniega, L. T., Ernst, D., & Forcehimes, A. (2005). Training, supervision and quality monitoring of the COMBINE study behavioral interventions. *Journal of Studies on Alcohol* (Supplement No. 15), 188-195.
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people for change* (1st ed.). New York: Guilford Press.
- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.

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- Miller, W. R., Yahne, C. E., Moyers, T. B., Martinez, J., & Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of Consulting and Clinical Psychology, 72*, 1050-1062.
- Miller, W. R., Zweben, J. & Johnson, W. R. (2005). Evidence-based treatment: Why, what, where, when and how? *Journal of Substance Abuse Treatment, 29*, 267-276.
- Moyers, T. B., Martin, T., Catley, D., Harris, K. J., & Ahluwalia, J. S. (2003). Assessing the integrity of motivational interventions: Reliability of the Motivational Interviewing Skills Code. *Behavioural and Cognitive Psychotherapy, 31*, 177-184.
- Roberts, M. (2001). *Horse sense for people*. Toronto: Alfred A. Knopf.



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