SAMPLE CHAPTER

PRINCIPLES AND PRACTICE OF
Group Work in Addictions

Edited by Robert Hill & Jennifer Harris
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Chapter 2

Motivation and change
The role of motivational interviewing in substance use groups

Luke Mitcheson and Brett Grellier

Introduction

Understanding what motivates our clients to take drugs and alcohol, and what motivates them to change these behaviours once they become problematic is, and will remain, a central preoccupation of anyone working in the field of addictions. Intuitive clinicians will know how therapeutic interventions must be able to respond to the subtle shifts in clients’ struggles to control their behaviour, but they may have found it difficult to synthesize academic and theoretical perspectives on motivation into useful practical knowledge. Considering how motivation may be influenced, for better or worse, in the context of group work adds another level of complexity to what is already a complex issue. Heather (1992) has described addiction as a motivational problem, and we start by defining motivation before considering why motivation should be of interest in clinical work and specifically in group work. Through the prism of knowledge about how to enhance individual motivation to change, we consider what could be usefully applied in groups.

What is motivation?

Motivation is a concept that is commonly invoked as key in all that we do. We infer that it is ‘motives’ that steer us in certain directions over others. Motives are understood to be largely instinctual and are shared with the animal kingdom, e.g., the need/drive for shelter, food, and water. Along with these basic motives are social needs and curiosity motives. Social needs pertain to our motivation to feel part of a group or to form romantic relationships. Curiosity motives relate to the seemingly innate need for sensory stimulation. Scientists have discovered that our motivation to fulfil our basic needs is regulated by homeostatic systems in our body in much the same way that a thermostat maintains a consistent temperature in our homes. For example, our bodies send messages to the brain that say that we
require glucose for our system to run optimally, and this activates particular areas of the brain that then motivate us to search for food.

How does this relate to addiction? The reasons why some individuals use and then become addicted to drugs are complex and relate to the inter-relationships of individual differences in terms of biological make-up, personality traits as well as social context (Mitcheson, Maslin, Meynen, Morrison, Hill, & Wanigaratne, 2010). This has led to integrative theories that incorporate physiological, psychological, and social perspectives, so-called bio-psycho-social theories (Orford, 2001; Wanigaratne, 2006).

We can theorize how motivation can initiate initial experimentation with substances and subsequent addiction problems. Both social needs and curiosity motives can be understood as motivating initial experimentation with drugs and alcohol. The consumption of alcohol in many western societies is a common social practice and the motivation to be part of a social group will motivate the desire to drink alcohol. Similarly, in certain social groups the consumption of illegal drugs can also be viewed as a social norm or a way of gaining special status within a particular subculture. The curiosity motive needs little explanation: the desire to seek out novel experiences is understood to be innate in higher-order species.

The consumption of drugs and alcohol can also be understood in the context of the homeostatic system. If normal coping methods for excessively high or low levels of arousal are absent or perceived to be ineffective, then drugs might be used to counteract this. As the body becomes accustomed to external stimulation then homeostatic systems develop around the ingestion of drugs in order to maintain the equilibrium. The messages sent to the brain therefore motivate actions to obtain more drugs.

An important aspect of these ideas is the extent to which motivation is a trait or whether it is better understood as a mediating variable in the change process. Miller (1985) concluded there was limited evidence for viewing motivation as a trait, thereby undermining the idea that clients with substance use problems have a particular ‘addictive’ personality. It is now recognized that motivation is better understood as a more dynamic and fluctuating construct.

Most practitioners with even a passing interest in addictions are likely to have heard of Prochaska and DiClemente’s (1983) transtheoretical model of change. This model proposed that individuals pass through a number of stages: pre-contemplation, contemplation, decision (preparation), action, and maintenance. Individuals were proposed to either remain at the maintenance stage or to relapse, which would then send them back to the pre-contemplation stage. In later work Prochaska and DiClemente (1996) suggested a spiral model in which individuals could move back and forth across all stages. This model has been extremely influential in the addictions field and an assessment of an individual’s stage of change has been used to inform the type of intervention applied. While these assessments might not
reveal anything more startling than whether the individuals are more or less ready to change their behaviour. This fact alone requires us to challenge the ‘one size fits all’ approach. This is worth keeping in mind when thinking about running groups and is discussed later. It follows that certain interventions may be better suited to clients at different times. For example, contingency management approaches that attend to extrinsic rather than intrinsic motivation would be appropriate at the pre-contemplation stage, whereas in the maintenance phase, where motivation is optimal, mindfulness-based approaches could be indicated. Despite the ubiquity of this model, there has been little empirical evidence to support the distinct stages. However, in practice, this model does provide a framework for a dialogue with individuals that helps them to conceptualize their own experience of change and can help services develop a more nuanced approach to service design.

Partly in response to some of the deficiencies of the stage model of change, West (2006) has developed the PRIME theory. This is a dynamic model that attempts to provide a conceptualization of the motivational factors for change across five interacting levels. PRIME is an acronym for ‘Plans’, ‘Responses’, ‘Impulses/inhibitory forces’, ‘Motives’, and ‘Evaluations’. This theory has integrated aspects of previous theories of addiction and may provide researchers with the opportunity to empirically test its principles, with the hope that it could influence future clinical interventions.

At this stage, given the theoretical ambiguities and lack of research to support a consensus about the role of motivation in the change process, practitioners might well ask whether the construct of motivation is a help or a hindrance to planning and running groups. Perhaps it is then useful to take a step into practice-based evidence to what experienced practitioners would consider to be self-evident. This would include the notion that some clients seem to be more motivated to change than others, but also that within individuals the desire for change also fluctuates over time. Motivation to change can also be imposed. Extrinsic motivation, such as ultimatums from courts or concerned family members, will not be universally effective for all people and this indicates that internal or intrinsic motivation will also need to be attended to. As a consequence of these subtle changes and shifting motivations, it is a reasonable conclusion that certain interventions are likely to be more helpful than others at particular times with particular individuals. This presents a fundamental conundrum to thinking about motivation in the context of group work: if motivation is so individually specific, how can it be directly worked with in groups?

In order to answer this question we focus on the theory and application of an individual counselling method known as Motivational Interviewing (MI) (Miller & Rollnick, 2002). We are not advocating a simple translation of these ideas to groups but believe there is a wealth of experience behind these ideas that can point us in the right direction when thinking about enhancing motivation through group work.
Motivational interviewing: core philosophy and principles

Motivational interviewing (MI) is a particular form of skilled communication designed to enhance intrinsic motivation to change and is closely associated with the work of Miller and Rollnick (1986). The core philosophy of MI is most closely aligned with Carl Roger’s humanistic theory of motivation (Rogers, 1957). The humanistic theory of change rests heavily on the assumption that humans are intrinsically motivated to move towards what is good and fulfilling for them. This assumption has yet to receive any compelling supporting evidence and social constructionist writers have argued strongly against this supposed innate drive (e.g., Gergen, 1999). However, we are interested here with how MI works in practice.

The initial description of MI was not derived from a philosophical or theoretical base, but rather from retrospective analysis of some common principles that Miller had been using in his clinical practice that did not seem to fit with the cognitive behavioural model he was working with at the time (Miller & Rollnick, 2009). Later on, Miller and Rollnick (2002) paid more attention to the philosophical principles, in particular humanistic philosophy, while recognizing differences between MI and Roger’s (1961) person-centred counselling. The most striking difference is MI’s role of directing conversation towards a motivational discourse, or ‘change talk’, that is in opposition to Rogers’ approach that values non-directiveness. Similarly, theoretical explanations of the process of change have come as a result of empirical findings and links have been made to the social psychological theories of cognitive dissonance (Festinger, 1957), reactance (Silvia, 2005), and self-perception theory (Bem, 1967; Laird, 2007). We also find a social constructionist perspective useful, in which the principles that direct communication create a novel discourse that opens up the possibility of change.

The core principles of MI are the expression of empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy. Based on the principles of Rogerian person-centred counselling, it is believed that the communication of a non-judgemental empathic understanding of the client and their difficulties facilitates change. Key to this principle is the acceptance that ambivalence about change is a normal part of human experience. The developing of discrepancy, relating to the theories of cognitive dissonance, is guided by the belief that change is motivated by a perceived discrepancy between present behaviour and important personal goals or values. For example, a client for whom retaining custody of their child depends on quitting drug use will find their current behaviour is in direct opposition to their goal of preventing their child being taken into care. Returning to the first principle, it is important that the arguments for change come from the client rather than the counsellor. It is the counsellor’s
role to open up possibilities in dialogue for the client to discover why it is important for them to change in order to achieve their personal goals. The third principle, rolling with resistance, guides the counsellor away from arguing for change, but instead acknowledging the client as the primary resource for finding answers and solutions. For example, if the client expresses that he is never going to be able to change, then the counsellor would empathically reflect this back rather than being caught in the ‘why don’t you’/‘yes . . . but’ trap. Finding yourself in this trap is a sign that you need to respond differently and get out of this communication dead end.

The final guiding principle of supporting self-efficacy relates to the client’s own belief in their ability to make changes. The emphasis here is on the client’s responsibility for choosing and carrying out change, with the counsellor skilfully communicating their belief in the client’s ability to change. This can be achieved in a number of ways, e.g., reflecting back to the client areas in their life where they have been able to make positive changes and then asking open-ended questions that help the client to discover transferable skills that they can apply to their current situation. In summary, MI can be understood as optimizing conditions for clients to become ready, willing, and able to make change (Rollnick, Miller, & Butler, 2008). The willingness for change is attended to through the creation of cognitive dissonance in which, through the empathic understanding and developing of discrepancy, the ‘why’ of change is created. The ability to make changes is attended to through the development of self-efficacy through which the client becomes confident that they know ‘how’ to change. The readiness to change is created when the ‘why’ and ‘how’ reach an optimum point: the reasons for change are clear and compelling and the client’s confidence in their ability to make the changes is assimilated.

**Motivational interviewing with groups**

There is sufficient evidence for MI-based approaches to be recommended by the NICE psychosocial guidelines for drug misuse (National Institute for Health and Clinical Excellence, 2007) and the core ideas are well known across the addictions field. Why not then directly apply MI to working in groups? Indeed, this very question was posed by Walters, Ogle, and Martin (2002) in their chapter entitled ‘Perils and possibilities of group-based motivational interviewing’, where they clearly inject a cautionary note into a simple application of MI to working with groups. In contrast to individual applications of MI, the evidence base for group-based MI is thin and one study reported worse results compared with simply giving feedback to people on their alcohol consumption (Walters et al., 2002).

Why might this be? Essentially, and despite appearances, MI is a complex and subtle counselling approach requiring the therapist to be sensitive to an
individual's ambivalence and therefore to adapt style and intervention accordingly. Even in sessions with individuals, research has shown that therapists following a MI protocol can, when the protocol is discordant with the client's ambivalence, lead those clients to become more resistant to change (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). While it may be theoretically possible to do MI in groups, in reality the sheer complexity of this would suggest otherwise. Walters and colleagues (2002) highlight a number of the processes occurring within a group, some of which we have represented diagrammatically in Figure 2.1 with a 'group' of two clients.

![Figure 2.1 Processes for a therapist to consider in group work.](http://www.routledgementalhealth.com/the-principles-and-practice-of-group-work-in-addictions-9780415486859)

Attending to these processes in a more typical group of eight or more people adds to the complexity. If we accept that doing MI for individuals in groups as devised may be beyond the capability of most practitioners, is there still a way to make use of some of the wisdom inherent in the interventions associated with this approach? We believe there is, and would refer back to the introductory chapter of this book and Yalom's (1975) curative group processes. To varying degrees, these curative processes are relevant to all of the core dimensions of motivation; importance, confidence, and readiness to change. The group can take less motivated individuals with them on the change process, provide arguments for change and undermine reasons for no change. But equally, when things do not go so well, these processes highlight how groups might undermine advances on these dimensions.

In the language of MI, resistance from some powerful group participants can have a demoralizing effect on others and the desire for cohesiveness may lead participants to undermine the therapist's attempts to roll with this resistance. Participants may seek to avoid dissonance both internally and within the group too, leading to an entrenchment of no-change or at least the status quo. An example from our experience of this process occurring is
clients glorifying drug taking in groups with a selective focus on the positive aspects of using, even when undergoing a voluntary drug detoxification.

Despite these risks we know that interpersonal pressure can work the other way too: the majority could shift the individual less ready for change towards change and reinforce this with the public commitment to change that a group facilitates. Recognizing the power of the group to enhance and create motivation, but also understanding that the group can do exactly the opposite, is essential. This is relevant where enhancing motivation is either an explicit focus of the group or an implicit aim within the wider context of a group. We consider these issues further with reference to the four principles of MI.

**Express empathy**

The challenge in a group context is maintaining equity of empathy to participants presenting diverse and conflicting views and ideas. This can in part be addressed explicitly in the setting of ground rules at the start of the group. Ideally, this would be done by asking participants which ground rules they would like to see in operation and agreeing the role of the facilitator and participants in monitoring and enforcing such rules. It is our experience that the essence of ground rules can be distilled down to a basic respect for each other, such that each person’s right to express an idea or opinion does not demean or belittle another participant. The more the group owns the ground rules, the more the participants are likely to adhere to them, thus giving some space for the facilitator to attend to more subtle differences within the group. Walters et al. (2002) suggest that strategies used to work with resistance, such as giving attention to the views that you want to amplify, using reflective listening, and acknowledging the difference of opinion in summary statements, can be useful. Like a conductor of an orchestra, the facilitator is highly active in monitoring the group process and directing the group to ‘perform’, i.e., fully participate. Rollnick et al. suggest that it can be helpful to ‘encourage the quiet, soften the loud’ (2008, p. 171). This can be done by drawing less vocal participants into the discussion with direct questions and by asking more assertive participants to summarize their key points for the group to consider.

Key to expressing empathy is recognizing the strengths and limitations of each participant and using these strategically in facilitating the group process. Despite the intention to create a supportive group that is tolerant of divergent opinion, there will inevitably be moments when you as the facilitator will have to take control of the group to keep it safe and move in a positive direction. Although this will lead to some participants expressing a loss of empathy, reminding the group of the core purpose of the group or the programme the group is part of (i.e., the meta-meaning of why people are in the group) may be required.
Develop discrepancy

Confrontation is the implicit goal of MI, but confrontation is not direct because this increases resistance to change. Instead, MI attempts to elicit the reasons for change from the client rather than attempting to persuade him or her that change is necessary (Miller & Rollnick, 2002; Tober & Raistrick, 2007). Theoretically, peers in a group have experiences to draw on that may enable them to challenge each other in a more direct and legitimate way than a professional would be able to do. When this works, it can be a short-cut to resolving ambivalence, the group norm providing a powerful motivator to consider different ways of thinking and being. We say theoretically because, unless skilfully managed, this can also be experienced as punishing and alienating and lead to participants withdrawing from the group and entrenching a position of no-change with the added burden of loss of self-esteem. Participants may also seek to maintain equilibrium in the group, to avoid conflict, and re-norm in a way that minimizes the extent and nature of difficulties participants may be presenting. Such behaviour can entrench a negative group position of no-change. Using the group to enhance discrepancy can be akin to handling a volatile explosive like nitro-glycerine—highly effective in the right circumstances but not without danger!

To avoid mishaps, we suggest some thought is given in the preparatory phase of the group to who is going to be in the group and what you as facilitators are hoping to achieve. In a cohesive, well-motivated group the ability to enhance discrepancy within the group will be better tolerated than in a group in which participants have more mixed levels of motivations. Rollnick et al. (2008) note that one of the traps to guiding in groups is conducting multiple individual consultations. In the right circumstances, inviting comment from other participants on another’s ambivalence, in such a way that allows an expression of empathy, may be useful, for example asking ‘Who else has felt stuck like this?’ or ‘How did things shift?’ Walters et al. (2002) suggest that breaking a group up into smaller working units with strategic placing of more motivated participants with others who may be less motivated can be useful too.

Roll with resistance

It is inevitable that resistance will be experienced in the group and that facilitators will be indirectly and directly challenged as obvious figures of authority and advocates of change. Of all the principles of individual MI, it is our experience that this is the most difficult to translate to a group setting. As Walters et al. (2002) highlight, the risk is that the group may re-norm around the more powerful and resistant participants. The facilitator is then set up to respond to bring the group back round to a more positive
atmosphere. The battle-lines are thus drawn. There is no easy solution to avoid this. At times the facilitator will need to be highly active and intervene. In extreme circumstances this may even require the facilitator to ask people to leave the group. The ground rules highlighted above may reduce the risk of a negative re-norming of the group occurring, as will the individual MI techniques for managing resistance. If it is one or two individuals being particularly resistant, then simply ignoring them and attending to the other participants may be effective. More direct interventions might include inviting alternative views with the aim of using the group norm to shift the resistant participants from their entrenched views. Rolling with resistance may be easier with two facilitators, so that there is support to step in and steer the group in another direction.

Inevitably there will be times when group facilitators will leave the group feeling that things have not gone well. This is when post-group reflection becomes crucial. In this space it may be helpful to reflect on what happened and what the resistance experienced was all about. To usefully understand it in motivational terms, rather than thinking a client or group is ‘unmotivated’, instead consider whether the behaviours exhibited were due to a lack of awareness of a problem or of a perceived need for change. Maybe there was simply a lack of interest in what you were offering as available treatment? The development of the MI approach challenges us to think about clients not as intrinsically unmotivated, but motivated for different things; the challenge to us as practitioners is to make what we offer relevant (Donovan & Rosengren, 1999).

Support self-efficacy

As with expressing empathy and developing discrepancy, groups also have the potential to help individuals develop self-efficacy, the ‘how’ of change. The facilitator’s role is to harness the knowledge and experience in the room to support explicit conversations about change. Equally, the facilitator needs to be mindful of the group getting mired in conversations about failure and no-change. We find solution-focused thinking useful here. As a facilitator your task is to be very interested in the resources that people use and the knowledge they have gained from their struggles in overcoming addictive behaviour. Facilitators can invite group members to comment on each other’s resources (‘How do you think X did that?’) as well as suggest things that have worked for themselves. Drawing on past successes and change experiences unrelated to substance use can be rich sources of ideas. Groups can be set up with these goals in mind. It is also useful to use the group to solidify commitment by encouraging public statements of commitment to actual change and explicit action.

Keeping in mind the four principles of MI can be a useful reference point during group work, even if the logistics and evidence base for doing pure MI.
remains to be established. More recent developments of MI have shifted to thinking about broader styles of communication. Rollnick et al. (2008) describe three of these: guiding, following, and directing. Each of these ways of communicating has a place within group work. A following (‘going along with’) style would best be suited to an exploratory open-ended group, and a directing (‘taking charge’) style to an educative group, for example one set up to deliver overdose training. Yet in both these groups, at times there will also be a place for the guiding style and indeed the guiding style should predominate in groups seeking to make participants fully active in the process. When talking to clients about the why, how, what, and when of behaviour change, the skill lies in structuring the conversation in a useful way that encourages the clients to take as much of the lead as possible.

As with MI, guiding with individuals utilizes four core counselling skills:

1. asking open questions
2. affirming your client’s position
3. listening reflectively and
4. summarizing.

They facilitate the principles of MI and are a useful set of skills to use when running groups. Using these skills as a guiding style in your interactions can help to facilitate motivation to change and foster a therapeutic environment that maximizes the success of the treatment intervention.

**Asking open questions**

Using open questions as opposed to closed questions will encourage your clients to talk and think aloud in the groups. In doing this you are more likely to facilitate conversations in the group and get people active in the process. A couple of well-chosen, open questions can be sufficient to direct the group to the core purpose and get people active and contributing. Asking open questions emphasizes collaboration and active participation.

**Affirming your client’s position**

This is one way of fulfilling the ‘express empathy’ principle of MI and the same provisos apply here too. Few clients start treatment completely ready, willing, and able to begin the difficult process of addressing their substance use. In spite of the problems that substance use may be causing in their lives, there will simultaneously be aspects of using that are valued and have positive or negative reinforcing qualities and that are therefore difficult to give up. It is important not to label or judge clients. Instead, empathizing with the dilemmas and difficulties your clients tell you about (their ambivalence) with responses such as ‘That feels like quite a struggle’ will help
develop an atmosphere of trust and understanding. As a facilitator the challenge remains as to how far you can maintain this position with particular individuals in a group when this seems to be against the general therapeutic atmosphere.

**Listening carefully and reflectively**

A clear understanding of your clients’ experiences will only happen through careful listening. Listening is an active process that communicates that you are interested in what your clients are saying and want to work with them to achieve change. Not listening carefully can result in your clients feeling misunderstood, rejected, and sceptical about treatment, reluctant to talk about what is going on, and perhaps disengaging. Reflecting back what your client has said, in a short summary, is a way of demonstrating that you have been listening. While it may not be possible to ensure that participants will listen to each other, a facilitator can still model how it can be done and set the tone of the group process.

**Summarizing**

Summarizing is a key part of MI and a key part of a facilitator’s role in groups. It shows that you have been listening, provides an opportunity to check that nothing has been missed, allows you to emphasize key points from the discussion and enables you to move the group on in a different direction.

In many respects the difficulties of adopting MI in groups reflects the difficulties of running groups generally. We believe the rich source of ideas and therapeutic tools from the MI literature offers the potential to help better facilitate groups as well as keep in mind the shifting interpersonal dynamics that can impact on participants’ motivations. The principles of MI, distilled down into a guiding counselling style and the basic communication skills outlined above, should be a cornerstone of any group facilitator’s competencies. Excellent resources for both experienced and budding practitioners of MI can be found at www.motivationalinterview.org.

**Conclusion**

Motivation is not a fixed concept and it increases or decreases as a function of shifting personal, cognitive, behavioural, and environmental determinants. Thus, it is possible that a client’s motivation may fluctuate throughout the course of a group or from one group to the next, or even during a single meeting. If this occurs, remember that motivation is not static, consciously owned, and controlled by the client, but an evolving interaction between therapist, client, the outside world, and the group.
The three key concepts in MI are that:

1. client motivation is critical for change
2. motivation is a dynamic rather than a static trait and
3. motivation is influenced by external factors, including the therapist’s and the group’s behaviour.

These three factors need to be attended to at all times, not only because of their importance in controlling behaviour change, but because we as therapists and group workers affect them just as much, if not more than the clients themselves.

References


