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Series Preface

Tony Rousmaniere and Alexandre Vaz

We are pleased to introduce the Essentials of Deliberate Practice series of training books. We are developing this book series to address a specific need that we see in many psychology training programs. The issue can be illustrated by the training experiences of Mary, a hypothetical second-year graduate school trainee. Mary has learned a lot about mental health theory, research, and psychotherapy techniques. Mary is a dedicated student; she has read dozens of textbooks, written excellent papers about psychotherapy, and receives near-perfect scores on her course exams. However, when Mary sits with her clients at her practicum site, she often has trouble performing the therapy skills that she can write and talk about so clearly. Furthermore, Mary has noticed herself getting anxious when her clients express strong reactions, such as getting very emotional, hopeless, or skeptical about therapy. Sometimes this anxiety is strong enough to make Mary freeze at key moments, limiting her ability to help those clients.

During her weekly individual and group supervision, Mary's supervisor gives her advice informed by empirically supported therapies and common factor methods. The supervisor often supplements that advice by leading Mary through role-plays, recommending additional reading, or providing examples from her own work with clients. Mary, a dedicated supervisee who shares tapes of her sessions with her supervisor, is open about her challenges, carefully writes down her supervisor's advice, and reads the suggested readings. However, when Mary sits back down with her clients, she often finds that her new knowledge seems to have flown out of her head, and she is unable to enact her supervisor's advice. Mary finds this problem to be particularly acute with the clients who are emotionally evocative.

Mary's supervisor, who has received formal training in supervision, uses supervisory best practices, including the use of video to review supervisees' work. She would rate Mary's overall competence level as consistent with expectations for a trainee at Mary's developmental level. But even though Mary's overall progress is positive, she experiences some recurring problems in her work. This is true even though the supervisor is confident that she and Mary have identified the changes that Mary should make in her work.

The problem with which Mary and her supervisor are wrestling—the disconnect between her knowledge about psychotherapy and her ability to reliably perform psychotherapy—is the focus of this book series. We started this series because most

therapists experience this disconnect, to one degree or another, whether they are beginning trainees or highly experienced clinicians. In truth, we are all Mary.

To address this problem, we are focusing this series on the use of deliberate practice, a method of training specifically designed for improving reliable performance of complex skills in challenging work environments (Rousmaniere, 2016, 2019; Rousmaniere et al., 2017). Deliberate practice entails experiential, repeated training with a particular skill until it becomes automatic. In the context of psychotherapy, this involves two trainees role-playing as a client and a therapist, switching roles every so often, under the guidance of a supervisor. The trainee playing the therapist reacts to client statements, ranging in difficulty from beginner to intermediate to advanced, with improvised responses that reflect fundamental therapeutic skills.

To create these books, we approached leading trainers and researchers of major therapy models with these simple instructions: Identify 12 essential skills for your therapy model where trainees often experience a disconnect between cognitive knowledge and performance ability—in other words, skills that trainees could write a good paper about but often have challenges performing, especially with challenging clients. We then collaborated with the authors to create deliberate practice exercises specifically designed to improve reliable performance of these skills and overall responsive treatment (Hatcher, 2015; Stiles et al., 1998; Stiles & Horvath, 2017). Finally, we rigorously tested these exercises with trainees and trainers at multiple sites around the world and refined them based on extensive feedback.

Each book in this series focuses on a specific therapy model, but readers will notice that most exercises in these books touch on common factor variables and facilitative interpersonal skills that researchers have identified as having the most impact on client outcome, such as empathy, verbal fluency, emotional expression, persuasiveness, and problem focus (e.g., Anderson et al., 2009; Norcross et al., 2019). Thus, the exercises in every book should help with a broad range of clients. Despite the specific theoretical model(s) from which therapists work, most therapists place a strong emphasis on pantheoretical elements of the therapeutic relationship, many of which have robust empirical support as correlates or mechanisms of client improvement (e.g., Norcross et al., 2019). We also recognize that therapy models have already-established training programs with rich histories, so we present deliberate practice not as a replacement but as an adaptable, transtheoretical training method that can be integrated into these existing programs to improve skill retention and help ensure basic competency.

About This Book

This book in the series is on motivational interviewing (MI), a client-centered approach for facilitating behavior change (Miller & Rollnick, 2013). MI is best suited for clients who are ambivalent about engaging in behavior change and is often used as a precursor to other formalized treatments (e.g., cognitive behavioral therapy). MI is a nuanced approach, and many trainees find that a multifaceted approach to learning is required to achieve MI competence. This multifaceted approach includes reading on the theory of MI (e.g., Miller & Rollnick, 2013), practice of MI skills, and feedback from peer or supervisor observers. The maxim "learning by doing" is appropriate in MI learning. A trainee may read about MI and be knowledgeable about the theory of it, but this knowledge may not translate to direct clinical skills. Practicing MI skills, with ongoing feedback, is needed to build and deepen a clinician's use of MI in clinical settings.

In this book, we adopt deliberate practice methods to support experiential—learn by doing—training opportunities. The described methods and stimuli can facilitate practicing a range of important MI skills. In addition, the book supports fine-tuning the "how" of intervention delivery, including in a flexible manner across diverse clinical scenarios. Importantly, this book is not intended to replace core coursework and exposure to foundational MI theory and principles of practice. Rather, it is intended to augment other common training components.

CHAPTER 1

Introduction and Overview of Deliberate Practice and Motivational Interviewing

As I (J. K. M.) sat on a wooden chair, in a basement classroom at the University of New Mexico, I listened carefully as Dr. William Miller (Bill), my graduate school mentor, described the foundational principles of motivational interviewing (MI) to my class of first-year clinical psychology graduate students. An eager and driven student, I was intent on learning and becoming proficient in MI. I'd read Bill and Stephen Rollnick's text on MI and felt that the core concepts (open questions, affirmations, reflections, summary statements), were techniques that I already used in my everyday conversations. Suffice to say, I felt pretty confident in my MI skills. As the class shifted from lecture to role-play, I had the opportunity to practice my MI skills with a peer. My confidence in my MI skills waned as the role-play continued. Why did my reflections sound like questions? What if my reflections were wrong and I misunderstood what the client (my peer) was saying? As I stammered my way through the role-play, I found myself so concerned with what I was going to say next (should I reflect? ask an open-ended question?), that I realized I was barely attending to what my client was saying to me. As I left the class, I realized I'd greatly underestimated the complexity of MI.

Undeterred, I began looking for opportunities to practice my MI skills, particularly reflections, as I found those especially challenging. I offered reflections to the grocery clerk (e.g., "It's been a busy day for you"), my partner, neighbors, and family members. These interactions yielded mixed results. On occasion, my reflection was met with a puzzled look, and it was difficult for me to know if the bewilderment was because the grocery clerk wasn't used to an in-depth discussion on the busyness of the store or if my reflection had missed the mark.

Fortunately, my self-directed MI practice was complemented with training and supervision from Bill, along with Theresa Moyers (Terri), whom I regard as one of the most skilled MI clinicians in the world. Over time, as I practiced my MI skills and incorporated the feedback I received from Bill and Terri, I became comfortable in MI. I learned how to fully listen to my clients and offer compassion, while eliciting and reflecting language toward a particular target change. My expertise in MI has taken more than 20 years to develop, but in my early training years, I would have benefited from deliberate

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practice, such as the structured exercises included in this book. These MI deliberate practice exercises are intended to elucidate the core techniques of MI as described in key MI texts (see the Required Reading in the sample syllabus in Appendix C). The repeated nature of the exercises is designed to increase comfort and proficiency in these core MI concepts, facilitating the transfer of these skills for use in clinical sessions with "real" clients.

As I grew in my comfort and skills as an MI clinician, I began to focus on effective MI training strategies. It became apparent that I was not alone in my early experiences of MI—to hold both a strong motivation to learn MI and an equally strong frustration with my struggle for mastery of the nuanced complexities of the approach. Research studies have demonstrated that learner confidence in their own MI skills often decreases after formalized training in the approach (Decker & Martino, 2013). This is consistent with the finding that MI learners often overestimate their MI skills before they are trained in the technique and underestimate their skills after they've received training (Hartzler et al., 2007). Deliberate practice can hone trainees' MI skills and foster realistic self-appraisal and confidence in the approach. Now that I've spent 20 years training others in MI, I am not surprised that trainees underestimate their MI skills after attending a workshop training. MI is a layered approach, consisting of foundational skills (e.g., open questions, reflections, affirmations) that seek to elicit and reinforce client language in favor of behavior change, while encapsulated in an overarching MI spirit. Having one without the others is not sufficient for the mastery of MI.

Overview of the Deliberate Practice Exercises

The main focus of the book is a series of 12 exercises that have been thoroughly tested and modified based on feedback from MI trainers and trainees. The 12 exercises represent essential MI skills. The last two exercises are more comprehensive, consisting of an annotated MI transcript and improvised mock MI sessions that teach clinicians how to integrate all these skills into more expansive clinical scenarios. Table 1.1 presents the 12 skills that are covered in these exercises.

Throughout all of the exercises, trainees work in pairs under the guidance of a supervisor and roleplay as a client and a clinician, switching back and forth between the two roles. Each of the 12 skill-focused exercises consists of multiple client statements grouped by difficulty—beginner, intermediate, and advanced—that call for a specific skill.

TABLE 1.1. The 12 Motivational Interviewing Skills Presented in the Deliberate Practice Exercises

Beginner Skills	Intermediate Skills	Advanced Skills
1. Simple reflections	5. Eliciting change talk	9. Simple and complex affirmations
2. Complex reflections, part 1: guesses at what the client means	6. Reflecting change talk	10. Autonomy support
3. Complex reflections, part 2: guesses at underlying client emotions or values	7. Double-sided reflections	11. Agenda mapping
4. Reflections and open-ended questions	8. Dancing with discord	12. Elicit–provide–elicit

For each skill, trainees are asked to read through and absorb the description of the skill, its criteria, and some examples of it. The trainee playing the client then reads the statements. The trainee playing the clinician then responds in a way that demonstrates the appropriate skill. Trainee clinicians will have the option of practicing a response using the one supplied in the exercise or immediately improvising and supplying their own.

After each client statement and clinician response couplet is practiced several times, the trainees will stop to receive feedback from the supervisor. Guided by the supervisor, the trainees will be instructed to try statement–response couplets several times, working their way down the list. In consultation with the supervisor, trainees will go through the exercises, starting with the least challenging and moving through to more advanced levels. The triad (supervisor–client–clinician) will have the opportunity to discuss whether exercises present too much or too little challenge and adjust up or down depending on the assessment. Trainees, in consultation with supervisors, can decide which skills they wish to work on and for how long. Based on our testing experience, we have found practice sessions last about 1 to 1.25 hours to receive maximum benefit. After this, trainees become saturated and need a break.

Ideally, MI learners will both gain confidence and achieve competence by practicing these exercises. Competence is defined here as the ability to perform an MI skill in a manner that aligns with the spirit of MI and is responsive to the client. Skills chosen for this book are considered essential to MI and often require practice and feedback.

The skills identified here are not comprehensive in the sense of representing all one needs to learn to become a competent MI clinician. Some will present particular challenges for trainees. A short history of MI and a brief description of the deliberate practice methodology are provided to explain how we have arrived at the union between them.

Goals of This Book

The primary goal of this book is to help trainees achieve competence in core MI skills.

The MI deliberate practice exercises are designed to accomplish the following:

1. Provide clinicians with the foundational skills of MI.
2. Help clinicians develop the ability to apply MI skills in a range of clinical situations (e.g., with varying levels of client ambivalence, a variety of target behaviors).
3. Move the skills into procedural memory (Squire, 2004) so that clinicians can access them even when they are tired, stressed, overwhelmed, or discouraged.
4. Provide MI clinicians in training with an opportunity to exercise the particular skill using a style and language that is congruent with who they are.
5. Provide the opportunity to use the MI skills in response to varying client statements and motivation to engage in a particular behavior change. This is designed to build confidence to adopt skills in a broad range of circumstances within different client contexts.
6. Provide clinicians in training with many opportunities to fail and then correct their failed response on the basis of feedback. This helps build confidence and persistence.
7. Finally, this book aims to help trainees discover their own personal learning style so they can continue their professional development long after their formal training is concluded.

Who Can Benefit From This Book?

This book is designed to be used in multiple contexts, including in graduate-level courses, supervision, postgraduate training, medical training, and other continuing education programs. It assumes the following:

1. The trainer is knowledgeable about and familiar with MI.
2. The trainer is able to provide good demonstrations of how to use MI skills across a range of clinical situations, via role-play, video, or both. Or, the trainer has access to examples of MI being demonstrated through the many MI video examples available (e.g., the series by Miller, Moyers, & Rollnick, n.d.; see https://www.changecompanies.net/products/motivational-interviewing-videos/).
3. The trainer is able to provide feedback to students regarding how to improve their MI skills.
4. Trainees will have accompanying reading, such as books and articles, that explain the theory, research, and rationale of MI and each particular skill. Recommended reading for each skill is provided in the sample syllabus (Appendix C).

The exercises covered in this book were piloted in 20 training sites from across three continents (North America, Europe, and Australia). Some training sites chose to translate the exercises into their native language to adopt them for use with their trainees. This book is designed for trainers and trainees from different cultural backgrounds worldwide.

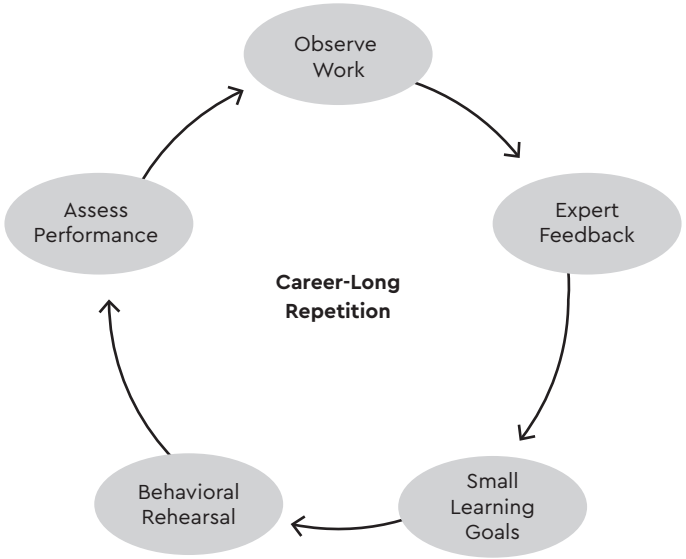
This book is also designed for those who are training at all career stages, from beginning trainees, including those who have never worked with real clients, to seasoned clinicians. All exercises feature guidance for adjusting the difficulty to precisely target the needs of each individual learner. The term *trainee* in this book is used broadly, referring to anyone who is endeavoring to acquire MI skills.

Deliberate Practice in Clinical Training

How does one become an expert in their professional field? What is trainable, and what is simply beyond our reach, due to innate or uncontrollable factors? Questions such as these touch on our fascination with expert performers and their development. A mixture of awe, admiration, and even confusion surround people such as Mozart, Leonardo da Vinci, or more contemporary top performers such as basketball legend Michael Jordan and chess virtuoso Garry Kasparov. What accounts for their consistently superior professional results? Evidence suggests that the amount of or time spent on a particular type of training is a key factor in developing expertise in virtually all domains. "Deliberate practice" is an evidence-based method that can improve performance in an effective and reliable manner.

The concept of deliberate practice has its origins in a classic study by K. Anders Ericsson and colleagues (1993). They found that the amount of time practicing a skill and the quality of the time spent doing so were key factors predicting mastery and acquisition. They identified five key activities in learning and mastering skills: (a) observing one's own work; (b) getting expert feedback; (c) setting small, incremental learning goals just beyond the performer's ability; (d) engaging in repetitive behavioral rehearsal of specific skills; and (e) continuously assessing performance. Ericsson and his colleagues termed this process *deliberate practice*, a cyclical process that is illustrated in Figure 1.1.

FIGURE 1.1. Cycle of Deliberate Practice



Note. From *Deliberate Practice in Emotion-Focused Therapy* (p. 7), by R. N. Goldman, A. Vaz, and T. Rousmaniere, 2021, American Psychological Association (https://doi.org/10.1037/0000227-000). Copyright 2021 by the American Psychological Association.

Research has shown that lengthy engagement in deliberate practice is associated with expert performance across a variety of professional fields, such as medicine, sports, music, chess, computer programming, and mathematics (Ericsson et al., 2018). People may associate deliberate practice with the widely known "10,000-hour rule" popularized by Malcolm Gladwell in his 2008 book *Outliers*, although the actual number of hours required for expertise varies by field and by individual (Ericsson & Pool, 2016). This, though, perpetuated two misunderstandings. First, that this is the number of deliberate practice hours that everyone needs to attain expertise, no matter the domain. In fact, there can be considerable variability in how many hours are required.

The second misunderstanding is that engagement in 10,000 hours of *work performance* will lead one to become an expert in that domain. This misunderstanding holds considerable significance for the field of psychotherapy and other clinical settings, where hours of work experience with clients has traditionally been used as a measure of proficiency (Rousmaniere, 2016). However, in fact, we know (Goldberg et al., 2016) that amount of experience alone does not predict clinician effectiveness. It may be that the *quality* of deliberate practice is a key factor. In addition, experience without feedback is like learning a new sport without a coach or team members. Feedback is essential in the acquisition of clinical skills and should be regarded as a key component in quality training.

Scholars, recognizing the value of deliberate practice in other fields, have recently called for deliberate practice to be incorporated into training for health care professionals (e.g., Bailey & Ogles, 2019; Hill et al., 2020; Rousmaniere et al., 2017; Taylor & Neimeyer, 2017; Tracey et al., 2015). There are, however, good reasons to question analogies made between clinical work, such as psychotherapy, and other professional fields, like sports or music, because by comparison clinical work is so complex and free form. Sports have clearly defined goals, and classical music follows a written score.

In contrast, the goals of clinical work shift with the unique presentation of each client in each clinical interaction. Clinicians do not have the luxury of following a score.

Instead, good MI is more like improvisational jazz (Noa Kageyama, cited in Rousmaniere, 2016). In jazz improvisations, a complex mixture of group collaboration, creativity, and interaction is coconstructed among band members. Like MI, no two jazz improvisations are identical. However, improvisations are not a random collection of notes. They are grounded in a comprehensive theoretical understanding and technical proficiency that is only developed through continuous deliberate practice. For example, prominent jazz instructor Jerry Coker listed 18 skill areas that students must master, each of which has multiple discrete skills, including tone quality, intervals, chord arpeggios, scales, patterns, and licks (Coker, 1990). In this sense, more creative and artful improvisations are actually a reflection of a previous commitment to repetitive skill practice and acquisition. As legendary jazz musician Miles Davis put it, "You have to play a long time to be able to play like yourself" (Cook, 2005).

The main idea that we would like to stress here is that we want deliberate practice to help MI clinicians become themselves. The idea is to learn the skills so that you have them on hand when you want them. Practice the skills to make them your own. Incorporate those aspects that feel right for you. Ongoing and effortful deliberate practice should not be an impediment to flexibility and creativity. Ideally, it should enhance it. We recognize and celebrate that clinical work is an ever-shifting encounter and by no means want it to become or feel formulaic. Strong MI clinicians mix an eloquent integration of previously acquired skills with properly attuned flexibility. The core MI responses provided are meant as templates or possibilities, rather than "answers." Please interpret and apply them as you see fit, in a way that makes sense to you.

Simulation-Based Mastery Learning

Deliberate practice uses simulation-based mastery learning (Ericsson, 2004; McGaghie et al., 2014). That is, the stimulus material for training consists of "contrived social situations that mimic problems, events, or conditions that arise in professional encounters" (McGaghie et al., 2014, p. 375). A key component of this approach is that the stimuli being used in training are sufficiently similar to real-world experiences. This facilitates *state-dependent learning*, in which professionals acquire skills in the same clinical environment where they will have to perform them (Fisher & Craik, 1977; Smith, 1979). For example, pilots train with flight simulators that present mechanical failures and dangerous weather conditions, and surgeons practice with surgical simulators that present medical complications. Training in simulations with challenging stimuli increases professionals' capacity to perform effectively under stress. For the MI training exercises in this book, the "simulators" are typical client statements that might actually be presented in the course of MI interactions and call upon the use of the particular MI skill.

Declarative Versus Procedural Knowledge

Declarative knowledge is what a person can understand, write, or speak about. It often refers to factual information that can be consciously recalled through memory and often acquired relatively quickly. In contrast, procedural learning is implicit in memory and "usually requires *repetition of an activity*, and associated learning is demonstrated through *improved task performance*" (Koziol & Budding, 2012, p. 2694, emphasis added). *Procedural knowledge* is what a person can perform, especially under stress (Squire, 2004). There can be a wide difference between their declarative and procedural knowledge.

For example, an "armchair quarterback" is a person who understands and talks about athletics well but would have trouble performing it at a professional level. Likewise, most dance, music, or theater critics have a very high ability to write about their subjects but would be flummoxed if asked to perform them.

In MI training, the gap between declarative and procedural knowledge appears when a trainee or clinician can speak about the theory of MI, such as the importance of reflective listening, but is unable to generate reflective listening statements in their own practice. They can speak to the "why" of reflective listening but can't offer the "how." **The sweet spot for deliberate practice is the gap between declarative and procedural knowledge.** In other words, effortful practice should target those skills that the trainee could write a good paper about but would have trouble actually performing with a real client. We start with declarative knowledge, learning skills theoretically and observing others perform them. Once learned, with the help of deliberate practice, we work toward the development of procedural learning, with the aim of clinicians having "automatic" access to each of the skills that they can pull on when necessary.

Let us turn to the theory of MI to help contextualize the skills of the book and how they fit into the greater training model.

Motivational Interviewing

MI was developed by Dr. William Miller (Bill) in the early 1980s. The approach grew out of Bill's clinical work in substance use treatment settings and was a stark alternative to the confrontational approach that prevailed in substance use treatment clinics at the time. MI continued to evolve as Bill began to collaborate with Dr. Stephen Rollnick, an early adopter of the approach. Together, they published the first MI text (Miller & Rollnick, 1991) and subsequent updated MI texts (Miller & Rollnick, 2002, 2013).

In the years since, MI has been widely disseminated, both in the United States and internationally. Hundreds of research trials have evaluated the efficacy of MI (e.g., Lundahl & Burke, 2009; Rubak et al., 2005) and found that it's effective as both a stand-alone treatment and in combination with other treatment modalities. Although the approach was originally developed for use with clients with alcohol or drug use disorders, its application and reach has expanded to include a variety of target behaviors (e.g., exercise, treatment adherence, vaccine acceptance, healthy eating). MI is often used in mental health, medical, criminal justice, and educational settings. It can be used as a starting point (i.e., Session 1) for other treatment modalities (Forman & Moyers, 2019) and in combination with other treatments to help build motivation for engagement in a longer duration of treatment, such as contingency management (Sayegh et al., 2017) and cognitive behavior therapy (CBT; Randall & McNeil, 2017).

Briefly stated, MI is a communication method (Miller & Rollnick, 2013) designed to elicit and strengthen a client's own reasons for engaging in a behavior change. It is client-centered yet directive and most appropriate with clients who are ambivalent about a behavior change. MI is intended to be brief, with interactions ranging from a few minutes to several sessions, depending on the clinical setting, the client's readiness and confidence to engage in a behavior change, and the complexity of the targeted change.

In sum, MI has a strong evidence base for use with a variety of target behaviors and across a range of clinical settings and populations. MI's popularity is likely due, in part, to the flexibility of the approach. It is client centered, so the principles and

values of the approach apply broadly, regardless of the particular client situation. MI also fills a treatment gap. There are numerous well-studied treatment interventions for clients who are ready to engage in behavior change. Take smoking cessation as an example. Smoking cessation is widely studied, and there are a number of evidence-based approaches designed to help a person quit smoking (e.g., varenicline, lozenges, CBT). If a client mentions to a health care provider that they would like to quit smoking, the health care provider has an array of options to present to the client. In these cases, when the client is ready to quit smoking, MI strategies can be used to further strengthen the client's commitment to the change (e.g., "What are the benefits of quitting smoking for you? How might your life be different in a year, after you've quit smoking?"), but MI was developed and is intended for use with clients who are ambivalent about a behavior change—in this example, quitting smoking. A client who is ambivalent about quitting smoking may say something like, "Yeah, I should quit smoking. I've tried to quit a dozen times. It never works. I know it's bad for me. I know it will probably kill me and I'm spending a ton of money on it. I just keep doing it. I smoke and I don't even know I am smoking these days. It's part of me." This type of example can leave a clinician scratching their head about what to say next. Knowing MI fills this gap, helping bridge an ambivalent client to further treatment options, when indicated. It also takes the onus for a client's behavior change off of the clinician, perhaps one of the reasons why MI training is associated with decreased clinician burnout (Pollak et al., 2016). In MI, clinicians view clients as the experts on themselves. A clinician is there to guide, elicit, and reinforce steps toward behavior change, but the clinician either explicitly or implicitly acknowledges that the clinician cannot force a client to change their behavior.

As we move into the next section and discuss clinician empathy and MI spirit, we ask you to pause for a moment. Identify a behavior change you have considered making. Perhaps you have been thinking about eating less sugar, drinking less alcohol, getting more sleep, or adding exercise into your routine. How would you feel if someone told you the top five reasons you should make this change? Would they fit for you? What if they told you how you should implement this change? You may have felt some resistance, perhaps wanting to explain why this change was hard to make, why you haven't been able to do it, or why you don't want to do it. This reaction, to push back, is what we expect based on MI theory. The more a clinician pushes an ambivalent client toward a particular behavior change, the more the client is likely to push back. The more the client pushes back during an MI interaction, the less likely they are to engage in behavior change.

If we consider the behaviors that are most applicable for MI in clinical and research settings (e.g., smoking, drinking alcohol, sleep, using condoms), there are likely longstanding reasons clients want both to change and to remain the same. If we return to our smoking example, the client is offering us both reasons to quit smoking and reasons to continue to smoke. They are stuck. They may also feel some shame. Perhaps they've been told to quit smoking countless times by health care providers, friends, or family members. They may anticipate the discussion and feel defensive before the subject is even raised. In MI, it is essential that clinicians meet clients with empathy, to convey understanding to the client. This doesn't mean that the clinician must share the client's experiences or sympathize with the client. Rather, the clinician should listen to the client, hear what the client is saying, and offer that understanding back to the client. This often occurs through reflective listening, but empathy can occur in myriad ways.

MI spirit refers to a "way of being" with a client. It may feel very natural to some clinicians; for others, it may take a period of sustained practice before it feels comfortable. There are four main aspects of MI spirit: collaboration, acceptance, evocation, and compassion. *Collaboration* refers to the shared partnership between a clinician and client. The MI clinician is there to guide, but the client is truly viewed as the expert on themselves. The MI clinician respects the client's autonomy in their decision-making process. *Acceptance* refers to the nonjudgmental stance that is crucial in MI. The clinician may internally disagree with the client's behavior (e.g., a client who is drinking and driving) and, at the same time, accepts the client for who they are. *Evocation* refers to a clinician's deliberate efforts to elicit the client's perspective, their ideas, and thoughts on behavior change. Finally, *compassion* refers to the warmth and support that is offered to a client in MI interactions.

The role of client language is central to MI. Evaluations of MI sessions using standardized behavioral coding systems have revealed a relationship between client language and subsequent treatment outcomes. In MI, client language is categorized broadly into change talk and sustain talk. Client *change talk* includes language moving toward a specific behavioral change. It includes reasons ("I am spending too much money on cigarettes"), desire ("I really want to quit smoking"), ability ("I think I can quit if I use smoking lozenges"), need ("I need to quit once and for all"), commitment ("Monday is my quit day"), and taking steps ("I've bought some nicotine lozenges to help with the cravings"). Observational evaluations of MI sessions have demonstrated a positive association between client change talk and improved treatment outcomes. A stronger relationship exists between client *sustain talk*, or language moving away from change, and poorer treatment outcomes. Client sustain talk includes the following categories: reasons ("I like taking smoke breaks with my friends at work"), desire ("I don't want to quit smoking"), ability ("I've never been able to quit; it's impossible"), need ("I don't need to cut back. My smoking is fine"), commitment ("I am never going to quit"), and taking steps ("I stopped using the patch") with a clear distinction in that the client is arguing to maintain the status quo (e.g., continue smoking).

In the deliberate practice exercises included in this text, we focus on building specific MI skills (e.g., open questions, reflections, affirmations, autonomy support statements). These MI skills are specific behaviors that you, as the clinician, can use in your work with clients. Mastery of these skills, however, does not equate to MI proficiency. They must be delivered within the spirit of MI to be considered MI. We strongly encourage all trainees also to read the theory of MI (e.g., Miller & Rollnick, 2013). It can't be stated enough that the use of MI techniques alone is not sufficient in MI. The techniques must be accompanied by the spirit of MI, the way of being and working with clients. The spirit of MI may be an easy shift for some and may be quite difficult for others. Some find that the spirit of MI does not align with their clinical framework. MI is not a one-size-fits-all approach. We encourage you to use this approach only if it feels right for you. The choice is yours.

MI Skills in Deliberate Practice

The MI skills described in this text represent the foundational concepts that are central in MI. The skills are a mix of the two critical elements of MI: a relational component and a technical component. The relational component refers to the client-centered,

empathic, and accepting relationship between an MI clinician and client (e.g., reflective listening, autonomy support statements, affirmations, dancing with discord, agenda mapping). In MI, clinicians seek to create a collaborative and nonjudgmental partnership with clients in which clients feel free to openly discuss their thoughts about a behavior change. Additionally, clients are given the space to think through their thoughts on behavior change. It's a process whereby the clinician and client are learning and discovering the client's reasons and plans for behavior change together, in a collaborative manner. This discovery process requires the clinician to be directive and understanding. It requires the clinician to reflect and ask questions and also to leave space for the client to share their perspective. The relational component of MI also emphasizes the client's autonomy in the change process. Clients may be officially told "this decision is up to you" (i.e., autonomy support statements) or it may occur more subtly, as the clinician asks the client what would be helpful to discuss with regard to the behavior change (i.e., agenda mapping).

The technical component of MI refers to a discerning focus on client change language. Ambivalent clients will naturally offer both change and sustain talk. The presence of sustain talk is both normal and expected in conversations with clients who are ambivalent about behavior change. In MI, clinicians learn to differentially respond to client change talk with the goal of strengthening or deepening the client's change talk statements. Clinicians must balance moving the client toward behavior change while maintaining a collaborative and client-centered approach. This can be tricky because clinicians need to decide how much and when to attend to client change talk versus client sustain talk. Clients tend to offer more sustain talk early in an MI session. This makes sense if we think of behavior change from the client's perspective. A client may begin an MI interaction feeling defensive, apprehensive, and unsure of what to expect. They may want to make sure the clinician understands why they have engaged in the behavior and how hard it may be to change. Early on, a clinician will want to develop rapport, to make sure the client feels understood. Moving too fast toward behavior change can leave the client feeling pressured to change or misunderstood. As the MI interaction continues and the client offers more change talk, the clinician may start to give preferential attention to client change talk, perhaps only reflecting change talk or offering double-sided reflections that end in change talk. Every client is different, so there's no set formula on how long a clinician should develop rapport before focusing more exclusively on client change talk. Client language will let the clinician know if they've pushed too far: Clinicians will hear increased client sustain talk, indicating they likely have gotten ahead of the client in the change process. This doesn't mean the clinician has failed or that the potential for change is doomed. Rather, the clinician can use this as an opportunity to reflect the client's perspective or highlight the client's autonomy in the change process.

Categorizing MI Skills

We have included 12 MI deliberate practice exercises in this text, each of which focuses on an individual skill. They represent foundational MI skills but are not an exhaustive list of all MI skills and techniques. The first 10 exercises represent key MI skills (i.e., open questions, reflections, affirmations, and autonomy support statements). Exercises 11 and 12 build on the skills presented in the earlier exercises (i.e., agenda mapping, elicit–provide–elicit).

The MI Skills Presented in Exercises 1 Through 12

The exercises begin with reflective listening, an essential and foundational MI skill (Exercises 1–3). Reflections are used to convey empathy and to move the client closer toward behavior change. Exercises 1 through 3 offer an opportunity to build on the complexity of the reflections offered, with Exercise 1 focusing on simple reflections and Exercises 2 and 3 highlighting two types of complex reflections: guessing what a client statement means and guessing the emotion or value underlying that statement. As discussed in the exercises, a key part of reflections is how they are offered to clients. Take the following example: "You aren't concerned about your drinking." The way these six words are enunciated can make a world of difference in a clinical interaction. If said with an inflection, this is a question, asking the client for confirmation or a response. Said sternly or harshly, the words sound confrontational, perhaps argumentative or incredulous. Offered as a statement, the six words may convey empathy when offered as a reflection. Often, new MI learners intend to offer reflections but find it difficult to transition from question-asking to reflections. Either their reflections may sound like questions (with an inflection at the end), or they may add a question to the end of the reflection (e.g., "You're concerned about your drinking. Is that right?"). This is where feedback from an observer is critical, otherwise a learner may build skills (e.g., repeated questions instead of reflections) that are inconsistent with the MI approach. Additionally, repeated practice of reflections is an effective way to build or reinforce new skills. Exercise 4 combines reflections with open-ended questions. This combination can be used to convey empathy to a client, while also eliciting the client's perspective.

Exercises 5 through 7 are focused on client language. Numerous research trials have demonstrated the relationship between within-session language and subsequent treatment outcomes, highlighting the importance of eliciting and reinforcing client language toward change. Through these exercises, trainees will learn how to identify and differentially respond to client change language. Exercise 8 expands on relationship discord, an amplified form of client sustain talk. As described earlier, client discord is a key signal that clinicians have gotten ahead of their clients in the change process. If and when this occurs, clinicians can pause, reflect the client's resistance, and may even want to change their approach ("I think I've gotten ahead of you. This is your decision. Let's talk a little more about your thoughts about [insert behavior change target]").

This text also includes a focus on clinician affirmations (Exercise 9) and autonomy support statements (Exercise 10), often referred to as MI-adherent clinician behaviors. These skills are important in both reinforcing client movements toward behavior change (e.g., "You've really thought a lot about the ways to quit smoking") and can be used to increase client self-efficacy for behavior change, a predictor of successful treatment outcomes. Autonomy support statements explicitly highlight the client's power and role in the decision to make a behavior change. This can be particularly impactful as many clients feel pressured or coerced to make a behavior change.

Finally, Exercises 11 and 12 are specific techniques that clinicians can use to identify and define the target behavior (as described in agenda mapping), and Exercise 12 provides a concrete way for clinicians to provide information in an MI-adherent manner.

A Note About Vocal Tone, Facial Expression, and Body Posture

As noted earlier, MI clinicians should give special consideration to their tone of voice. Tone of voice differentiates whether a clinician's expression is a reflection, question, or confrontational. Similarly, clinician body language is another form of expression, and

clinicians should consider whether their body language is consistent with their verbal expressions. In general, clinicians should appear open and curious (e.g., refrain from crossing arms and closing self in) while allowing the client the space to think and process the reaction. Eye contact norms vary, but clinicians should avoid holding an extended gaze with the client because this could feel forced or aggressive. Additionally, clinicians should pause in the conversation and create space for the client to respond to the clinician statement. If clinicians rush to fill the space (e.g., immediately asking a question after a reflection), they are not allowing the client the opportunity to offer their perspective. These pauses can be uncomfortable at first, especially if this is new to the clinician, but will often feel more comfortable to the clinician over time.

The Role of Deliberate Practice in MI Training

Evaluations of effective methods of training clinicians in MI have occurred for more than 20 years. A number of trials have examined the utility of workshop training and training enhancements (e.g., ongoing coaching and feedback) and, unsurprisingly, have indicated that there is a not a one-size-fits-all approach to effective MI training. Nonetheless, the training literature indicates that ongoing coaching, supervision, feedback, or a combination of these are necessary to prevent MI skill decay. Over time, a clinician may return to asking questions instead of reflections or may lose their focus on eliciting and enhancing client change language.

Additionally, deliberate practice exercises have always been a core part of MI training. During in-person workshop trainings, trainees will often offer reflection after reflection to "build their MI muscle." Additionally, exercises may intentionally artificially limit the range of clinician responses (e.g., only reflect or ask open questions) to increase clinician comfort with new MI skills.

MI learners should be knowledgeable about the theory of MI (Miller & Rollnick, 2013). For broader reading on clinician interpersonal skills, learners may want to read *Effective Psychotherapists* (Miller & Moyers, 2021). There are MI texts for specific populations, such as adolescents and young adults (Naar & Suarez, 2021), diabetes management (Steinberg & Miller, 2015), health care settings (Rollnick et al., 2007), court-mandated populations (Stinson & Clark, 2017), psychological problems (Arkowitz et al., 2017), and group settings (Wagner & Ingersoll, 2012). For further information on MI skills and for activities to deepen MI skills, learners may want to read *Motivational Interviewing for Mental Health Clinicians: A Toolkit for Skills Enhancement* (Frey & Hall, 2021) and *Building Motivational Interviewing Skills: A Practitioner Workbook* (Rosengren, 2017).

Overview of the Book's Structure

This book is organized into three parts. Part I contains this chapter and Chapter 2, which provides basic instructions on how to perform these exercises. We found through testing that providing too many instructions upfront overwhelmed trainers and trainees, and they ended up skipping past them as a result. Therefore, we kept these instructions as brief and simple as possible to focus only on the most essential information that trainers and trainees will need to get started with the exercises. Further guidelines for getting the most about deliberate practice are provided in Chapter 3,

and additional instructions for monitoring and adjusting the difficulty of the exercises are provided in Appendix A. **Do not skip the instructions in Chapter 2, and be sure to read the additional guidelines and instructions in Chapter 3 and Appendix A once you are comfortable with the basic instructions.**

Part II contains the 12 skill-focused exercises, which are ordered on the basis of their difficulty: beginner, intermediate, and advanced (see Table 1.1). Each contains a brief overview of the exercise, example client–clinician interactions to help guide trainees, step-by-step instructions for conducting that exercise, and a list of criteria for mastering the relevant skill. The client statements and sample clinician responses are then presented, also organized by difficulty (beginner, intermediate, and advanced). The statements and responses are presented separately so that the trainee playing the clinician has more freedom to improvise responses without being influenced by the sample responses, which should only be turned to if the trainee has difficulty improvising their own responses. The last two exercises in Part II provide opportunities to practice the 12 skills within simulated MI interactions. Exercise 13 provides a sample MI session transcript in which the MI skills are used and clearly labeled, thereby demonstrating how they might flow together in an actual MI interaction. MI trainees are invited to run through the sample transcript with one playing the clinician and the other playing the client to get a feel for how a session might unfold. Exercise 14 provides suggestions for undertaking actual mock sessions, as well as client profiles ordered by difficulty (beginner, intermediate, and advanced) that trainees can be used for improvised role-plays.

Part III contains Chapter 3, which provides additional guidance for trainers and trainees. While Chapter 2 is more procedural, Chapter 3 covers big-picture issues. It highlights six key points for getting the most out of deliberate practice and learning from being in the roles of trainer, trainee, and observer. The importance of the trainer–trainee relationship and responsive communication is described.

Three appendixes conclude this book. Appendix A provides instructions for monitoring and adjusting the difficulty of each exercise as needed. It provides a Deliberate Practice Reaction Form for the trainee playing the clinician to complete to indicate whether the exercise is too easy or too difficult. Appendix B includes a Deliberate Practice Diary Form that can be used to during a training session's final evaluation to process the trainees' experiences, but its primary purpose is to provide trainees a format to explore and record their experiences while engaging in additional, between-session deliberate practice activities without the supervisor. Appendix C presents a sample syllabus demonstrating how the 12 skill-focused deliberate practice exercises and other support material can be integrated into a wider MI training course. Instructors may choose to modify the syllabus or pick elements of it to integrate into their own courses.

Downloadable versions of this book's appendixes, including a color version of the Deliberate Practice Reaction Form, can be found in the "Clinician and Practitioner Resources" tab at https://www.apa.org/pubs/books/deliberate-practice-motivational-interviewing.