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# MOTIVATIONAL INTERVIEWING IN GROUP WORK ON RISK BEHAVIORS

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*Until the individual acquires hope*
*and the motivation to engage in treatment,*
*no progress will be made*
(Irvin Yalom)

**group therapy**
**risk behaviors**
**Motivational Interviewing**

**Summary**: Motivational Interviewing (MI) is a counseling and therapy method based on empirical research (EBP). MI has a well-documented efficacy in the individual work with clients showing risk behaviors (substance abuse, behavioral addictions, aggressive behaviors, sexual risk behaviors). Its effectiveness stems from the Carl Rogers' humanistic psychotherapy approach combined with the specific tools identified during years of studies on motivation in psychotherapy focusing foremost on pro-health behavior. The article presents the motivational approach and the proposed guidelines for the group work in risk behaviors along with description of its philosophical background, tools, therapist's role and work. The author quotes the methods congruent with the MI spirit and describes the correlation (analyzed in the DM context) between the presence of specific phrases (change talk) in the client's narrative and introducing actual change in one's life. The article proposes certain frame of assumptions for the MI group work, including the characteristic phases of motivation progress in the group members, and the key elements in the preselection and group forming. It is an attempt to describe the capabilities and limitations of MI work in the context of the author's own experience in working with groups as well as against the background of other theoretical approaches to group work.

## Introduction

Motivational Interviewing (MI)[1] is a method which effectiveness in individual work is well documented (more than 1,000 publications in EBSCO database). The source of the theoretical basis for MI are clinical trials of people addicted to or abusing substances. MI was created as a grounded theory. Data from evaluation of therapeutic interventions made by competent judges were combined with the theoretical assumptions of humanistic psychotherapy. The first observations showed that therapists who use most of interventions which express empathy had the highest percentage of patients introducing and maintaining pro-health changes. Miller and Rollnick [1] in studies on the effectiveness of therapeutic effects proved the thesis, that the motivation of individuals is an important factor in the occurrence of a change, and the motivation of the patient/client is closely dependent on the skill of the clinician in terms of its extraction and amplification. In building of motivation not only the context of relationships occurred to be important, but also its dynamics and multidimensional character. The authors developed a method of high efficiency, which combines humanistic philosophy of Carl Rogers with a precisely defined work tools. The creators of MI characterize it as follows: "Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion" [1, p. 55]. This paper presents motivational interviewing describing the key phenomenon of ambivalence in this approach and the so-called change talk, which is a variable that explains the existence of a new adaptive behavior. This article proposes guidelines for the group work using MI method taking into account the specific steps associated with the development of group motivation and the key elements in the selection of participants and forming. Reflections on the use of MI in groups are directly related to the therapeutic work of the author and based on therapeutic experience gained while trying to implement this method in his groups.

## The effectiveness of motivational interviewing in risk behaviors

The described approach is used in the short-term work with people showing risk behaviors and in motivational sessions to undertake treatment. In case of methadone abusers one motivational session preceding the participation in therapy decreased the rate of drop out from 49% to 30% [2]. Another study [3] shows that participation in the motivational session causes greater involvement in the process of therapy, and at the end of the three-month therapy 64% of participants remained abstinent or declared no symptoms, in contrast to the control group (29% of people), whose therapy was not preceded by motivational session. Lounadhl and Burke [4] in the study "Omnibus" compared the efficacy of MI and other approaches in four different meta-analyzes with regard to various risk behaviors (alcohol abuse, drug abuse, gambling, sexual risk behavior etc.). In the meta-analyses, MI effectiveness indicator was higher by 2%, 3%, 13% and 15% compared with the subjects who

[1] In the text the author uses the following terms interchangeably: motivational approach, interviewing, motivational interviewing, MI, which refer to —Motivational Interviewing (MI)

participated in other types of assistance interventions (CBT, 12 steps program). The effectiveness of MI was the highest in relation to alcohol abusers.

In MATCH project (one of the largest studies on the effectiveness of treatment of addicts conducted in 1997/1998) studied the impact of different therapeutic methods in two groups of addicted patients (952 outpatients and 774 hospitalized patients). The subjects participated in four MI sessions in the 1st, 2nd, 6th and 12th week, compared with twelve sessions conducted in the cognitive-behavioral approach, and the 12 steps approach. The comparison included the following variables: the percentage of days abstinent (PDA) and the average number of drinks per one day (DOD). In the follow-up study after the first and the third year the comparable level of improvement in 2/3 of participants was observed in all three interventions [4]. The main difference resulting from the study concerned several times smaller amount of MI sessions [4].

When working with teenagers, the interviewing can be even more promising. A group of youth after one motivational conversation participated in 17 therapeutic sessions, and its period of abstinence was twice as long as compared with the control group taking part in an average of 6 sessions [5]. Jensen, Cushing et al. [6] analyzed the effectiveness of MI in nineteen studies conducted on a group of teenagers using alcohol, drugs, smoking cigarettes or using several substances at the same time. The studies included the impact of MI conducted in 1–4 sessions (six of these studies included more than one session, thirteen studies were based on one session). Size effect measured with Cohen's d coefficient (d = 0.2–0.4 low value, d = 0.4–0.6 average value, d = 0.6–1.0 high value) showed significant efficacy in reducing the amount of used substances in 12 of the 19 studies. In one study the effect was negative, in five studies it was within 0.0–0.18 and in the remaining ones was at a the level of 0.2–0.8.

In conclusion, the results of meta-analyses show high efficiency of interviewing in motivating to undergo therapy and effectiveness in introducing changes in behavior at least at the same level as that of other approaches, but achieved in a smaller number of sessions. Larger amount of MI sessions gives also a greater effect in terms of changing behavior [4].

## Elements of motivational interviewing

Motivational interviewing is a concept of short-term work. It is used in many therapeutic (individual, group, in cognitive-behavioral and systemic therapy) and non-therapeutic contexts (motivation to pharmacotherapy and psychotherapeutic treatment, social assistance, educational and pedagogical support). It is the closest to the idea of humanistic psychotherapy. The most important elements of interviewing: philosophy — the spirit of dialogue, precisely defined tools, working area and the role of the therapist are discussed below.

## Philosophy

The idea of interviewing is expressed in the assumptions of humanistic psychotherapy of Carl Rogers, which are: absolute respect for the experience and difficulties experienced by a person, empathic communication — that builds the openness and helps to discover and understand the state of mind experienced by difficulties, respect of autonomy (in terms of thoughts, emotions, intentions, decisions, actions and common work area). The person is treated as a partner, and the task of the helper is to work in the area of important ambivalence presented by this person and with taking into account the "change talk".

## Tools

Defined tools to lead a conversation give therapist precise guidelines differentiating interventions at different stages of work. The MI approach takes into account the use of four basic tools. *Open questions,* relevant to the phase of change and the process of cooperation, help to extract the language of change and develop ambivalence, to explore values, objectives, expectations, meaning and intentions. *Reflection* — simple and complex (reflection of ambivalence, needs, emotions, values etc.) allow the client to see a different perspective and develop a new narrative of the problem (for example, anger can be accompanied by a different state of mind — helplessness, sadness, grief, excessive pressure, anxiety, loss of control etc.) and help to enhance the willingness to change. *Reinforcements* are aimed at highlighting the resources, effort and involvement to change, enhance the sense of efficacy and self-esteem. *Summaries* are extended reflections of specific sequence of the process of the interview, they show stage of the work and conclusions (collecting summary), allow to move to another area of motivation (temporary summary), gather information from various stages of the interview and show ambivalence (linking summary ) [1].

## Working area

The main area of work in MI is to develop ambivalence and elicitation of the language of change. Ambivalence is an intrinsic dispute of two adversaries, in which each has its own right. One of them has less experience, the more limited issue, and rarely comes to the fore. The therapist has to help to verbalize these issues and in the development of intrinsic dialogue, intrinsic discussion between the needs, values, or in other words "to support the dialogue Self" [7]. Ambivalence is close to the concepts of cognitive dissonance or intrapsychic conflict, it may also reflect defense mechanisms. It is both, a sign of health, the mechanism pushing for change, the development of creativity, and a signal of stagnation — if it does not find a solution for a long time. A person experiencing ambivalence may experience conflicting emotions, have conflicting thoughts and needs. Cocaine use causes rapid mood changes, brings relief and euphoria, but on the other hand, involves a risk of addiction, social stigma, withdrawal syndrome, health and legal consequences. The longer the duration of ambivalence, the greater the risk of consolidating risk behavior and the higher the level of helplessness in the lack of change. Bringing the language of change is implemented by exploring ambivalence (exploring opposing trends experienced in relation to risk behavior). For example, the reason for alcohol abuse may be an attempt to cope with anxiety, while there

may be a danger of family problems or health problems. Developing of ambivalence (the exploration of the source of fear, discovering the values and needs that are in conflict with abuse) and discovering existing resources (one way may be searching for exceptional situations, in which, despite the need to run away into a risk behavior — a person managed to stop or postpone a particular activity) will be crucial for the whole process of motivation. Change talk allows to recognize the willingness to make changes and the possibility of taking activity towards its implementation. Change talk is a form of verbalized self-motivation which reflects a certain state of mind. Change talk is a prelude to the real behavior changes that may occur — as the research showed — up to three years after the session, while sustain talk, identified as resistance to other approaches, is a negative predictor of the effectiveness of therapy [9]. Manifestations of motivation are expressed in the semantics of change talk which is the reverse of sustain talk. White [8], in the field of narrative psychology, said that the extraction of a new narrative about the problem is the beginning of its change. Change talk is preparatory and mobilizing. Preparatory change talk is expressed in the form of:

- desire signaling a push "for": "I want to drink less", "next time I hope to stop the explosion of anger";
- ability — to notice one's own resources, that is expressed in hypothetical form: "I would be able to go to the casino less often, if I hadn't met with these people";
- reasons to change — "I could live longer, waste less time, money, and I could be in a relationship, if I didn't take drugs";
- needs observed in the imperative: "I have to d something with myself", "This is my responsibility".

Mobilizing language represents movement toward resolving ambivalence in favor of the change and manifests itself in the form of:

- obligation — "I'm not going to go to bed with an unknown man after this weekend party";
- activation — "I'm willing to give up my daily glass of beer which is an addition to the dinner";
- taking steps — "Since tomorrow I don't take drugs …" [1, 9].

## The role of the therapist

The task of the therapist is to extract and strengthen the motivation. There are some basic rules of conduct.

Skilful expressing of empathy and acceptance is an attempt to understand the diverse needs and values of the client without issuing judgments, evaluations, criticism, moralizing and using other confrontational tools that Gordon [6] defines as communication blockades. In this approach, empathy is the most important lever of change. The person changes his/her opinion, if he/she feels that the problem may come to the fore in an atmosphere of compassion [1]. The mechanism of influence of empathy on the change has not been fully recognized. Research show that the higher level of empathy coincides with the amount of changes, a time of sustaining a change and less likelihood of drop outs [1, 3].

Emphasizing ambivalence and contradictions during the conversation brings out the discrepancies between values and actions, between the diverse emotions and needs, between beliefs and decisions [1]. The typical examples are: the simultaneous experience of love and hate, the need for relief and self-destructive actions, the desire to maintain the family and drug abuse.

Following clients' resistance is accomplished by showing understanding regardless of the context of his problems, life situation, beliefs, values and experiences. According to MI, resistance is a function of the interaction between the client and the therapist. It can grow as a result of the incorrect intervention or intervention inappropriate to the stage of the process and to the stage of change. The resistance may be a manifestation of the therapist's interventions that do not fall within the area of proximal development, inadequate to emotions and needs, and of too fast pace of work. The most common cause of resistance is coercion, lack of readiness to work on something, too strong pressure from the therapist and overly confronting interventions [1].

Supporting self-efficacy is expressed in avoiding the role of an expert, in strengthening the autonomy and decision-making on the change. Risk behaviors usually are in conflict with the values of the person who takes it, or in conflict with social norms. Taking psychoactive substances, people generally feel anxiety, fear about the health, the opinion of others, and the shame and fear of disclosure. With high probability it can be assumed that an alcohol or drug abuser was confronted or confronted himself/herself with difficulties of changing behavior. A meeting with a specialist in the context of risk behavior often causes huge anxiety. Additional confrontation, especially at the initial stage of work, probably will increase it, activate defense mechanisms, resistance and will delay the change or trigger apparent change. Tension is stronger when the person is more helpless to change his/her behavior. The fact of referring to specialist shows that there is motivation important for change and system of values, that led a person to the decision to seek help. Furthermore, the tension caused by confrontation often leads to conceal risk behavior, causing increased tension and increases the probability of rebound in risky way. Experiences show that addicted patients leaving therapy session deal with everyday tension in the form of substance use, and being ashamed keep this fact from a therapist. Raising tension through interventions such as interpreting, confronting, compliance, suggesting, evaluating, analyzing and diagnosing the problem, proving harm, presenting a critical attitude, by Gordon [10] is defined as communication barriers (roadblocks) that interfere with the exploration of the state of his/her own mind and emphasize the unequal relationship between the therapist and the client. The therapist that is in favor of change, suggesting the need for its implementation before the client will be ready for it, with high probability will cause resistance [1]. An important reason for maintaining risk behavior is the lack of understanding of the problem and acceptance of the weakness by the environment. Growing fear of helplessness and stigmatization heard in the social discourse complicates the situation.

Foucault [11] emphasizes that intrapsychic difficulties are rooted in the evaluating narrative of persons who have power in society — doctors, therapists, spiritual leaders, politicians [11]. Negative narration about addiction increases conflict in an individual because of difficulties in coping with problem and fear of its disclosure. People who abuse alcohol, smoke during pregnancy, amphetamine users, gamblers or people undertaking sexual risk

behavior can articulate many consequences of their behavior, if they talk with a person that is willing to understand. Building the relevant parameters of cooperation by emphasizing the autonomy will result in freely expressed need for change, simplified exploration of states of mind (emotions, thoughts, needs, intentions), opening the possibility of wider cooperation, activation of the ability to change the perspective and to perceive other arguments. The task of the therapist is to identify these arguments, which may indicate the signals to change (i.e., change talk) and to demonstrate acceptance of and respect for the sustain talk. The therapist can examine what are the benefits and losses associated with the status quo (substance use) and the benefits and losses arising from the change of behavior. The therapist also examines, how psychological needs can be fulfilled without substance use, how to experience relief, reduce anxiety and increase social competence in a different way.

Motivational approach, unlike many models of addiction treatment, focuses on different parameters of cooperation in pursuit of implementation of humanistic values, with an emphasis on the empowerment of a person having the resources to change. The task of helping person is to support in extraction of these values and to emphasize the sense of agency. A comparison of some theoretical assumptions of work using MI and Minnesota Model — one of the first and most common methods of working with addicts — is presented below.

Table 1. **Author's own elaboration based on: 1) Miller RW, Rollnick S. Motivational Interviewing: Helping People Change; and 2) Woronowicz BT. Addiction. Genesis, therapy, recovery. Media Rodzina Publishing House; 2009.**

| | Motivational Interviewing | Minnesota Model |
|---|---|---|
| **Goal of help** | Goal is determined by the patient, with careful help of the helper to focus on the main problem, and with respect to the autonomy. The purpose may vary on different stages of work. | Goal is defined as work toward maintaining lifelong abstinence from all psychoactive substances. |
| **Scope of help** | Help is within the current possibilities of development of the person or in the area of the closest possible change. | Maintaining the abstinence, work on the mechanisms of addiction, development of competence serving the life in sobriety. |
| **Diagnosis** | Work on change of behavior can take place without a diagnosis. | Treatment is preceded by a diagnosis of addiction. |
| **Structure of work** | Processes of change (commitment, focus, extraction, planning); taking into account the Transtheoretical Model by Prochaska and DiClemente. | Twelve-step program |
| **Assumptions about working with addiction** | Intrinsic motivation — strengthening of agency, elicitation of ambivalence, elicitation of change talk which is a predictor of change. | Extrinsic motivation — recognition of the diagnosis by the patient, helplessness against the illness and an assumption that one of the most important elements of the illness are mechanisms of denial. |
| **The role of the helper** | Understanding by the helper of the mechanisms that raise motivation of the person; adapting the work tool to the stage and the process of change. | A desire to allow the addicted person to identify the mechanisms of addiction and symptoms of the illness, which can cause the need for change in his/her life. |

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| **The relationship between the helper and the assisted person** | Partnership, based on the principles of humanistic psychotherapy — absolute acceptance, respect of autonomy and empathy expressed to the person. | Mentoring, based on treatment of the patient with respect, understanding and dignity for people who suffer from the illness. |
| **Motivation** | Motivation is the basic condition of change. | Motivation is not a necessary condition for achieving change. |
| **Language of problem description** | Neutral description of difficulties in a language accepted by the client. | Language description is characteristic for the approach, e.g., a person is determined by the diagnosed illness — an alcoholic, a drug addict. |
| **Resistance** | Resistance is a signal for the helper to change the way of work or the working area. The resistance results from the interaction between the helper and the assisted person. In MI, the term resistance is now replaced by the term "sustain talk" to emphasize the relational origin of client's response. | Resistance is the manifestation of the mechanisms of addiction. |
| **Cooperation with other approaches** | The possibility of integrating the interviewing with other therapeutic approaches, e.g., with CBT, systemic approach. | Inclusion of the relatives in the healing process; the use of an interdisciplinary team of specialists — doctors, individual therapists, group therapists. |

## The dynamics of motivation — the stages of risk behavior change and processes in motivational work

Prochaska and DiClemente [12] created the Transtheoretical Model of Change, presenting motivation as a continuum of several phases, enrolling in the concept of MI. The first stage of change is precontemplation — lack of awareness of the problem, the person does not feel the ambivalence and does not experience crises related to behavior; contemplation — a person experiences ambivalence, collects information, evaluates behavior, feels the need to change and at the same time maintains the risk behavior that brings a number of benefits; preparation — the third stage, in which a person considers arguments "for" and "against" various options of change, looks for a method, plans, focuses on the positive aspects of the change; action — using strategy of change and its implementation; sustaining actions — a person makes efforts to maintain the change; and the reoccurrence of risk behavior — a return to earlier stages. Each stage requires a differentiation of intervention by the specialist to support a progress to the next stage of change.

Miller and Rollnick [1, 9] pointed to four processes in work with a client having a significant impact on overcoming the next stages of change [1, 9]:

- commitment is the first process of collaboration, and its definition is consistent with the concept of building an alliance or creating a therapeutic alliance. It is also the most important part of interviewing, which fulfils several functions: it builds a sense of trust and safety, helps to reduce tension and anxiety limiting mentalization problems. According to a study on the effectiveness of therapy, 20% of the variance is explained by properly established and built therapeutic alliance [13].

- directing — it is a directive process where a specialist, on the basis on his/her own knowledge, experience and information obtained from the patient, intervenes in the area of his/her most important problems. Example: "I drink because it helps me in stress, I cannot cope any longer, I argue with someone every day, and sometimes I burst out, yank with someone, and then I come home and I'm tired of everything, lately I took few pills, but I woke up. I know that next time I must use a higher dose." In the above-described situation, it is advisable that the therapist in first place take care of portraying the difficulties provoking suicidal thoughts and focused on finding resources for dealing with situations which may result in tendencies leading to suicidal behavior. In such a situation group may be an additional support, sometimes stronger than the individual work. It should be noted that it is important to examine the risk of suicidal tendencies before taking the person to the group.
- elicitation — it involves extracting discrepancies and resources to cope with difficulty by the client. The task of the therapist is being sensitive to sustain talk and supporting the change talk. Daryl Bem [14] proved that people become convinced about the things that they say — self-perception theory [14] and they react with resistance to the information provided by others, which for them are obvious formulation arising discord (reactance) [15]. These assumptions are used in cultural contexts in which alcohol abuse, violence and drug use are stigmatized. Presenting information such as "Drugs are harmful and you need to stop taking them, because you are wasting your health" will not bring benefits, such as campaigns based on the induction of fear visible on packs of cigarettes.
- planning is the final stage of work on the problem, but in many cases the motivational work ends up at triggering the change. Previous processes conducted properly can activate in a person a decision, after which he/she will implement the change alone. This process requires a large mindfulness from the therapist. Work on planning, without considering a pace of work appropriate for a particular person, the appropriate passage through the preceding processes, will be ineffective.

**Assumptions of group work using motivational interviewing method**

The ambivalence manifests itself at the level of intrapsychic conflict and can be evoked in an individual work, as well as under the influence of the group. It can be assumed that the group is more effective in this regard. The specificity of its functioning provoke participants people to reveal more contradictions, it develops a wider range of ambivalence, and thus can present more arguments in favor of change and against the status quo of risk behavior. The participant thanks to the group can identify his/her own ambivalence and support others in developing their ambivalence, and hence in changing behavior.

In the group working using the MI method the change may occur as a result of similar mechanisms that exist in individual work:

- behavior modeling — an important function of the group is learning social skills (especially important in behaviors such as risky sex, aggression and substance abuse due to peer pressure). Working with the group in the spirit of MI with the use of

reflections, strengthening adaptive behavior and non-confronting questions, opens up a wide variety of behaviors that can be modeled. Yalom [16] emphasizes that the search for patterns of behavior to follow among the participants of the group and in the person of the therapist is one of the strongest factors of recovery in the group therapy;
- internalization of empathic behavior of persons who respect the autonomy of other participants;
- development of group ambivalences regarding risk behaviors and the development of discrepancies in terms of emotions, values, beliefs about individual experiences. Participants can identify their own discrepancies through the narratives of other participants and thereby increase the chance of identifying more convictions that builds sustain talk;
- change talk expressed by one participant in the group can increase the motivation of other people to look for areas of change;
- reflections, as one of the basic tools in MI, allow for more efficient metallization of mental states of others.

The group also triggers several other mechanisms: identification, community of experiences and behaviors, gaining knowledge and advices from other participants that are strong elements of impact in the change.

**Phases of group development in Motivational interviewing**

Wagner and Ignersol [17] proposed four phases of development of the group in motivational approach:

- commitment phase — setting norms of the group, the principles of communication and other parameters for secure collaboration. The task of the therapist is to make the process of building commitment and alliance easier, building parameters of safe collaboration which will make, at a later stage, inclination of different perspectives;
- perspectives development phase — presenting topics to work, arguments and expressing doubts. The role of the therapist at this stage is to emphasize the similarities between the participants in order to build relationships, facilitate the identification, expressing acceptance for different perspectives and experiences;
- widening the perspective — putting greater emphasis on the differences between the participants, highlighting the challenges, encouraging to personal reflection and developing differences and personal values;
- phase of decisions and actions — the desire to solve the problem. Motivating participants to take small steps toward the change. Direction of work in the last phase depends largely on the individual needs of the participants.

## Group work and individual work

In group work, as well as in individual work, it is important to deepen the problem, its skillful directing and maintaining pace of work which is adequate for the group and individual participants. The group is primarily to strengthen the motivation in the context of risk behavior, and the secondly to build social skills. The therapist reinforces the motivation of the participants to exchange thoughts, encourages the discussion between them. It is important to emphasize the direction in which the group is moving, in contrast to the attention focused on the individual work of the participants. Example: "Tomasz says he is ready to abandon the use of amphetamine and the best way for him is total abstinence, Robert says he does not see the point in abandoning drugs, as he has made several attempts, which proved to be ineffective." It will be more beneficial to emphasize: "Everyone has a different experience with amphetamine and different ideas in respect to how to deal in the future, there are also concerns about relapses." In contrast to the individual work of the therapist's role is to put more emphasis on summarizing the thematic areas discussed the group, naming difficulties and highlighting common values that bring the participants together and building group cohesion. For example: "Is is about the relationships with people were less important in the period of drinking, when one begun to abuse substances, cessation of addiction for some people was associated with a large abnegation and loss of important benefits, and in others evoked a sense of emptiness that is hard to fill." The role of the therapist as a person modeling the relationship with others is definitely more important. The aim of the meeting is to make the participants more motivated. The work should be focused on the development of the ambivalence of the whole group, rather than individual participants [18]. The strength of the group is also an obligation undertaken in front of the group is more power than in individual work.

## Own experiences

The author has several years of experience in the use of motivational methods in the individual work with adults, teenagers, families and groups. He underwent two-year training in MI and obtained a certificate of the motivating therapist. He combines the motivational approach with systemic understanding. He also applies MI in work with people with disorders of the axis I of the DSM (affective disorders, anxiety, psychosis, obsessive-compulsive disorder). In work with groups, he uses MI within the short-term interventions up to 12 meetings in the private clinic (with adults addicted to alcohol, drugs) in education and childcare Centers, schools, non-governmental organizations and correctional facilities (with youth and young adults with behavior like: alcohol abuse, drug abuse, designer drug abuse, risky sexual behavior, aggression, criminal behavior, violence). This work has not been subject to statistical elaboration. Selected processes of assisting work were supervised or intervised. The following conclusions are drawn from the author's own experience and author's attempt to extrapolate MI, created as a method for individual, on group work. In creating a closed group several elements should be taken into consideration:

- work using motivational interviewing can take place at different stages of help. It can be used as a method of building a group, the method preceding the therapy, motivating to group or individual therapy. It can also support the therapeutic work and be used at different stages of work with a group in the process of engaging in the situation of group crisis or severe resistance. It also works as an independent method of group work or combined with systemic and cognitive understanding, with psycho-educational work, or support work. Participants of a group can simultaneously undergo individual therapy, if the individual therapist's approach does not exclude participation of the patient in both processes;
- type of risk behavior — people involved in group work build the parameters necessary for cooperation more quickly, if there is a common experience. In the group in which the majority of people are alcohol abusers, participants using other substances may feel less understood. We also live in social reality, where alcohol abuse is more accepted than drug abuse. Thus, the drug abusers are more stigmatized and may feel more discomfort in a group, experience less acceptance and respect from the group;
- psychological and psychiatric consultation before starting the group work is helpful in the context of the examination of motivation and social skills to work in a group, and help rule out disorders and behaviors that impede the use of it;
- disorders of the axis I of DSM — affective, anxiety or psychotic disorder may reduce the opportunity to work on risk behaviors in a group setting. These problems might require at first pharmacological treatment and/or individual psychotherapy, allowing to reduce the ailment increasing risk behaviors;
- strong social anxiety may exclude a person from the group when the level of tension does not allow active participation in the meetings. They may prove to be excessive stressor deterrent to this type of experiences. In this situation, it is also indicated to start the work from individual meetings;
- severe antisocial behavior and current suicidal tendencies of participants — they can cause greater level of anxiety in the group, which will make it difficult to get involved in the process and to feel empathy for others;
- disproportion of participants who are at different stages of the change. Participants of risk behaviors group are usually at different stages of the change. Excessive disproportion in the number of participants who are at extremely remote stages of the change may hinder work with the group, and can also increase the risk of drop outs of persons who are at the early stage of the change.

In the motivational work with a group these elements are important:

- differentiation of motivational interventions in such a way, that participants who are at different stages can benefit from the therapeutic effects;
- identification of the group process and the use of intervention in a manner appropriate to the process. Premature use of intervention extracting ambivalence in a situation, when people are at the stage of engagement, may lead to their exclusion;
- different ambivalences — different ambivalences result from different system of values, which may give rise to criticism, activate different beliefs and tension between

people. The role of the therapist is to emphasize these differences and decisive response to the attempts to exclude the participant;

- resistance in a group can be the result of individual difficulties of participants, a manifestation of the lack of appropriate parameters for cooperation, building openness and commitment, and above all, as in the individual work, it may be a sign of excessively confronting or inadequate interventions of the therapist. Previous group experience of participants accustomed to the confrontational style of work or a work based on complete abstinence. Perception of not-confronting approach can be perceived by the participants as a sign of weakness or lack of experience of the therapist. The reflection of deeper problems, showing ambivalence behind such a response, investigating the expectations or discussing the participant's reaction by the group may be helpful in this situation;
- reliance on the work of natural leaders, people with the highest social competence, leading a group toward cooperation and changes in non-adaptive behavior — especially important in case of youth and young adults. Clearly defined goals and focus on tasks and taking care of the appropriate atmosphere will be additionally beneficial in the youth group.

In case of a group at the facility, where freedom is restricted by law, it would be beneficial to work in less numerous groups, from 8 to 10 people. Institutional coercion of school and facilities which often do not ask for permission for motivational work, rises considerable difficulties. Environment managed in an authoritarian way takes away a large part of autonomy and decision-making. In addition, problems can be posed by a significantly different educational system in the facility, characterized by using behavioral methods (allocation of points, ratings, permits, the use of sanctions disproportionate to the offenses, the use of inadequate rewards, punishing only persons who use psychoactive substances in situations when a person is addicted). These methods are forcing people to skip standards in order to avoid sanctions, they often demoralize, at best, they increase external motivation instead of developing internal motivation. In such a situation it will be possible to work toward increasing autonomy in experiencing difficulties and in broadening the experience of mental states. On the other hand, this system will not be useful to build the autonomy of behavior and the tension resulting from the risk of sanctions will limit the expression of emotions and expectations. Observations indicate a strong demand for this type of interventions in facilities, but often work to achieve the change in the overly rigorous system loses raison d'etre. Young people in group work abreact the tension, confront with the therapist and other participants, cross the borders, have a sense of injustice and a lot of anger. A well-defined contract with the institution and the group may be useful here may, but it is not always sufficient. Working in such conditions will certainly require strict supervision, in cooperation with the second therapist or with the whole facility team. The issue of working with young people in facilities with restricted freedom, opens the area that is beyond the scope of this article.

Yalom [15] draws attention to a number of recovery factors in a group work: altruism, group cohesion, universality, interpersonal learning at the input, interpersonal learning at the output, guidance, catharsis, identification, restoration of family situation, understanding each

other, instilling hope, existential factors. In the case of addicts and substance abusers the strongest recovery factors are consistent elements with the spirit of the motivational approach: altruism — manifested in empathetic behaviors; universality — the belief that one is not the only person with the problem; instilling hope — awareness that the group was able to help others, manifested in expressing change talk. In case of people with psychiatric diagnoses most important is identification — to find someone who can be an inspiration, and modeling by the therapist and other group members.

## Recapitulation

Group meetings are a particular kind of work during which the therapist can use the competencies of participants and may model skills for the development. Group gives a greater sense of support, if it passed through the stage of commitment, building relationship or conflict. The strength of the group also gives a possibility to emphasize a broader spectrum of different needs and emotions, it gives the opportunity to elicit a greater number of ambivalent states, allows for a greater range of support and mutual learning and improving social skills. In contrast to individual work with the use of interviewing, the therapist puts more emphasis on taking care of the process of building cooperation and models the discussion, retreating at a time when the group members will begin to internalize the spirit of the method, the tool and will begin to use them effectively. Experience shows that young people captures the spirit of work through dialogue faster than adults. People who have not experienced other methods of therapies, also learn reflective and supportive messages faster.

Studies show a rapid increase in the use of psychoactive substances by youth and young adults in recent years, particularly THC, amphetamine and designer drugs. Furthermore, the age of sexual initiation lowers, which in combination with the use of psychoactive substances intensifies the problems. Extreme increase in the use of online media and games — though it does not constitute such a threat as the aforementioned problems — significantly affects the development of social competence (adversely affects the emotional intelligence in case of games based on violence, the understanding of the perspective of others, own mental states, and on the development of empathy). In the face of growing social difficulties demand for group work, in the author's opinion, will steadily increase. Emerging new therapeutic problems will require ever greater flexibility from the specialists. The described approach is dynamic — recommendations and guidelines for dealing with people experiencing various problems are being changed with the increase of amount of research. Recent MI studies, confirmed in own observations, show that work with young people in the area of partnership with the accentuation of their decision-making and autonomy is far more beneficial. It is also helpful to use more reflections. A better outlined structure of work, shorter interventions and simpler language may be useful in case of people with cognitive problems. In case of people diagnosed with a psychosis, it is helpful to summarize the stage of work very often. Attention should be paid to the use of reflections, that may be part of a productive symptoms. The greatest strength of MI is the ability to work with people having risk behavior spectrum problems which are additionally burdened with negative social consequences. Studies show favorable effects of work through dialogue in minority groups [5], which experience more stressors, and are at risk of aggression in their environment.

There is a tendency to include MI components into other approaches: psycho-educational and supportive groups, groups focused on solutions, work with couples and families, often in cognitive-behavioral therapy. MI is also applicable in the field of medical and social services. It is also consistent with the assumptions of narrative therapy and there are many common elements with an approach based on mentalization [19]. Research area of motivational interviewing in group work has already began to develop in Western countries. Due to the effectiveness of this approach in individual work and reducing the time and costs in the group methods, this proposal can be very promising — not only for participants of groups, but also for decision-makers taking into consideration the economic factor of treatment.

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