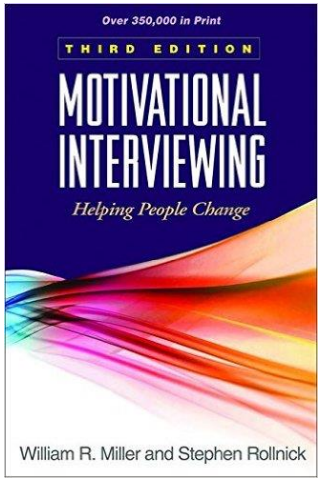
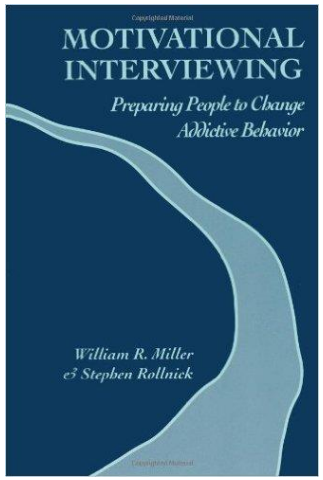
Motivational Interviewing

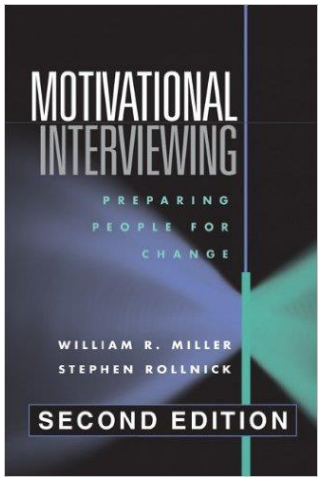
John F. Kelly, Ph.D.

Disclosures

- Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.







What people really need is a good listening to…

Motivational Interviewing (MI)

- What is MI and its assumptions?
- What are the clinical strategies involved in MI and what is its “spirit”?
- How effective is MI as an intervention for SUD?
- How does it work?
- Some conclusions…

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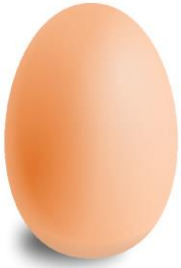
STAGES OF CHANGE:
RELATED TREATMENT & RECOVERY SUPPORT SERVICES

PRECONTEMPLATIVE

In this stage, individuals are not even thinking about changing their behavior. They do not see their addiction as a problem: they often think others who point out the problem are exaggerating.



CONTEMPLATIVE

In this stage people are more aware of the personal consequences of their addiction & spend time thinking about their problem. Although they are able to consider the possibility of changing, they tend to be ambivalent about it.

PREPARATION

In this stage, people have made a commitment to make a change. This stage involves information gathering about what they will need to change their behavior.

ACTION

In this stage, individuals believe they have the ability to change their behavior & actively take steps to change their behavior.

MAINTENANCE

In this stage, individuals maintain their sobriety, successfully avoiding temptations & relapse.

HARM REDUCTION
* Emergency Services (i.e. Narcan)
* Needle Exhanges
* Supervised Injection Sites

SCREENING & FEEDBACK
* Brief Advice
* Motivational Interventions

SREENING, BRIEF INTERVENTION, & REFFERAL TO TREATMENT (SBIRT)

CLINCAL INTERVENTION
* Phases/Levels (e.g., inpatient, residential, outpatient)
* Intervention Types
  - Psychosocial (e.g. Cognitive Behavioral Therapy)
  - Medications: Agonists (e.g. Buprenorphine, Methadone) & Antagonists (Naltrexone)

NON-CLINICAL INTERVENTION
* Self-Management/Natural Recovery (e.g. self-help books, online resources)
* Mutal Help Organizations (e.g. Alcoholics Anonymous, SMART Recovery, Lifering Secular Recovery)
* Community Support Services (e.g. Recovery Community Centers, Recovery Ministries, Recovery Employment Assistance)

CONTINUING CARE (3m- 1 year)
Recovery Management Checkups, Telephone Counseling, Mobile Applications, Text Message Interventions

RECOVERY MONITORING (1-5+ yrs)
Continued Recovery Management Checkups, therapy visits, Primary Care Provider Visits

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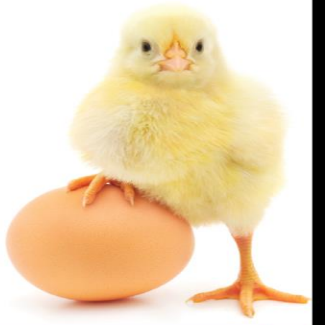

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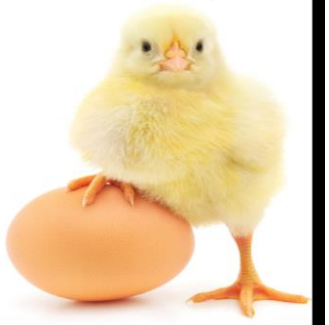

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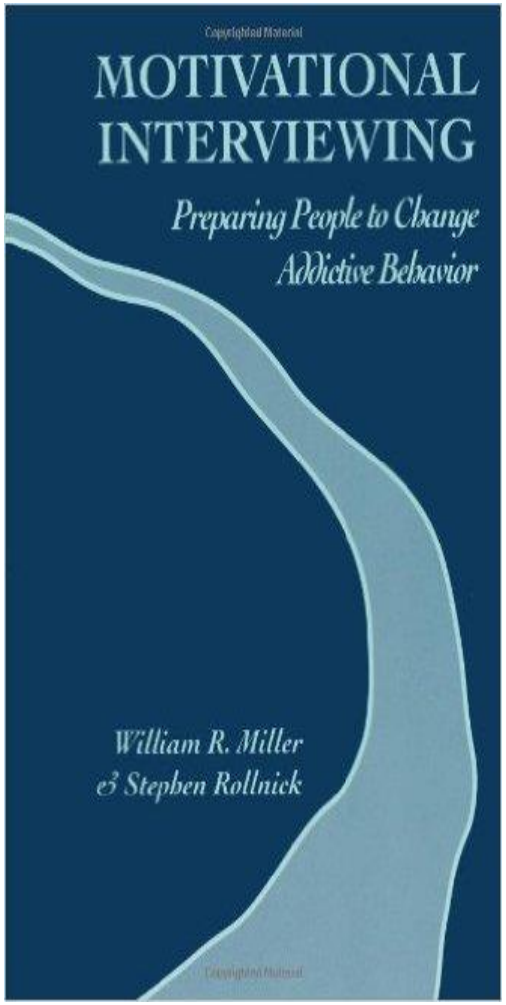
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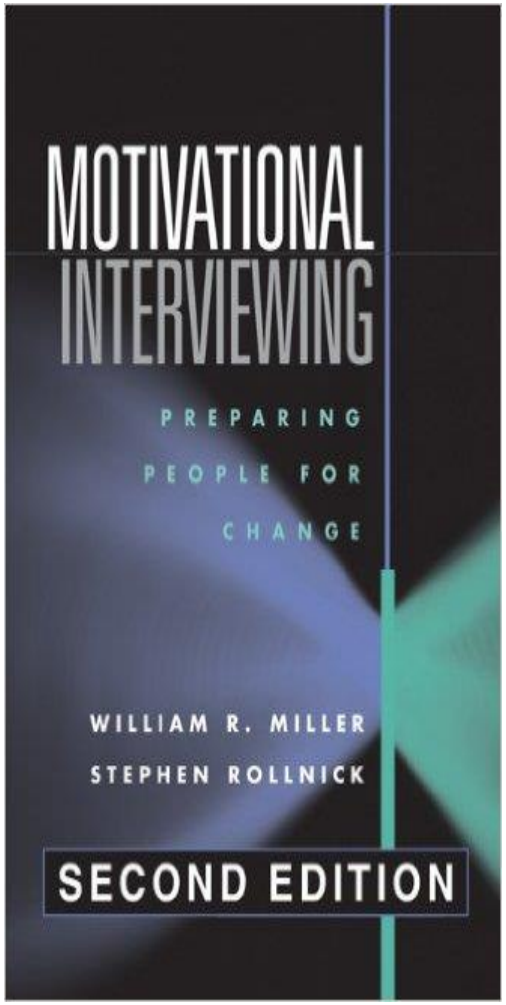
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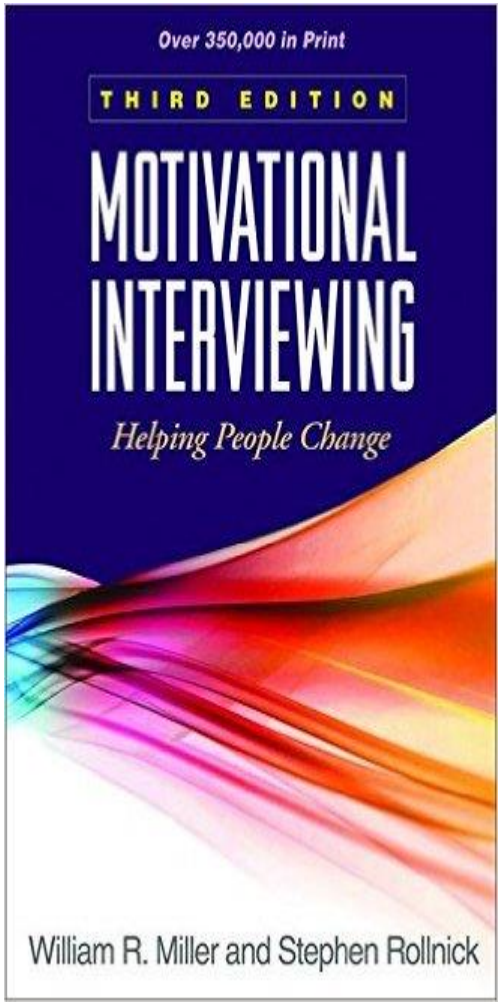
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What is MI?

"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**".

-Miller and Rollnick, MI 3rd Edition, 2013

It can be a helpful general style of "being with" and counseling patients and has been developed as discrete therapies (e.g., Motivational Enhancement Therapy).

MI has both **relational** (accurate empathy/unconditional positive regard) and **technical/directive** (designed to clarify and amplify "change talk") elements

Assumptions of MI

- People often ambivalent about change, but labeled pathologically as “resistant” “in denial” “oppositional”
- When a helper offers directive expert advice about change to ambivalent individuals, person likely to argue the opposite
- Giving advice/education alone rarely effective in helping people change
- **People have experience, skill, and innate wisdom to facilitate effective change**
- All people have innate worth; capable and do best when making **own decisions**
- Creating the right conditions for change catalyzes transformation (origins in **self-regulation and humanistic/patient-centered psychological** theories of change)
- **Motivation is a clinician rather than a patient issue**

Motivational Interviewing (MI)

- What is MI and its assumptions?
- **What are the clinical strategies involved in MI and what is its "spirit"?**
- How effective is MI as an intervention for SUD?
- Does it work the way we think it does?
- Some conclusions…

MI Practice Principles (READS)

R Roll with resistance

E Provide empathic understanding

A Avoid argumentation

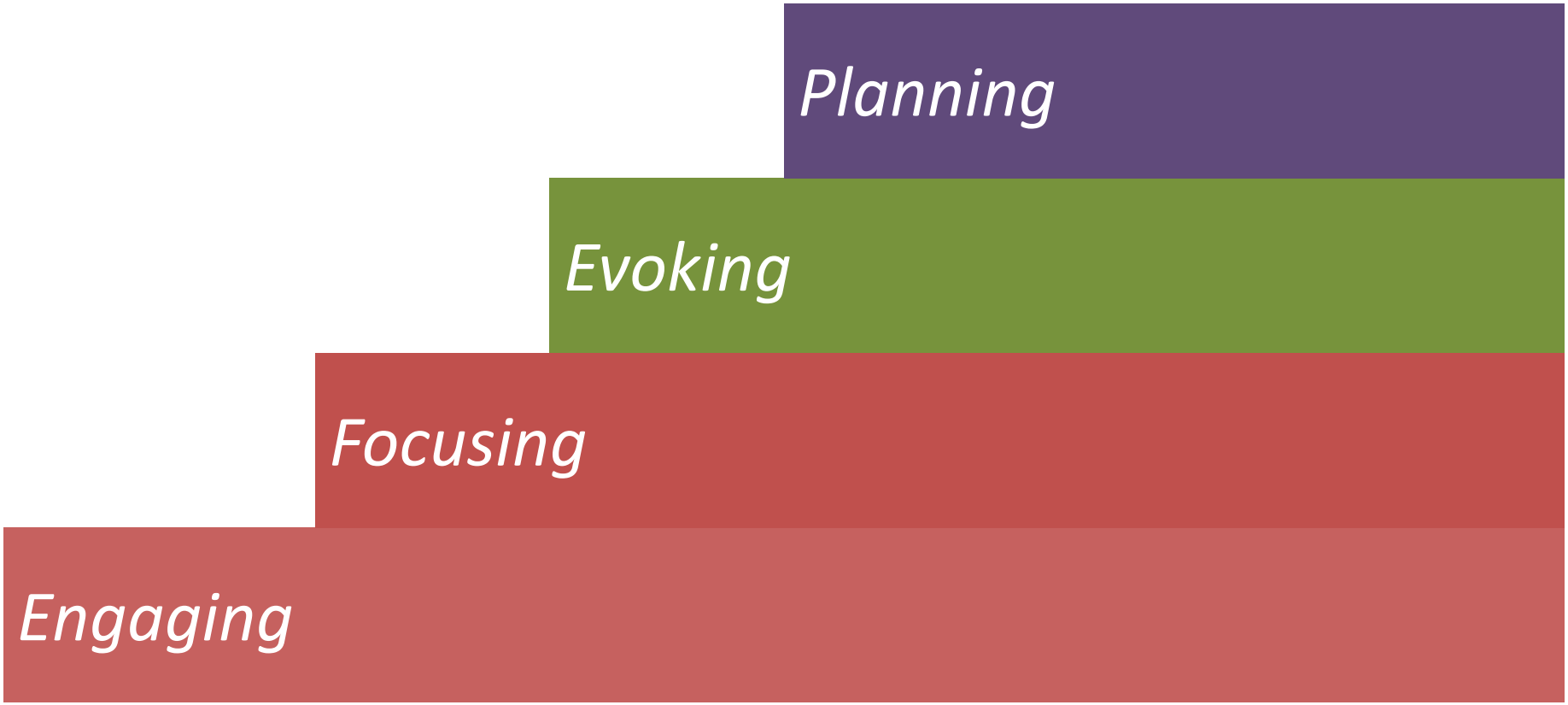
D Develop discrepancies between patient's own values and drinking behavior

S Support patient's self-efficacy

Essential Practice Components (FRAMES)

F	Provide **Feedback**	*"Your results show…"*
R	Encourage personal **Responsibility**	*"It's up to you. It's your choice"*
A	Give clear **Advice**	*"I would strongly recommend…"*
M	Provide a choice or **Menu** of options	*"There are a number of things that you might do…"*
E	Be **Empathic** and supportive	*"Change can be tough but you don't have to do it alone…"*
S	Support for **Self-Efficacy**	*"You can do this…"*

Four Processes of MI



Four Processes of MI

Planning
Process of creating a plan for change
"What do you think you'd like to do about your drinking/drug use?"

Evoking
Having the person verbalize their own arguments for change
"What are some of the things you don't like about your alcohol/drug use?"

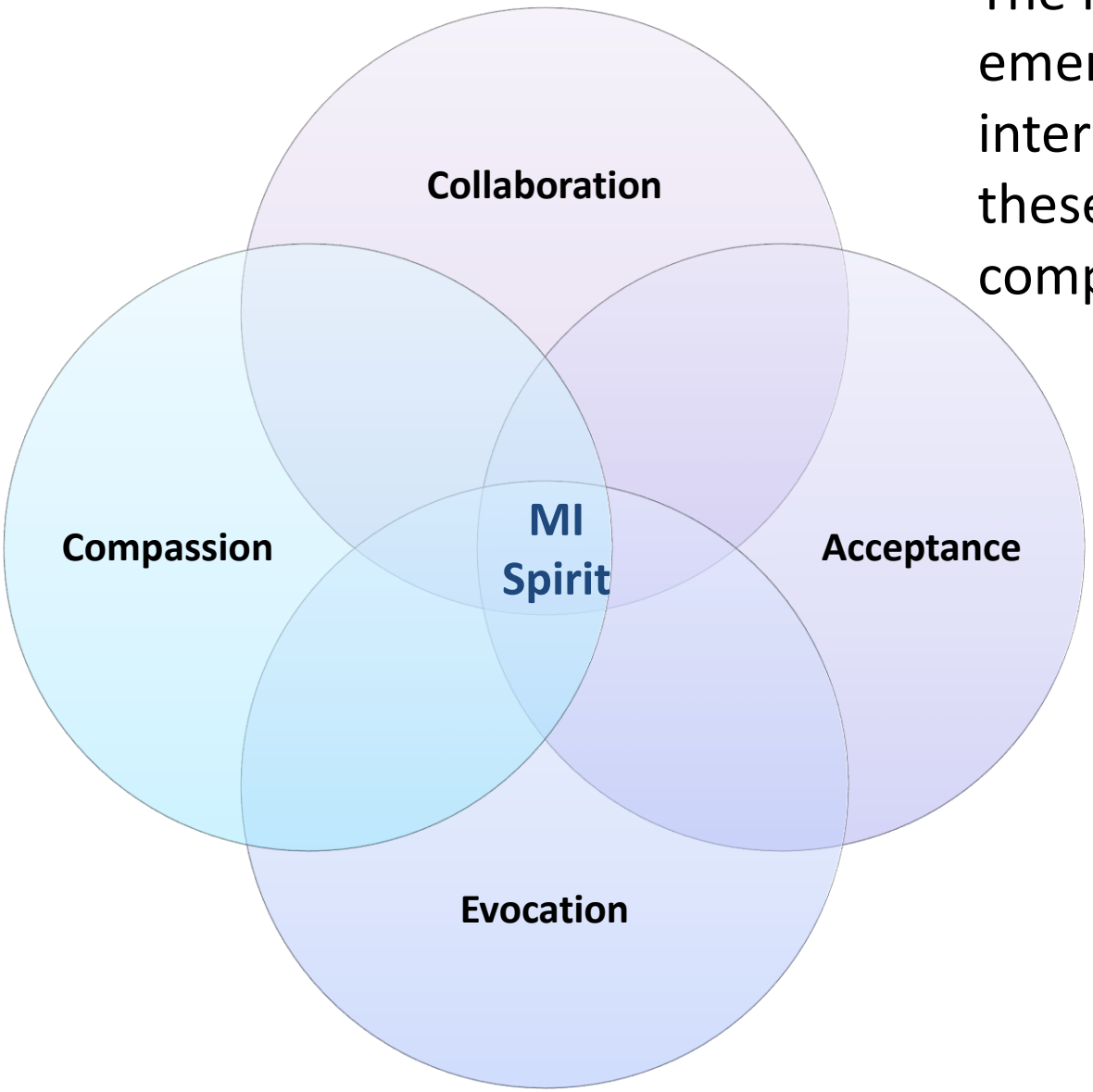
Focusing
Creating a therapeutic agenda to direct and anchor the conversation
"What's troubling you that brings you here?"

Engaging
Therapeutic/Working alliance: a prerequisite for everything that follows
"I'm glad you're here…"

Motivational Interviewing and MI "spirit"

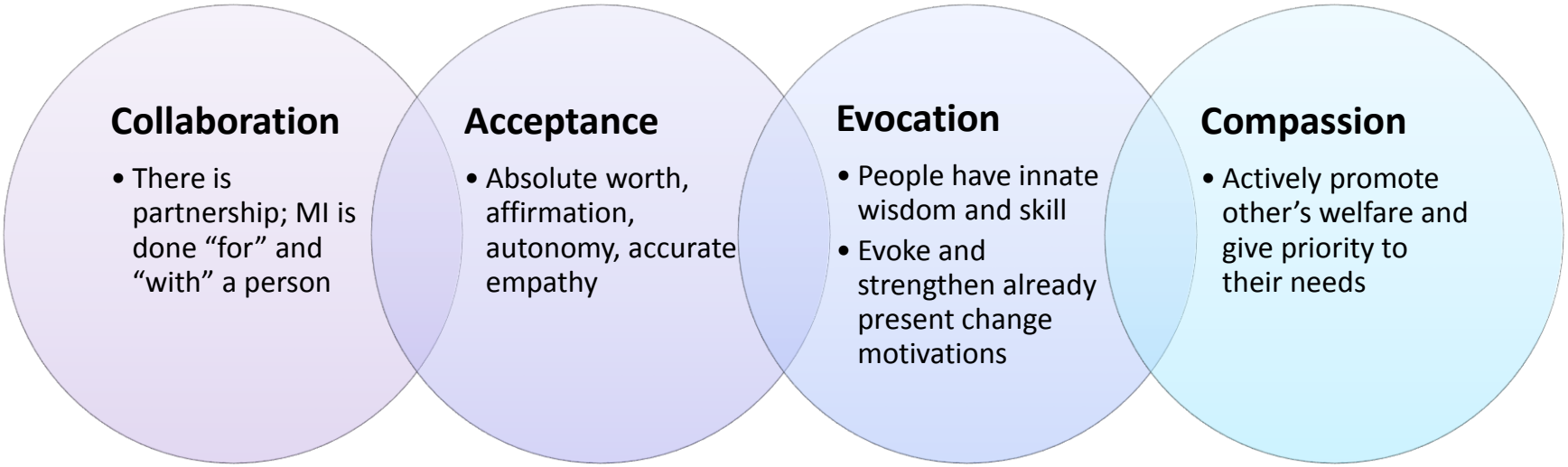
- MI is now recognized more to be not a strong "technical" therapy like CBT; but rather a formalized contextual therapy with specific goals
- If delivered in too technical a way diminishes benefits- it'll be the words without the music (it should be more like improvisational theatre instead of a scripted play)
- It is based in genuineness and client-centered positive regard…
- **MI Spirit** came about after meta-analysis (Hettema et al, 2005) found that when clinicians stuck to a therapist MI manual the effect sizes were much lower…

The Underlying Spirit of MI



The MI spirit emerges at the intersection of these four components

MI "Spirit": Four Key Interrelated Elements



Core MI Technical Skills

Open-Ended Questions	Affirming	Reflective Listening	Summarizing	Informing and Advising *(with permission)*
GOAL: • Elicit information/ verbalization	**GOAL:** • Support self-efficacy/ confidence	**GOAL:** • Accurate empathy • Engagement	**GOAL:** • Accurate empathy • Engagement	**GOAL:** • Help build knowledge, skill, self-efficacy
"What is it that concerns you about your drug use?"	*"This is hard for you."*	*"So, your mother really irritates you."*	*"You've said a number of things, so let me see if I'm understanding you right, you…"*	*"Could I have your permission to make a suggestion about how your might do that?"*

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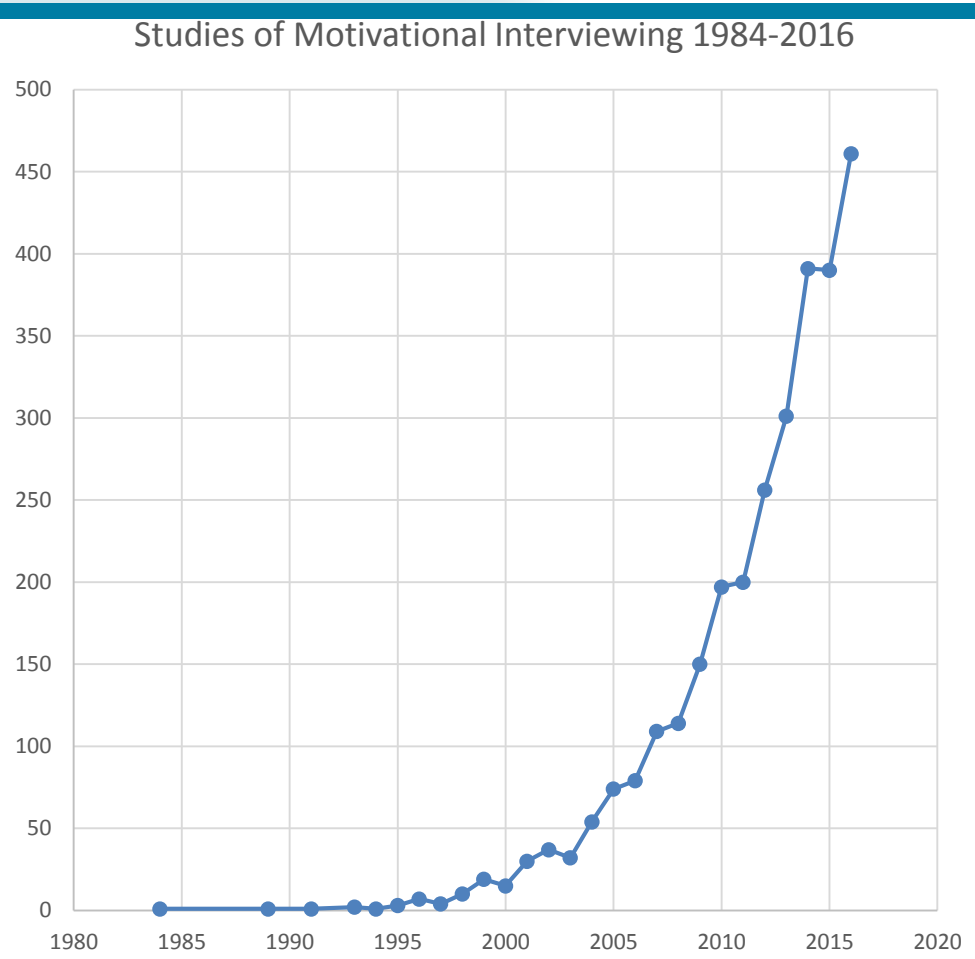
Outcome Research on MI

- Since 1990, the number of publications on MI has doubled about every 3 years
- Currently >1200 publications, including 200+ randomized clinical trials
- Meta-analyses generally conclude that MI has small to medium effect sizes across variety of outcomes, with most examining addiction



High degree of variability in effects across studies, sites, clinicians

- **Many RCTs have found no meaningful effect related to MI** (Carroll et al, 2006; Carroll et al, 2001; Miller et al, 2003; Foxcroft et al, 2014)
- **Substantial therapist effects remain in some well-controlled trials of manual-guided, closely-supervised MI interventions** (Miller et al, 1993; Project MATCH 1998c)
- Multisite trials have also found site-by-treatment interaction effects: sometimes with **no overall significant effect when averaging across sites** (Ball et al, 2008)
- Seems to work somewhat for alcohol but not for other drugs when added to standard treatment either in retaining or improving outcomes (Donovan et al, 2001; Miller et al, 2003; Rosenhow et al, 2004; Carroll et al, 2006).
- Has no meaningful additional benefit for young adults with alcohol misuse (Cochrane Review with 66 trials of MI; Foxcroft et al, 2014)
- Unclear what level of MI fidelity Is "good enough" to promote change; too technical adherence to "manualized approach" may diminish effects.
- May simply be a decrease in unhelpful counselor responses – possible that MI training improves outcomes if it suppresses counter therapeutic responses (reduces counter change talk)
- Similar overall efficacy despite the difference in treatment intensity

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Motivation Hypothesis Causal Chain Analysis – Project MATCH

Hypothesis: Clients low in motivational readiness to change would have better outcomes in MET than in CBT

RESULTS:

- **No supporting evidence for any proposed treatment specific causal mechanisms**
- Treatments did not differentially influence working alliance, coping, or attendance during treatment, motivational readiness to change, processes of change, or abstinence self-efficacy
- In general, degree of overall treatment attendance (irrespective of which treatment) and working alliance predicted outcomes
- Strong support across all treatments for initial motivation on working alliance and alcohol use over 1yr follow-up and 3yr follow-up

Dismantling MI Components (Morgenstern et al, 2017)

Goal: To test the causal role of key hypothesized active ingredients and mechanisms of change within MI in reducing alcohol use among individuals with Moderate-Severe AUD.

Self-Change

- Decision-making, motivation, actions individuals bring to treatment as part of change episode
- Impact of study procedures (e.g., assessment reactivity)

Spirit-only MI *(**relational**/common therapy factors)*

- Therapist stance (warmth, egalitarianism)
- Extensive use of reflective listening
- Avoid MI-inconsistent behaviors
- Avoid MI specific bxs (amplified/double-sided reflections, advice, change plan)

MI specific elements (***relational+ directive**/strategic factors*)

- Enhance discrepancy (structured feedback, advice, double-sided reflections)
- Elicit & reinforce positive **change talk** (change plan)

Self-Change Condition

Self Change (SC)—incorporated elements hypothesized in MI literature to contribute to change, but not associated with relational or technical active ingredients.

included normative feedback, personal responsibility, and efforts to foster self-efficacy.

After receiving normative feedback, participants were asked to attempt to change on their own during the next eight weeks; told that research had shown that some individuals could reduce their drinking without professional help; and that completion of the IVR as well as research interviews might prove helpful in that effort. Offered treatment at end of 8 wk period.

Dismantling Study Design: Recruitment, Treatment Assignment and Follow-up Diagram

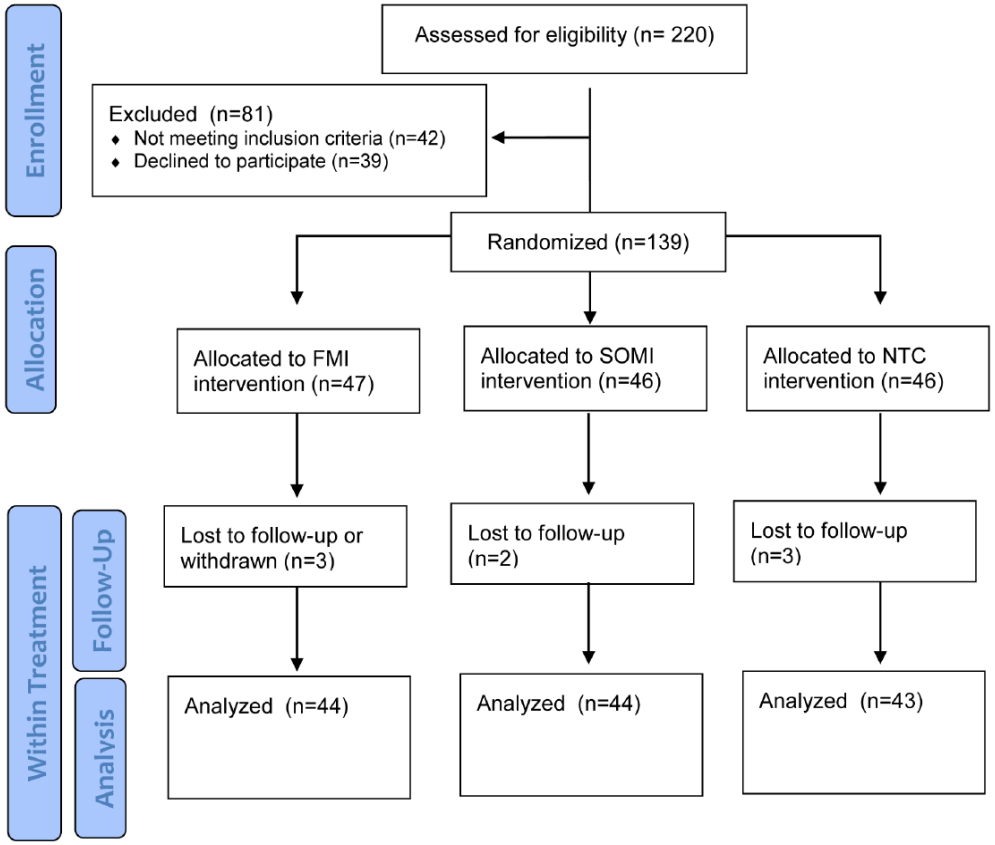


Figure 1.
Study flow and attrition.

Condition Differences Related to Fidelity and Discriminability

FMI and SOMI carefully coded by independent raters for adherence and competence of all (FMI) vs relational only (SOMI) presumed therapeutic components with strong support for fidelity to each approach….

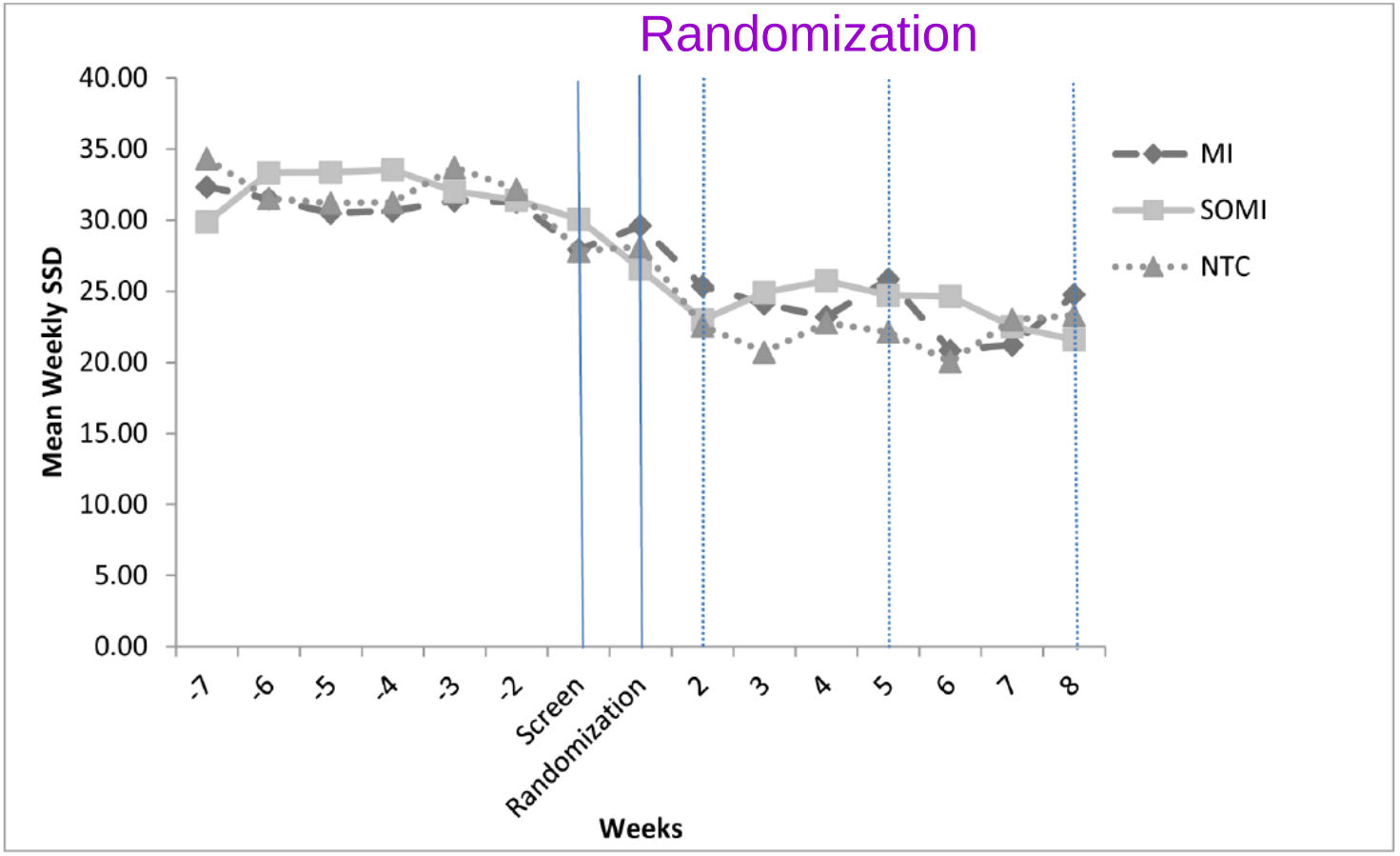
FMI used more direction and elicited much more change talk than SOMI; SOMI was found to be more empathic…

Table 2.

Condition differences related to fidelity and discriminability

	MI *M* (SD)	SOMI *M* (SD)	*p*-value
MITI 3.1.1.[a]	(N = 30)	(N = 24)	
MI Adherent Behaviors[b]	7.6 (3.9)	6.6 (4.4)	NS
Global Scales			
Autonomy/Support	4.4 (.6)	4.4 (.6)	NS
Empathy	4.5 (.5)	4.9 (.3)	<.01
Collaboration	4.3 (.8)	4.5 (.6)	NS
Direction	4.6 (.7)	2.6 (1.4)	<.001
Evocation	4.2 (.7)	3.1 (1.2)	<.001
% of sessions with score over 4 in all 5 global scales	83.9	50.8	--
% of sessions with score of 4 in 3 global scales (Autonomy/support, empathy and collaboration)	87.1	94.7	--
Structured Activities[c]	3.9 (2.9)	0.43 (0.8)	<.001
DARN-C Coding[d]	(N = 25)	(N = 24)	
Commitment Talk Frequency Change Neutral Sustain	20.2 (7.05) 5.98 (2.43) 14.2 (5.88)	12.3 (5.09) 4.52 (2.78) 13.3 (6.77)	<.001 NS NS
Commitment Talk Strength[e]	0.39 (0.40)	−0.08 (0.47)	<.001
DARN Talk Frequency Change Neutral Sustain	79.7 (24.6) 28.1 (11.4) 37.7 (15.4)	50.0 (21.5) 24.4 (10.7) 34.7 (16.0)	<.001 NS NS
DARN Talk Strength[e]	1.01 (0.34)	0.57 (0.59)	<.005

Alcohol use trajectories by Treatment Condition



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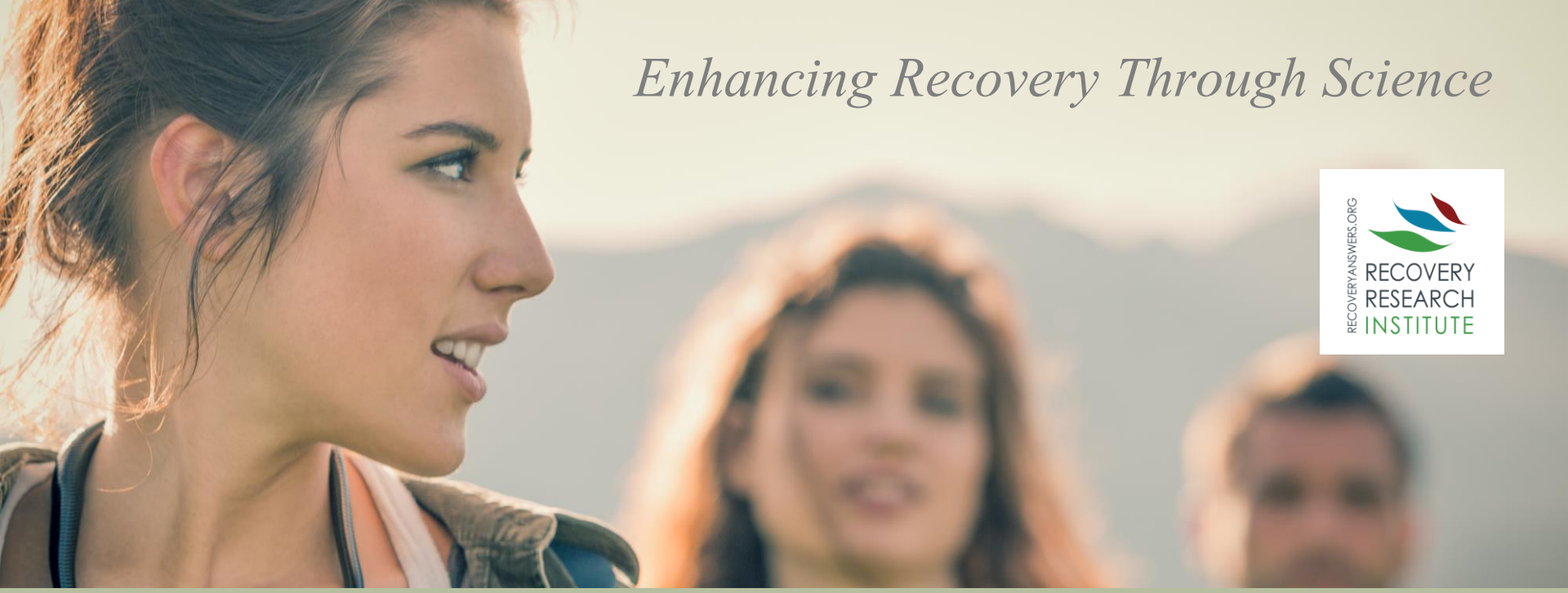
Conclusion

- MI is an evidence-based intervention with effectiveness that varies widely across counselors, studies, and sites within studies.
  - It is currently unclear what exactly the active ingredients of MI are
- Fidelity of delivery is an important consideration in understanding outcomes of MI and should be well documented in studies using reliable observation codes.
- The “technical” aspects of MI may not be the specific active ingredients and the causal chain as to how it works has some support, but is largely unsupported
- MI encompasses useful therapeutic techniques to reduce resistance to change and help people change when patients are ambivalent about change; derivatives (MET) are often on par with other active treatment approaches in affecting change in substance use.



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