MOTIVATIONAL INTERVIEWING

Engaging People into Treatment and Change

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Engagement in Alcohol & Drug Treatment

- Deane, Wootton, Hsu, & Kelly, 2012
  - Measured dropout by 3 months from 8 residential (modified therapeutic community) drug and alcohol treatment programs run by the Australian Salvation Army (N = 618)
    - 10 month program
Engagement in Alcohol & Drug Treatment

- Deane, Wootton, Hsu, & Kelly, 2012
  - 57.3% dropped out before 3 months
    - Minimum length of treatment sufficient to result in significant improvements (e.g., Simpson, 1979)
  - This is at the low end of the range for dropout from long-term programs
    - 50 – 80%
In randomized controlled trials of outpatient alcohol treatment, 18% of patients drop out after 1 visit, 26% from 1-4 weeks, 30% from 2-5 months; 25% of patients remained after 6 months

- Carroll (1997)
Engagement in Mental Health Treatment

- 40% of clients in 12 psychotherapy studies did not attend a single session
  - Hampton-Robb, Qualls, & Compton (2003)
- 47% of clients in 125 psychotherapy studies dropped out prematurely
  - Wierzbicki & Pekarik (1993)
Engagement in Mental Health Treatment

- 20% of clients in 669 psychotherapy studies (26% in effectiveness studies) discontinued prematurely
  - Swift & Greenberg (2012)
- In the US, the average number of sessions attended in employee assistance, university clinic, local and national HMO clinic, and community mental health settings was 3-5
Engagement in Alcohol & Drug Treatment

- Deane, Wootton, Hsu, & Kelly, 2012
  - Why? Looked at 11 possible client factors
    - Age, Gender, Primary substance used, Criminal involvement, Alcohol or drug cravings, Symptom distress, Self-efficacy to abstain, Spirituality, Forgiveness of self, Forgiveness of others, Life purpose
  - All of these together explained less than 10% of the variance in dropout
Engagement in Alcohol & Drug Treatment

Deane, Wootton, Hsu, & Kelly, 2012

Why were they surprised?

“Finding reliable predictors of dropout and retention in drug treatment has proven difficult in prior settings... Numerous other empirical studies have found few client-related predictors, and, of these, the amount of variance explained has been moderate at best... Furthermore, individual predictors have generally been found to be inconsistent across studies...”
Engagement in Mental Health Treatment

- No patient characteristics have been consistently supported in research on anxiety disorders treatment
  - Taylor, Abramowitz, & McKay (2012)
- Younger, less educated clients dropped out of therapy at slightly higher rates
  - Swift & Greenberg (2012)
Engagement in Medical Treatment

- No appreciable or predictable effect sizes have been uncovered as a consequence of patient characteristics, personality traits, or demographic factors
  - Christensen & Johnson (2002)
Engagement in Treatment

- Looking for the reasons for failure to engage in treatment and change in client characteristics is not the answer.
Why don’t clients engage in treatment and change?
Against Change

- The benefits are outweighed by the costs
  - The unfamiliar is scary
  - Loss of ease/pleasure/satisfaction
  - Current behavior helps cope with stress
  - Impact on lifestyle and other priorities
  - Effect on social connections / relationships
  - Guilt and shame
  - Threat to sense of self

- Fear / expectations of failure
Against Treatment

- Low Motivation for Change
- Practical Issues
  - Finances
  - Access
  - Conflicting Obligations
  - Safety
- Symptom Issues
  - Vegetative
  - Affective
  - Cognitive
- Functional Issues
  - Life in chaos
  - Multi-tasking
  - Demands of substance use
Against Treatment

◆ Treatment Characteristics
  ● Intensity
  ● Modality
  ● Quality
◆ System Factors
  ● Provider overload
  ● Service fragmentation
◆ Negative Expectancies
  ● Efficacy
  ● Aversiveness
  ● Necessity
◆ Negative Experiences
  ● Personal
  ● Vicarious
Against Treatment

- Help-Seeking Attitudes
  - Privacy vs. Self-disclosure
  - Self-reliance vs. Dependency
  - Care-giving vs. Self-care

- Relationship Expectancies
  - Authoritarian/Controlling vs. Authoritative/Guiding
  - Exploitative/Intrusive vs. Respectful/Supportive
  - Incompetent/Uncaring vs. Nurturant/Involved
Against Treatment

- Cultural issues
  - Stigma
  - Community preferences
  - Client / Clinician differences
    - Race
    - Religion
    - Ethnicity
    - Gender
    - Age
    - Class
When Do People Engage in Treatment and Change?
“Ready, Willing, and Able”

- Importance
  - Problem recognition
  - Favorable Cost/Benefit Expectancies
    - Expected benefits outweigh the costs
    - Expect decision to make things better
  - Values
    - Decision supports what matters most
When Do People Engage in Treatment and Change?

“Ready, Willing, and Able”

- **Confidence**
  - High self-efficacy (believe change is possible)
    - Specific
    - Global

- **Commitment**
  - Form an intention to change
  - Make change a priority
Treatment and Change

- **Ambivalence**
  - Conflict between...
    - Preference for two or more mutually exclusive objects or actions
    - A preferred object or action and the belief that it is unobtainable or impossible
Stages of Change
Prochaska & DiClemente, 1992

Termination

Maintenance
Variable Ambivalence

Preparation
Residual Ambivalence

Precontemplation
Low Ambivalence

Contemplation
High Ambivalence

Action
Very Low Ambivalence

Stages: Precontemplation, Contemplation, Preparation, Action, Maintenance, Termination

Ambivalence Levels: Low, High, Variable, Residual

Stages of Change
Prochaska & DiClemente, 1992

Precontemplation
Unwilling, Unable
Not Ready

Contemplation
Willing? Able?
Not Ready

Preparation
Willing, Becoming Able
Getting Ready

Action
Willing, Able
Ready

Maintenance
Willing, Able,
Ready?

Termination

Adapted from a slide by Dub Wright
Talking with People about Change

Precontemplative

- Don’t see a problem, believe benefits of change outweigh the costs, or believe they can change
- Five R’s (adapted from DiClemente, 1991)
  - Reluctant
  - Rebellious
  - Rationalizing
  - Resigned
  - Receptive/Deceptive
How Many Of You Have Ever…?
Talking with People about Change

Contemplative

- Facing a decision about change, people consider their options and contemplate the pros and cons of making different choices.
Talking with People about Change

Contemplative

◆ Stuck in ambivalence
  ● Don’t know what they want/need to do (conflicting options have advantages/disadvantages) and/or
  ● Don’t believe they can do what they want/need to do (succeed at accomplishing a desired choice)
Ambivalence Under Pressure

Six R’s
- Reluctant
- Rebellious
- Rationalizing
- Resigned
- Receptive/Deceptive
- Relieved
The Righting Reflex

- Urge to set things right (fix)
  - Advice, education, persuasion, direction, confrontation

- Triggers reactance
  - Defending autonomy by resisting control

- Triggers defensiveness
  - Protecting self-esteem by rejecting criticism
Family Therapy Studies
- 12 families with aggressive children age 3.8–13.1
- Coding systems for therapist and client behavior
  - Observation of videotaped sessions
    - “Teach” & “confront”: increased resistance
    - “Facilitate” & “support”: decreased resistance
- What if you had therapists systematically alternate between these two kinds of responses?
Resistance Responses per Minute

Manipulation (ABAB) of Facilitate/Support & Teach/Confront

Patterson & Forgatch, 1985
Resistance and Change

- Drinker’s Check-Up: Confrontational Feedback vs. Client-centered Feedback (Miller, et al., 1993)
  - More confrontation = More drinking at 1 year
  - More confrontation = More patient resistance
  - More resistance = More drinking at 1 year

- Project MATCH (Karno & Longabaugh, 2005)
  - High-reactance patients: directiveness (interpret, confront, introduce topics) = worse outcomes
Ambivalence, Resistance, Motivation

- It’s normal (though unpleasant and undesirable) for people to get stuck in ambivalence
- Motivation for change is influenced by interpersonal interactions
- Interpersonal pressure (unsolicited advice, persuasion, direction, confrontation) makes ambivalent people sound and feel “resistant”
Ambivalence, Resistance, Motivation

“Resistance” tends to elicit unhelpful reactions (negative communication cycles)

“Resistance,” therefore, is not a client problem—it is a practitioner problem

Accepting and understanding ambivalence is the first step toward helping clients resolve it
If ambivalence is not overcome through education, persuasion, direction, or confrontation, how is it resolved?
Motivational Interviewing

- Collaborative, goal-oriented style of conversation for strengthening a person’s own motivation and commitment to change
  - Person-centered counseling style
  - Address ambivalence about change
  - Attention to the language of change
If ambivalence is not overcome through education, persuasion, direction, or confrontation, how is it resolved?

The Pressure Paradox

Acceptance facilitates change as pressure to change elicits resistance
The Spirit of Motivational Interviewing

◆ Acceptance
  ● Absolute Worth
    ♦ Recognizing the natural tendency toward growth
    ♦ Valuing the person for who they are
  ● Affirmation
    ♦ Prizing (unconditional positive regard)
    ♦ Attunement to strengths and positive intentions
The Spirit of Motivational Interviewing

♦ Acceptance
  ● Autonomy Support
    ♦ Honoring and supporting the right and capacity for self-determination
    ♦ Recognizing personal responsibility for change
  ● Accurate Empathy
    ♦ Communicating understanding of the person’s thoughts and feelings without judgment
The Spirit of Motivational Interviewing

- Compassion
  - Openness to and concern for others’ suffering
    - Wish to relieve suffering and promote well-being
  - Sense of shared humanity
    - It takes courage to make choices without knowing with certainty whether or not they are right
    - We are all fallible and flawed, bound to make mistakes despite our good intentions and best judgments
The Spirit of Motivational Interviewing

- Partnership
  - Active Collaboration
    - Change is most likely where the aspirations of clients and practitioners meet
    - Both members of the relationship have unique expertise that can contribute to the facilitation of change
Research Support
Alcohol Treatment

- Miller, Taylor, & West (1980)
  - Empathy strongest predictor of outcome in differing behavioral treatments for problem drinkers

- Moyers & Miller (2013)
  - Review of the research: Low empathy is toxic in substance abuse treatment regardless of counseling approach
Valle, 1981

Client Relapse Rates

Follow-up Points

- 6 Months
- 12 Months
- 18 Months
- 24 Months

Low Skill
Medium Skill
High Skill
Research Support
Counseling and Psychotherapy

- **Empathy**
  - Medium-sized effect across psychotherapies (Elliott, Bohart, Watson, & Greenberg, 2011)

- **Collaboration / Goal Consensus**
  - Medium-sized effect across psychotherapies (Tryon & Winograd, 2011)

- **Affirmation / Positive Regard**
  - Medium-sized effect across psychotherapies (Farber & Doolin, 2011)
If ambivalence is not overcome through education, persuasion, direction, or confrontation, how is it resolved?

The Language of Change

We learn what we think as we hear ourselves speak
The Spirit of Motivational Interviewing

◆ Evocation
  ● Clients talk themselves into change (or out of it)
  ● Drawing out and strengthening motivation for change already present, if dormant
Change Talk

- Preparatory (DARN)
  - Desire: I want to…
  - Ability: I can…
  - Reasons: I should because…
  - Need: I have to…

- Mobilizing (CATs)
  - Commitment: I might… → I’ll try… → I will…
  - Activation: I’m ready to…
  - Taking steps: I’ve begun to…
Research on Change Talk

- Preparatory talk $\rightarrow$ commitment talk$^{1,5}$
- Increasing intensity of commitment talk $\rightarrow$ change$^{1,5}$
- Change talk $\rightarrow$ change, sustain talk $\rightarrow$ no change$^{4,6,7,8}$

1 Amrhein et al., 2003 2 Amrhein et al., 2004 3 Moyers & Martin, 2006 4 Moyers et al., 2009 5 Hodgins et al., 2009 6 Magill et al., 2014; 7 D’Amico, et al., 2015 8 Barnett et al., 2014
Research on Change Talk

- Training in MI is associated with stronger change talk in clients
- MI-consistent behaviors increase probability of patient change talk
- MI-inconsistent behaviors increase probability of patient counter-change talk

1 Amrhein et al., 2003  2 Amrhein et al., 2004  3 Moyers & Martin, 2006  4 Moyers et al., 2009  5 Hodgins et al., 2009  6 Magill et al., 2014; 7 D’Amico, et al., 2015  8 Barnett et al., 2014  9 Fischer & Moyers, 2014
Motivational Interviewing

- Collaborative, goal-oriented conversation for strengthening a person’s own motivation and commitment to change
  - Evokes movement toward a goal by partnering with people to elicit and explore their own reasons and ability for change within an atmosphere of acceptance and compassion
Applications of MI
Adults and Adolescents

- Alcohol and Drug Abuse/Dependence
- Co-Occurring Disorders
- Eating Disorders
- Medical Settings
  - Primary Care, ER, Specialty Care, Dentistry
- Public Health
  - Sexual Risk Reduction (HIV), Smoking
- Criminal Justice
  - Probation & Parole
- Psychiatric Disorders
  - Depression, Anxiety, Psychosis
MI for Treatment Engagement

- Inpatient to aftercare among non-psychosis dual diagnosis adults (N ≈ 200)
  - Diagnosis: Mood and substance use disorders
  - MI + Treatment-As-Usual vs. TAU
    - MI = 45-60 pre-discharge "Motivational Engagement" session, individually or in small groups
Daley & Zuckoff, 1998

Percent Attending First Aftercare Session

MI
Historical
MI for Treatment Engagement

- Inpatient to aftercare among psychiatric and dually diagnosed adults (N = 121)
  - Diagnosis: Mood, psychotic, and substance use disorders
  - MI + Treatment-As-Usual vs. TAU
    - MI = Brief feedback meeting + MI session
Percent Keeping First Aftercare Appointment

- **Psychiatric Patients**: MI - 63%, TAU - 42%
  - *p* < .01

- **Dual Diagnosis Patients**: MI - 42%, TAU - 16%
  - *p* < .01
MI for Treatment Engagement

- MI increased treatment attendance (70% vs. 40%) by inpatients discharged to integrated outpatient treatment for schizophrenia and substance use disorder
  - Bechdolf, et al. (2012)
Meta-analysis of controlled trials of MI for treatment adherence (N = 29)
- $d_c = 0.48$ (medium size effect)
- Alcohol and/or drug (21), psychiatric (3), diet and exercise (2), smoking (1), pain (1), sleep apnea (1)
- MI sessions = 3.14 (5.20); hours spent in MI = 2.46 (3.53)
Hettema, Steele, & Miller, 2005

Effect Sizes of MI over Time
Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010

- Meta-analysis of controlled trials (N = 119)
  - All Outcomes
    - $g = 0.22$ (range = -1.40 – 2.06), $p < .001$
  - Adherence (n = 34): $g = 0.26$, $p < .001$
    - vs. control (n = 20) $g = 0.35$, $p < .000$
    - vs. bona fide intervention (n = 14) $g = 0.12$, $p = .053$
  - Effects larger with more intervention time
  - Advantage of cost-effectiveness
How do you do it?