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▶ Counselor skill influences outcomes of brief motivational interventions.

Gaume J., Gmel G., Faouzi M. et al. Request reprint

Journal of Substance Abuse Treatment: 2009, 37, p. 151–159.

Few studies can manage the painstaking analyses needed to identify what makes for successful counselling. This Swiss study broke new ground in dissecting why some brief interventionists had far better results than others with risky drinking A&E patients.

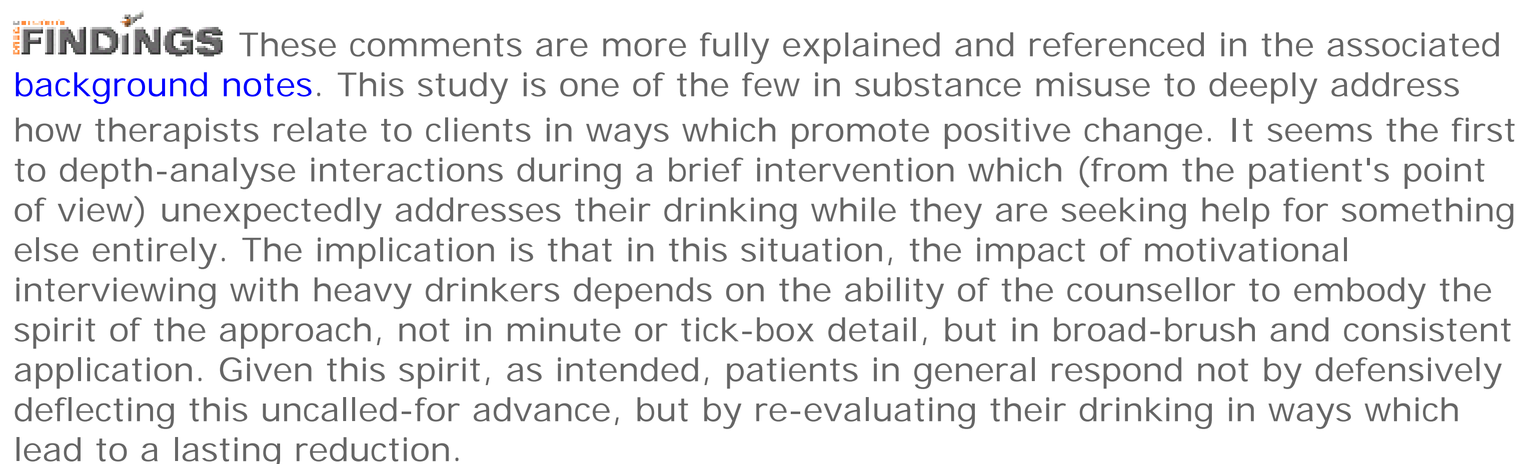
Abstract The featured report is one of several from a study of brief advice to heavy drinkers among injured adult patients attending a Swiss emergency department. Among 8439 patients, 1472 heavy drinkers were identified by a health screening survey, of whom 987 joined the study. They were randomly allocated to carry on as usual, to also be assessed by a researcher for about half an hour, or in addition to receive about 15 minutes of advice on drinking immediately after assessment. Adopting the style of motivational interviewing, this compared the patient's drinking with national norms and led the patient to consider the pros and cons of their drinking and their readiness to change, culminating if appropriate in a setting a goal for change. Over the following year, this typical brief intervention format did not lead to greater reductions in drinking. About two-thirds of the patients continued to drink heavily regardless of advice and/or assessment.

During a period of the study and when patients allowed, intervention sessions were audio-taped. 97 sessions could be rated for the degree to which the counsellor adhered to a motivational style, and for comments from the patient indicative of their ability and willingness to change their drinking. Of these ratings, an initial analysis found that only the patient's expressed degree of ability to change was related to later drinking; none of the counsellor's behaviours was significantly linked. However, this analysis tried to separately link each behaviour (in)consistent with motivational interviewing's principles with drinking. The possibility remained that combining these behaviours to characterise the counsellor's overall style would yield significant results.

This was the approach taken in two further reports, one of which was the featured report. An earlier analysis established that counsellor comments consistent with the style of motivational interviewing were most likely to elicit positive statements about changing their drinking from the patient. The featured report related the same (and other) measures of counselling style to later drinking, limiting itself to interventions conducted by five counsellors with similar qualifications and experience and uniform preparatory training. Despite this they differed significantly in the their patients' weekly drinking at the 12-month follow-up, and in the degree to which this represented an improvement on the amount they were drinking on entry to the study. At the extremes were one counsellor whose patients ended up drinking on average 18 UK units *more* per week, while another registered an average nine unit reduction.

These differences were at least partly accounted for by how far the counsellor was able to actually deliver the intervention in a motivational style. Drinking reductions were greater the more the counsellor demonstrated acceptance of the patient, conducted the intervention in the intended spirit, made more comments consistent versus inconsistent with a motivational approach, avoided inconsistent comments, elaborated on the patient's comments rather than simply reflecting them back, and reflected back the patient's comments with or without elaboration rather than asking questions. Empathy levels narrowly missed featuring among these strong and statistically significant links. These same attributes tended to even out the relationship between the patient's expressed feelings of (in)ability to change and how much they did change their drinking over the 12 months. Highly skilled counsellors had good outcomes almost regardless of the patient's doubts. The less skilled were effective mainly with patients who already expressed high levels of ability to change.

While accepting the need for replication in a larger study, for the authors their results suggested that an optimal combination of motivational interviewing skills results in better drinking outcomes, regardless of whether the patient is confident (or expresses confidence) in their ability to cut back. The pattern of results across all the reports from the study implies that training should focus on developing an overall approach consistent with motivational interviewing (with a particular focus on avoiding inconsistent behaviour) rather than on the frequent use of particular 'micro' techniques. Since training was equalised in the study, it also seems important to select staff with a 'natural' ability to adhere to the spirit of motivational interviewing when counselling patients.



FINDINGS These comments are more fully explained and referenced in the associated background notes. This study is one of the few in substance misuse to deeply address how therapists relate to clients in ways which promote positive change. It seems the first to depth-analyse interactions during a brief intervention which (from the patient's point of view) unexpectedly addresses their drinking while they are seeking help for something else entirely. The implication is that in this situation, the impact of motivational interviewing with heavy drinkers depends on the ability of the counsellor to embody the spirit of the approach, not in minute or tick-box detail, but in broad-brush and consistent application. Given this spirit, as intended, patients in general respond not by defensively deflecting this uncalled-for advance, but by re-evaluating their drinking in ways which lead to a lasting reduction.

As intended by its creators, the findings show that true-to-type motivational interviewing

can counter low motivation and doubts, elevating outcomes to near those of the most promising patients. While training doubtless played its part in developing this ability, still it left big differences between counsellors, who presumably varied in the degree to which they could implement what they learned. The more 'trainable' dimensions of the frequency of recommended types of comments were relatively uninfluential, the more nebulous 'spirit' dimensions more important. Despite expert training and supervision, the result was some therapists whose patients drank more than they did before, others whose patients drank less, a finding which turns the spotlight on staff recruitment. The implication is that without appropriate recruitment, much of the effort put in to training and supervision will be wasted.

The same message emerged from a study of motivational interviewing training which found that initial gains in skills had waned two months later. However, this was not the case for the addiction and mental health clinicians who, even before training, had been more proficient than the other trainees would be after training. Not only did these 'natural experts' start from a higher level, they went on to absorb and retain more of what they had learned.

How easy it is to find such people must be a concern. In the featured study all the counsellors were clinical psychologists educated to master degree level, trained by an experienced therapist and supervised throughout using actual client session recordings or observations. This exceptional combination of qualifications, training and ongoing support still resulted in just one of the therapists having a marked positive effect on drinking.

While these are important findings with echoes in other studies, inevitably they stand on a narrow and inadequate evidence base. Studies which probe deeply enough to make sense of what is going on in therapy require labour-intensive analyses, so tend to be limited to perhaps one site and a few therapists, by-products of studies designed to address the effectiveness not of therapists, but of therapies.

Particular caution is needed before assuming that the implications extend to substance misuse treatment. The dynamics in the emergency department are likely to be very different from those in substance misuse treatment clinics, whose patients have already acknowledged their problems and decided at least to give treatment a try. In this situation, the overwhelming influence is the strength of the patient's resolution. Therapists can still make a noticeable and sometimes substantial difference, but generally more in terms of whether clients want to extend the relationship by staying in treatment, than in whether they change their substance use.

Among several less serious concerns, the featured study's main weakness is the non-random allocation of patients to therapists, meaning varying caseloads might have influenced the therapists' performances. However, this does not seem to account for the findings. Confidence in these and in their generalisability is increased by findings from different contexts with similar implications.

Across a range of caseloads, one review of how motivational interviewing works has highlighted (as the featured study did) the importance of therapists avoiding behaviours inconsistent with a motivational approach. Most relevant however are other brief intervention studies of patients not seeking treatment. These confirm that in such circumstances, some therapists are much more able than others to realise the potential

of a motivational approach. Avoiding directive and confrontational behaviour seems particularly important with people who when they attended their GP, emergency department, or college, were not expecting their substance use to be addressed at all, let alone in such terms. Even patients who, while not seeking treatment, have volunteered for a check-up of their drinking habits, have reacted badly to such approaches. As in the featured study, other studies have also found that embodying the overall spirit of the approach is related to good outcomes, while the sheer quantity of 'correct' micro-behaviours is not. In one study the least effective of three therapists conducting motivational interventions for heavy drinking was also the one who *most* often used specific recommended techniques.

The dynamics of the therapist-patient encounter seem to differ in a treatment context. Like brief intervention studies, studies of patients actually seeking treatment for substance use problems have confirmed the importance of the overall spirit of the approach rather than micro measures of the frequency of correct therapist behaviours. However, they have been less clear about the damaging impact of behaviours inconsistent with a motivational approach. Within an overall supportive and accepting context, patients react well, or at least, not badly, to a degree of confrontation and caring concern, even if the patient's permission has not been sought. With clients seeking help for a serious substance use disorder, there is more reason to show concern, be directive, and to warn about possible consequences. Patients who themselves are concerned and seeking direction might see the total absence of such comments from their therapists as withholding their true feelings, perhaps even as uncaring. For these patients the absence of a directive approach can be positively damaging, while those who like to see themselves as in control react badly to directive therapists.

Thanks for their comments on this entry in draft to Jacques Gaume, of the Alcohol Treatment Centre at Lausanne University Hospital. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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