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Motivational arm twisting: contradiction in terms?

Motivational interviewing would seem the ideal way to defuse resentment and improve the engagement of offenders ordered in to treatment. Then why are the studies so few and the results so patchy?

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Thanks to Bill Miller, Jim McCambridge, Dwayne Simpson, Don Dansereau, Gerard Connors, and John Witton their comments. Thanks also to Bill Miller, Janice Brown, Terri Moyers, Paul Amrhein, John Baer and Damaris Rohsenow for help with obtaining and interpreting their work. Though they have enriched it, none bear any responsibility for the final text.

In the previous issue we explored motivational interviewing as a preparation for people voluntarily entering treatment, and found that its mixed record might be explained partly by whether patients were in need of a motivational boost to begin with. When they were, the approach had something to 'bite on' and generally improved retention and/or substance use outcomes. Given this record and its origins in overcoming resistance to treatment, motivational induction ought to have a special role in boosting the motivation and deflecting the anger and resentment of people coerced[i] into treatment by courts, families or employers. The result should be visible in enhanced engagement and greater benefits.[1] Whether these are the results is the main question addressed in this review.

By the end of this article, with results from voluntary and legally coerced populations under the belt, we are in a position to ask what the this and other

i The limitations of designating patients as coerced, pressured or voluntary are acknowledged. Many legally coerced patients welcome the opportunity for treatment, many who appear to have chosen to enter treatment to deal with their problems have in fact been pressured by families, employers or other third parties.

literature means for the practical business of how to select and train motivational therapists.

Incompatible with criminal justice?

What hampers this endeavour most is a dearth of relevant studies. Despite its supposed suitability for patients coerced in to treatment, research on motivational induction has been almost entirely limited to drink-drivers, young people, and mothers or mothers-to-be. There are no controlled studies of the many thousands of adult offenders ordered into treatment by courts because their revenue-raising offending is thought to have been motivated by drug dependence; whether drug court, DTTO and similar programmes would benefit from a motivational start remains an open question.

This may be a first clue to an incompatibility between motivational interviewing and the criminal justice system. A key issue is the degree to which motivational interviewing can (or can credibly) stick to its person-centred, non-directive principles, and whether these can persuade offenders to open up, when the system within which it is operating is explicitly oppressive, directive, and intended to limit rather than enhance the autonomy of the offender. 'It's up to you what you do about your substance use'is arguably an inappropriate stance for someone involved in controlling that substance use in order to prevent crime and/or safeguard children and the public. In some studies this incompatibility is clear in the reactions of the clients and in an un-motivational like insistence on one acceptable outcome, with predictably negative results.

Another reason why motivational interviewing sometimes seems to have missed the mark is that the criminal justice net has caught people whose don't really have a substance misuse problem, yet this is the focus mandated for the interview and for their 'treatment'. Another is the lack of the resources – psychological, intellectual, physical, economic, and social – needed to implement change or even to get to grips with motivational interviewing's discussion based reasoning, a lack particularly acute among criminal justice clients. These are some of the reasons for creating new approaches which incorporate motivational elements but are tailored for criminal justice populations; see *Making it more concrete*.

Yet when the population and circumstances have been conducive, and therapists have been able to implement key elements of the motivational style, they have been rewarded by the usual positive reactions from patients who find themselves relieved of denigrating labels or injunctions about what they must do. Some studies too have found the expected improvements in engagement and substance use outcomes. Even in these, the issue remains of whether it was motivational interviewing which created the benefits or 'just' sympathetic individual attention – 'just' in quotes, because one of the most important virtues of the approach may be that it clears the way for dehumanising 'therapeutic' responses to be replaced by re-humanising ones such as empathy, validation, respect and optimism.

Depressed drink drivers respond

Of the three relevant studies of motivational interviewing with drink-drivers, only a study in Mississippi could assess whether motivational interviewing was a useful

supplement to normal programmes. It was, but only for drinkers who also suffered from depressed mood.

1 At the time Mississippi's educational programme for first time drink-driving offenders consisted of four weekly classes each lasting two and a half hours. During the first offenders completed assessment instruments, the results of which were fed back during the last session in the form of a computer-generated report. In between were class discussions and exercises and other educational activities.

Over 4000 offenders agreed to participate in a study which for a random selection replaced class time with two 20-minute individual counselling sessions from counsellors trained in motivational interviewing.[2] The first was used to bring feedback forward to the second week. Since this was also the first 'treatment' session, it occupied an induction slot in the overall programme. As well as giving feedback, where appropriate counsellors offered referral to services. The second individual session took place during time allocated to the last of the four classes. Offenders were also offered a further optional review session four to six months later, which about half attended.

Over typically the next three years, drink-driving offence records revealed that the modified programme had significantly improved on the usual classes, but only among the quarter of offenders who had felt most depressed or sad on entering the programme. Without the individual sessions, 26% were reconvicted, with them, 17%, a worthwhile 35% reduction in recidivism. Among the bulk of offenders not feeling so down, results from the enhanced and standard programme were virtually identical – about 20% committed a further offence.

The effect was to counteract (in fact, reverse) the poor prognosis of the more depressed offenders. This result did not seem to be due to attending the follow-up sessions and generally held regardless of which site the classes were held in, when they were held, race, gender, age, education, and offending history or severity of drink problems. And of all these variables, only depressed mood predicted who would react better when the classes were supplemented by individual sessions.

Unfortunately, this clear-cut result does not have an equally clear-cut explanation. On the face of it there is a conflict with findings that non-directive, relatively unstructured therapies like motivational interviewing work best with people who present as anything but depressed – angry people who defensively resist direction and like to feel in control of their lives.[3 4 5 6 7] One such study directly found that depressed clients did best in more structured therapy and worst when required to take the initiative.[8 9]

But in Mississippi, motivational therapy was *not* being compared with a more directive individual therapy, but with classes which were not conceived of as therapy at all. It seems likely that offenders whose drinking was tied up with feelings of worthlessness and depression needed individual attention and referral to services which could directly address these issues, while those whose drinking was primarily social did just as well with the group education classes.

Among the question marks over the study are how many offenders refused participation, the degree to which counsellors stayed true to motivational interviewing principles (no post-training supervision or checks on fidelity of

implementation are mentioned) and, if they did, whether it was these which made the difference or the individualised attention capable of assessing and responding to their needs for help.

2 In New York state, 25 convicted drink/drug drivers referred by the courts for assessment at an outpatient substance abuse clinic received motivational-style feedback of the severity of their substance misuse problems and the reasons for their heavy drinking.[10] Eight were diagnosed as having a drink problem; before they could resume driving they were required to attend treatment which they all completed. Of the remaining 17, though not legally required to do so, 14 chose to attend risk-reduction sessions, attending at least five and on average 17. Only among the three who refused these sessions were there any drink/drug driving re-arrests (one only) over on average the next two years. The clinicians saw these results as an encouraging indicator that motivational interviewing could improve engagement with treatment, highlighting the way clients became more willing to disclose and discuss their drink problems. Though promising, with no control group who did not have motivational feedback it is impossible to say whether this was a key factor.

3 Another promising but (again because there was no comparison group) inconclusive study took place in low-security prison in the US mid-west with a high proportion of repeat drink/drug driving offenders.[11] During the study 330 inmates completed the prison's addiction treatment programme. Prison regime commitments permitted 38 to participate in a further voluntary programme consisting of an initial motivational interview feeding back assessment results followed by relapse prevention skills training groups. Of the 38, 25 opted for the supplementary sessions, all repeat drink-driving offenders. Of these, just two failed to complete. Participant feedback suggested they had found these sessions more helpful than the preceding prison programme, a typical group education programme based on the disease model of addiction, completing which required acceptance that one was dependent on alcohol or drugs.

When substance use is the problem, adolescents can respond well

Teenagers typically enter treatment under pressure from or having been directed by families, courts, schools or welfare services[12 13] and retention and outcomes are often poor.[14] These unwilling, often angry and uncooperative youngsters ought to be fertile ground for motivational interviewing, but there are reasons why this approach might be inappropriate.

Foremost is an inability to focus on the long-term pros and cons of continued drug use, partly because for many young people the cons have yet to be too pressing, and partly because envisaging how you want to be in the future, and how continued drug use might conflict with that, require experience and a long-term vision which youngsters may lack.[15] There must also be a question over whether it is realistic to expect adolescents to be given, or to take, full responsibility for their lives and choices, yet these principles lie at the heart of the motivational interviewing. For example, acceptable therapeutic goals are commonly constricted to abstinence.

Those who have got into this much trouble so early in their lives often face daunting difficulties and live with families unable to effect positive changes for them. With escape routes constricted, the periodic drug use or under-age drinking which typically brings them into trouble with the law may to them seem a valued way of coping. The downsides of their drug use may be hard for them to identify, the upsides more salient. Trying to motivate the youngster by getting them to weigh up the pros and cons may not just be difficult but also beside the point.

While these factors may limit the degree to which motivational interviewing can boost motivation, others will limit how far motivation can be expressed in action and outcomes. Youngsters lack resources and the autonomy to self-initiate important changes: moving home, leaving or changing school, escaping poverty or abuse, or replacing the peers and adults in your life with better role models or more effective parents, are all largely beyond them and subject to control by adult authorities.

There is a real chance then that classical motivational interviewing will miss its mark with youngsters. In the few studies we have, this seems to have largely been the case. The exception is a study whose subjects truly did seem to have significant substance use problems warranting treatment, though its findings were somewhat undermined by a low follow-up rate.

4 This positive study is unpublished and available only as a dissertation from one of Bill Miller's doctorate students.[16] This account combines the account in the dissertation with Dr Miller's descriptions[17] [18] [19] and accounts in other reviews[20] [21] [22]

It took place at the adolescent treatment programme of Bill Miller's New Mexico centre, which works with adolescents with "overwhelming" problems not just with drugs but with the law, their schools, and their families.[23] Reluctant 'clients' forced there by parents or the criminal justice system typically resent being told by adults that they should 'say no' to drugs and half fail to return after initial contact.[24] To find a way to stem the outflow, 77 youngsters aged 14-20 starting outpatient treatment were randomly assigned to normal admission procedures or additionally to a motivational interview lasting from half an hour to an hour conducted by two research therapists.[25] Most were Hispanic in origin. Three-quarters were under a legal mandate to attend for treatment and most of the remainder had been sent by their parents. Around 80% each had been through previous treatments and been arrested. About a third were primarily diagnosed as dependent on alcohol and a quarter as abusing the drug and 43% were seen as dependent on use of several substances. In the past three months they had used alcohol or other drugs on eight days in ten and on about 60% of days had used alcohol heavily or used illicit substances at least three times. All but a few had used cannabis. These seems little doubt that most had real and multiple problems and were in need of help reducing their substance use.

Beforehand all the youngsters had undergone a three to four hour assessment by the same researchers, an extensive battery of survey instruments recording substance use, related and other problems, testing cognitive ability, and assessing motivation for change. For the motivational group assessment was immediately followed by the motivational interview which incorporated feedback of assessment results compared to national peer norms.[26]

No fidelity measures were taken but the therapists were clinically supervised by William Miller and one (the study author) seems to have been particularly well versed in the approach, having completed two workshops with its originators and having been trained to trained other counsellors . Conducted without a manual, from the description their approach adhered to motivational principles. Clients were left to draw their own conclusions about the relationship between their substance use and any problems in their lives, a decisional balance exercise covered the pluses as well as the minuses of substance use, and confrontation was avoided. The assessment was reported using interactive and graphical methods intended to engage the clients. However, there was "clear advice to reduce consumption" and the youngsters were encouraged to engage with the centre's treatment programme and in particular to attend the orientation group and meet their counsellor. In the context of their problems such advice may well have seem a warranted expression of concern rather than an irrelevant intrusion and the researchers record that the clients appeared open to exploring their substance use [with] a respectful and empathic counsellor working in a collaborative manner."[27] The interview was presented as integral to the overall treatment which participants were encouraged to attend and to feed into that process what they had learned in the interview, The therapists too shared their assessments with the unit's normal staff.

The unit's records showed that 72% of the control group went on to meet their unit counsellor, an improvement on past performance which may be attributable to the extended assessment or the selection of more compliant clients in to the study.[28] However, all but two of the motivationally inducted clients saw their counsellor, at 95% a further significant improvement. These youngsters stayed in treatment for an average of 17 sessions compared to six after the regular intake procedure, a statistically significant difference and a major achievement. The difference was most marked among those with dependence problems who stayed for 20 sessions versus eight.[29] The minority of youngsters diagnosed as abusing but not dependent stayed for five sessions after motivational induction, on average one or two more sessions than after normal intake. On discharge the unit's staff rated the motivational clients as having on average achieved significantly more of their goals.[30] [ii] and 64% were seen as having achieved at least three-quarters of their goals compared to just 36% of the controls.[31]

Repeated attempts were made to re-interview the youngsters three months later but only half could be re-assessed. This included 60% (25) of the motivational clients but just 48% (14) of the controls, a significant difference, itself indicative of greater stability or perhaps affiliation with the therapists who themselves conducted by the follow-ups, though not always with individual with whom they had conducted the intervention. The results indicated that the motivational clients who could be contacted were using illicit drugs or alcohol much less than the starting sample while the controls' substance use was relatively unchanged. How far this was due to a real effect of the motivational interview and how far to attrition of subjects from the study is unclear.

In the intervening three months the motivational patients said they had had spent 70% of their days free of alcohol or drugs other than tobacco versus 43% after

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ii Dissertation main text says no but conclusions say yes as does Dunn review.

normal intake, a big gap which was reported as statistically significance in the original study[32] but just short of this by another analyst.[33] Over this period, motivational clients who could be recontacted had used illicit drugs on half the days (26% versus 59%) of normally admitted patients, just short of statistical significance.[34] There was a similarly large gap in days of alcohol use[35] but when missing subjects were taken into account,[iii] this fell just below statistically significant levels.

Heavy use of substances (excessive drinking or drug use three or more times in a day) was particularly clearly affected, being indulged at intake by 81% of motivational clients failing to 24% at follow-up versus 65% and 73% among the controls, a statistically significant advantage for the motivational clients.

Outcomes consistently favoured the motivational group, suggesting a real effect not just on retention but also on short-term post-treatment substance use. What produced these effects is a more open question. A hint of the mechanism can be found in the author's observation that instead of the expected resistance, the adolescents responded opened up[iv] to what for them was an probably an unexpected approach, perhaps quite different from their customary interactions with adult authority figures.

In this study the motivational interview must be seen as the culminating part of a combined assessment/intervention session lasting up to five hours. Apart from low follow-up, question marks over this study include the fact that only a fifth of the unit's prima facia eligible adolescent intake were included in the study (nearly all those not included refused consent),[36] whether the motivational clients reported less substance use at follow up because they wanted to please the people who had been their therapists, how far the therapists adhered to motivational interviewing principles, and, if they did, whether they might have had a similar impact using a non-motivational approach.[37]

5 The latter possibility is suggested by a study in Baltimore. Instead of comparing a motivational interview with normal procedures, this compared it to a different kind of induction.[38] [39] Both were conducted by therapists who would not undertake the main treatment, equalising the degree of extra, sympathetic attention the youngsters received. Each of the five clinics implemented one sort of induction in the first half of the study then switched to the other.

Inductions were intended to prepare the 194 youngsters for 19 weekly group therapy sessions focused on relapse prevention skills training,[40] a programme developed for 14–18-year-olds with at worst moderate substance use problems.[41] Most had been referred by the juvenile justice service after being arrested for substance-related violations. Before coming they had used substances (mainly cannabis) on one out every three days and (apart from the legal complications) few reported major drug-related problems. Generally, they saw little need for treatment.[42]

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iii By allocating them the mean of the control group.

iv They were "open to exploring their substance their substance use [with] an empathic and respectful counselor working in a collaborative manner".

The 75-minute motivational induction aimed to elicit a "formal commitment to discontinue substance use based on the personal costs already experienced from use and the anticipated benefits of abstinence".[43] A decisional balance (pros and cons of continued drug use versus stopping) exercise was followed by the development of a "change plan". In contrast, the alternative session focused on the treatment to come – what the youngster expected, their concerns, and what would happen and why – a form of 'role induction' seen by the researchers as a "minimal" input against which motivational interviewing could shine.

This was not what happened. Typically the teenagers stayed in treatment for 14 out of the scheduled 20 weeks, but they left *earlier* if treatment had been preceded by the motivational interview.[44] This was the case at all five clinics in the study[45] and across all five, statistically significant, but how to interpret this finding is unclear. To reach the 'success' criterion of sustained drug-free urine tests, the clinics could extend treatment. In these cases, retention beyond the scheduled 20 weeks is an indicator that things are going *badly*, not that the client has productively engaged with the service. Also, when the researchers examined the results they found that a few youngsters had stayed in treatment well beyond the 20 weeks because they had problems staff wanted them to resolve before leaving, and these happened to be the ones given the role induction session.[46]

Given these caveats the apparent retention deficit due to motivational induction can probably be discounted. Fitting this interpretation is the fact that which session the youngsters had received made no difference to post-treatment substance use outcomes measured six and 12 months after treatment started.[47] Drinking and criminal activity remained at roughly pre-treatment levels, though the youngsters were now using cannabis less often.

The ineffectiveness of the motivational interview in this study contrasts with the New Mexico findings; see study 4. Possible explanations are that in Baltimore all the youngsters had some kind of one-to-one induction session with the same therapists. The nature of the motivational interview with its closed ended, sole acceptable objective may also have differed from what was probably a more classical approach from Bill Miller's student. Rather than (as in New Mexico) distinguishing it from the usual responses they came across, for the Baltimore youngsters the therapists' insistence (however subtly put) that they should commit to stopping drug use and show how they are going to do it may have seemed pretty familiar. Though the therapists were trained, there is no mention of post-training supervision or checks on the fidelity of implementation. There is also the possibility that in Baltimore the motivational interview and the subsequent treatment were based on a false premise – that for these youngsters, substance use was the root or major problem in their lives. Their substance use was characterised as "low severity",[48] involving illegal drug use on a third of days. In contrast, the New Mexico sample had used illicit drugs practically every day and most had been diagnosed as dependent rather than just 'abusing' substances.[v] Baltimore's motivational interviewers may have found it hard to elicit the minuses on the decisional balance sheet supposed to generate a drive towards committing to

v Judging from the average retention figures there must have been about three times as many dependent as abusing youngsters.

abstinence, and most found themselves unable to move on to complete the session with a commitment to a change plan.[49] Eliciting such a commitment is perhaps the key way motivational interviews generate change.[50]

Though their drug problems were relatively minor, the same cannot be said of the rest of the lives of the Baltimore youngsters. Most of the clinics in the study served economically depressed areas and their clients were generally juvenile delinquents for whom low level drug use was one among a number of risky and criminal activities. Treating that in isolation seems to assume that this was their core problem, an assumption based on the accident of their having been caught using drugs as opposed to engaged in some other criminal activity.

Rather than reducing substance use because the motivational interview or treatment induced a change of heart, the Baltimore youngsters may have been reacting mainly to the consequences of being caught. It seems likely that nearly 6 in 10[51] [vi] faced the threat of a positive drug test being treated as violation of probation,[52] most too of being ordered into more restrictive (possibly inpatient) treatment, and others may have faced sanctions from schools or other agencies. Between three and six months after starting treatment, cannabis use fell, but for half[53] the patients this period overlapped with treatment and drug testing, and for some both continued well beyond this point.[54] Between nine and 12 months, when most would no longer have been subject to testing, cannabis use bounced back, though not to pre-treatment levels. Meantime, drinking was unchanged, perhaps because it was not subject to the same testing regime sanctions.[55]

Uncontrolled studies

The remaining studies did not directly test whether starting treatment with motivational interviewing improved outcomes but do attest to the limitations of motivational (and other) treatments for multiply problematic young cannabis users.

6 A study of probation-referred young adult cannabis users is covered here because of the parallels with studies of younger users. Its subjects were 18-25-year-olds referred to an outpatient clinic by probation services in New Haven Connecticut, patients the clinic had found to be poorly motivated for treatment and poorly retained.[56] The 65 who joined the study averaged 20 years of age and were referred either to three sessions of motivational enhancement therapy or to this plus vouchers for attending these sessions and doing so promptly. Following a manual, during the sessions patients were encouraged to prepare a "quit contract" for giving up cannabis at a set date, to develop a change plan to do so, and to continue with outpatient treatment. Therapists were trained and supervised through two cases but there is no mention of ongoing supervision or support or checks on the fidelity of implementation.

Three-quarters were unemployed and they reacted as expected to the offer of up to $120 worth of vouchers by complying with the treatment timetable, without this noticeably increasing their willingness to carry on with treatment or to reduce their cannabis use. Just 14 patients took up the offer of further treatment, slightly but not significantly more often if they had been offered vouchers. Even among those who

vi 57% had been on probation in past 90 days and about the same % reported criminal justice pressure to enter treatment.

attended all three sessions, the motivational interviews on their own were associated with only a small reduction in cannabis use, from 10 days a month before treatment to eight the month after it had ended.

As in Baltimore (see study 5), these young adults were multiply delinquent. They averaged five previous arrests and had already spent on average nine or ten months in prison. Almost all were single and most had failed to complete a basic education. In the context of this unpromising start to adult life, their use of cannabis one day out of three could have been an inappropriate focus for the provision of support.

7 The basic treatment in the multi-site US Cannabis Youth Treatment Study consisted of two one-on-one motivational enhancement sessions followed by three cognitive-behavioural therapy sessions conducted in small groups of five or six children.[57] Running over six weeks, it was intended to be a brief, low-cost initial treatment which could be widely adopted even in non-clinical settings such as school welfare services.[58] Post-training supervision and checks on the fidelity of implementation ensured that the therapies were delived3ered as intended.[59] The motivational sessions incorporated assessment feedback and comparison of cannabis use against national norms, followed by completion of what was called a "personal goal worksheet" but which was meant to lead to a pre-ordained conclusion – ceasing to use cannabis. Subsequent group sessions were geared to acquiring the 'skills' (such as refusing drug offers) and resources (non-drug using friends and alternative activities) to become and remain drug-free.

All four clinics in the trial provided this basic treatment plus two others lasting 12 weeks, twice as long. At two clinics the basic regime was built on with seven further cognitive-behavioural sessions or these plus family support and parent education. In the other two clinics, rather than building on the basic sessions, two different approaches were tried. One occupied 10 sessions with the youngster and another four with their parent(s) or other carer, aiming to help both develop rewarding non-drug using activities for the child. The second was a form of family therapy which also sought to engage other significant figures in the child's life (such as teachers and probation officers) to establish a social environment conducive to healthy development.

None of these more extensive or more elaborate alternatives significantly improved on the basic approach. Over the next 30 months, all were followed by worthwhile but limited improvements in substance use and related problems:[60] "across all sites and conditions, a large number of adolescents continued to use drugs and generate high costs to society".[61]

Such improvements as there were could not all be attributed to the treatments. Most clients were involved with the criminal justice system and a fifth spent considerable periods in detention, hospital or other controlled environments, so were unable to maintain drug use.[62] Over the 30 months there was also considerable turbulence in individual drug use and drug problem trajectories.[63] [64] By definition, all the youngsters started treatment with substance use problems, the existence of which was one of the main outcome measures. On this count they could not get worse, but 'natural' turbulence could mean that, even without treatment, at any later point some would get better.

More sensitive measures of the extent of substance use and of related problems provide a more encouraging picture, for example, more than a 40% reduction over the first year in drug problems, and there were also significant and substantial reductions (40% to 70%) in missing school, crime, conflict, and behaviour problems.[65]

This at best partly encouraging picture should be seen in the light of the treatments and the populations being served. Some treatments were longer and more expensive than others but all were relatively brief, cheap and non-intensive.[66] And though some did involve family and others, they were limited in the leverage they could exert or the resources they could provide to change the child's life. Much was left to the child or their parent(s) (for half the children, in the singular) to engineer after being motivated, skilled and pointed in the right direction by the therapists.

Before treatment, 80% of the youngsters did not feel their cannabis use was a problem[67] and many may have been right, at least in the sense that it was not the overriding difficulty in their lives. Some may have not have needed treatment at all, others a much more holistic, intensive and persistent attempt to rebuild their lives.

About a third of the sample went on to use cannabis little and to avoid prison or other controlled environments. Compared to other study participants, they tended more often to be a white girl[vii] living with both parents, before treatment using cannabis less often and less seriously entangled with the criminal justice system.[68] These youngsters with more intact conventional supports may have profited as well from an intervention much briefer than even the briefest in the study. From another study we know that mainly employed adult cannabis users do as well as after two sessions of motivational interviewing as after extended cognitive-behavioural therapy.[69]

For others with multiple and severe difficulties in their lives, all the treatments may have been inadequate and perhaps misdirected at cannabis use, when much of the study's sample was characterised by criminality, criminalisation, school problems, violence, victimisation, psychological disturbance, broken families, and, in the US context, atypically high rates of alienation from religious affiliation.[70] [71] [72]

For example, after treatment nearly a fifth of the sample used cannabis little but only because they spent long periods in prison or other closed environments. Typically they were young black teenagers from single parent families who started treatment heavily involved with the criminal justice system.[73] Before treatment they were on an unpromising trajectory which up to 12 weeks of low-intensity therapeutic contact was unable to divert. Their fates may have had as much to with how America treats its young, black males from deprived backgrounds as with any behavioural problems of their own, which tended to be no more and usually less common in this group than in the others.

Another small set of youngsters consistently used cannabis at high levels after treatment. They tended to have been using cannabis and alcohol relatively heavily before treatment and here multiple behavioural and psychological problems were more common than in the other groups. Intensive, continuing psychological, practical and social support may have been needed to break these patterns.

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vii Though most were boys.

Parents can benefit – depends on whether motivation is the issue

Especially in the US context, drug using parents and parents-to-be are commonly directed in to treatment by child welfare services. As with unwilling young patients, motivational interviewing ought to have a role in defusing defensiveness and anger, but conceivably with more success. As adults and as parents, these referrals may be more inclined to look to the future and therapists should find more leverage in their decisional balance exercises – clear potential downsides to drug use in the form of the effects on the child or the parent's prospects of being allowed to keep them. The two main studies recorded in one case the expected positive results and in the second, no extra benefits. The difference was possibly that in the first (study 8), motivation was the main impediment to engagement, in the second (study 9), highly stressed and under-resourced lives.

8 In Connecticut assessment staff faced the challenge of motivating substance using parents referred by child welfare services.[74] Often angry usually resistant to treatment,[75] most did not re-attend for outpatient treatment. At one of the provider units serving the state's programme for drug using parents, the standard assessment was replaced with one which gathered the same information over the same time, but using a motivational interviewing style. In both cases the unit's own staff conducted the assessments after a day's expert training in the principles of motivational interviewing. There was no manual to follow not mandatory supervision or checks on the fidelity of implementation, but the therapists did have access to continuing problem-solving support.[76]

Sixty parents (of the 75 asked) joined the study and were randomly allocated to normal or motivationally enhanced assessment.[77] The enhanced version doubled the proportion who went on to attend their first treatment session from 29% to 59%, a statistically significant difference. From then on the drop-out rate was about even, half of the attendees coming just one more time. Including the initial session, 30% of the motivational group attended at least three times – 13% more than controls, but no longer a statistically significant advantage. The researchers speculated that drop out after the first treatment session was due to the patients encountering different therapists who adopted a more confrontational approach.

In this study the participants were typically white women in their 30s whose substance 'problems' were confined to occasional drinking and cannabis use and very occasional cocaine use. Probably the major impediment to treatment entry was simply not wanting to go or not seeing the need rather than a disordered lifestyle or lack of resources. To them the normal 90-minute assessment may have seemed an unwarranted interrogation leading potentially to enforced treatment, stoking both their anger. Pervading it with responses which demonstrated caring and understanding and which acknowledged their autonomy seemed to improve their perception of the agency to the point where most were prepared to at least give it a try. The impact of adopting a non-confrontational style may have been augmented by the staff's enthusiasm at being involved in a prestigious research project and their enthusiasm for an approach which promised to resolve a major source of disappointment – rejection by 7 in 10 of their clients.[78] Such optimism

communicated to patients could have been a powerful influence, whatever the approach.

9 Positive findings in Connecticut contrast with nil effect from a motivational interviewing intervention with new mothers in (probably) Oklahoma.[79] The 71 women in the study had attended an intake session for a year-long programme for women who used drugs while pregnant. Over 8 in 10 had been referred by child welfare services after having their newborn child removed from them when a test revealed illicit drug use. The consequences of continuing to test positive while in treatment could include being denied visits to their children. Despite this considerable pressure, over the first two months only half the scheduled therapy sessions were attended and half the urine tests were either missed or positive for drugs.

It was hoped that incorporating a motivational interview in the intake session and two further interviews a week and two months later would improve retention and outcomes. Women were randomly allocated to this procedure or to educational videos at times corresponding to the first two motivational interviews and at the two-month stage to an extra home visit. To avoid an inflexible approach mismatched to the client, trained motivational therapists were not asked to follow a manual and or to complete certain tasks, but given complete freedom to follow the client's lead. Fidelity checks indicated that on average they faithfully followed motivational interviewing principles.

Disappointingly, the motivational interviews did not significantly improve attendance at the extra sessions or at the main treatment sessions, half of which were missed. Urine test results too were unaffected; again, about half were missed or positive for drugs or alcohol.

The problem it seemed was that the motivational clients rarely gave much of a lead. The treatment service regularly reported each client's progress to the child protection and criminal justice. At risk as they saw it of perpetuating the loss of their child, very few owned up to any substance misuse problems or to any ambivalence about a drug-free life, depriving the therapists of essential grist to the motivational interview. That their confidence was false or misplaced was indicated by urine test results, by a past history of attempts to stop using drugs with no lasting success, and by a drug use profile considerably more severe than in Connecticut; two-thirds were primarily using either cocaine or amphetamines rather than cannabis or alcohol.

Other explanations include the possibility that the videos portraying loss of child custody due to drug use and the subsequent return of the child had an impact rivalling that of the motivational interviews. Another important influence may have been the nature of the client group – poor single, unemployed and under-educated mothers on welfare with a history of psychiatric symptoms, criminal convictions and domestic violence. Perhaps what they lacked was not motivation to regain their newborn children, but the resources to put this in to effect. More intensive psychological and practical assistance might have been more to the point than motivational boosts.

10 This seems to have been the case among a similar population studied in Baltimore.[80] The caseload was pregnant women attending for their first prenatal care visit at one of three obstetrical clinics. Overwhelmingly black, unmarried, unemployed, poorly educated and with multiple unmet basic needs,[viii] 90 of the 120 women who agreed to enter the study[ix] had used heroin, cocaine or cannabis in the past month and about half had a history of dependence on cocaine. They were offered four weekly motivational counselling sessions aimed at reducing drug use plus financial incentives for delivering drug-free urines. But by the third session over half were skipping their appointments and drug-free urines were a rarity. The motivational sessions aimed to mobilize the "patient's inner resources" but both these and the women's practical resources were severely depleted; half had a history of major depression and over a quarter were diagnosed as suffering from trauma-induced stress disorder.

Appreciating these difficulties, part way through the study the researchers tried starting each session by identifying unmet basic needs and referring the women to relevant social and welfare services, later supplemented by providing escorted transport to the appointments. Following this enhancement, at least the first two counselling sessions were better attended, after which it seems many of the women had got the help they needed to sort out their housing (however inadequately), transport and mental health care needs. Women offered this extra help also cut down their drug use to a greater degree (eg, over a third had two consecutive drug-free urines compared to just 6% of the other patients) though still over half did not produce a single drug-free urine.

Adapting to a group format

In criminal justice settings treatments are typically delivered to groups rather than individuals and especially in residential or prison-based programmes, therapeutic communities are often the major or sole treatment modality. For the motivational approach to play a role in these settings ways must be found to transform an individualised, one-on-one intervention in to a group format. One particularly thoughtful adaptation has been used as an induction to outpatient treatment with promising initial signs of improved motivation,[81] but only in a study in New Jersey has a similar programme been tried with legally coerced patients.

11 In New Jersey a non-residential substance misuse service found that referrals sent by courts and other legal authorities who could see no point to their treatment (as they saw it, they didn't have a problem to work on or a goal to work towards) failed to benefit and tended to leave early.[82] For these 'no-goal' clients, a group run on motivational interviewing lines was established as an introduction to the centre's "traditional abstinence-based" treatment programme. It met six times led by therapists trained in motivational interviewing. The set programme included decisional balance exercises and in the fourth session a discussion of reactions to

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viii The hospital system concerned provides more charity care than any other hospital in Baltimore; www.hopkinsmedicine.org/organizations/JHHospital/, 22 October 2004.

ix 130 were asked suggesting use of these drugs by over two-thirds of newly attending women at the clinics.

written feedback each member had received after an individual assessment of their drinking and drink problems compared to national norms.

Four out of every ten clients admitted to the service were eligible for the group, an indication of how many were coerced in to a treatment they saw no point in. Mainly because of limited spaces, not all joined the group. The study compared the progress of 75 who did against 92 who did not. Overwhelmingly they were single male problem drinkers and despite their attitude to treatment, over 60% had alcohol or drug problems sufficiently severe to attract a diagnosis of dependence.

Treatment completion was the main outcome measure, defined as attending the closing counselling session with a period of abstinence from drugs or alcohol behind one and satisfactory progress in other problem areas. On this stringent basis, 56% of the motivational group completed against 32% of those not admitted to the group and they had also attended more of their treatment sessions (83% versus 76%).

However, the two groups differed in ways which tended to favour the motivational group, more of whom were employed and fewer diagnosed as dependent. When these variables as well as age were taken into account, there remained significant but now only slight advantages for the motivational group in terms of completion and session attendance. Because the offenders were not randomly allocated, these remaining advantages might have been be due to other, unmeasured differences between the groups. They may also have been simply due to the extra group therapy time given to these offenders rather than the approach taken.

Arguing against this is the researchers observations of the now familiar reactions to the motivational approach: surprise at not being confronted with "alcoholic" labels and at not being told "what was good for us"; resultant deflection of resistance and anger leading to an improved atmosphere, greater openness, and less conflict; and the salutary impact of learning how far one's drinking exceeded national norms. The relief of staff as well as patients is palpable in the paper.

One of this study's achievements is to show that the problems in conducting a motivational approach in a group format can be overcome. Adaptations included allowing participants to read their feedback reports before discussing these in the group, so they could choose which elements to make public.

No universal benefits; depends on the people, the approach, and the circumstances

For each of the major types of coerced clients, motivational induction has had some successes but there have also been cases where it has not improved on normal or alternative procedures. The one study of drink-driving offenders capable of answering this question (study 1) found recidivism reductions only for the minority of offenders suffering depressed mood at intake, possibly because these were the subset in need of a treatment as opposed to the usual educational response.

With young people, enhanced engagement in treatment and substance use reductions have been found in one study (study 4) but not in another. In the successful trial motivational interviewing was probably true to its principles and elicited the usual positive reactions from youngsters surprised at not being told what

to do, and the caseload was in need of substance-focused help. In the unsuccessful trial (study 5), the approach may have differed little from the usual 'Don't do it' responses encountered by the youngsters, and though their problems were multiple and severe, substance use was not the major focus of their concerns yet was the focus of the intervention. In other studies too, motivational interviewing may have been undermined by an insistence on one acceptable outcome (no illegal use) and an inappropriate focus on substance use in the face of multiple severe problems (studies 6 and 7).

Similar differences may account for mixed fortunes with mothers ordered for assessment or treatment by child protection authorities. When stressed and under-resourced lives were the main features of the caseload, motivational interviewing was unable to make much of a difference (studies 9 and 10). When these were less pressing and motivation more the issue, improved engagement with treatment was the result (study 8).

Last is the one controlled study of group format motivational interviewing. Among this mixed bag of offenders, the result was slight improvements in engagement with treatment for those (the majority) unable to see a point to the treatment they were being forced in to.

Across these caseloads, it seems that substance-focused motivational interviewing is ineffective or only marginally effective when substance use is not the major problem in the offenders' lives (studies 5 6 10). Even when substance use problems do seem relatively severe, patients will not open up to a motivational therapist whose reports back to legal authorities could have severe consequences for themselves and their families (study 9).

Still of the six studies capable of testing motivational interviewing, in four there were positive outcomes for some subgroups (studies 1 11) or for the sample as a whole (studies 4 8). In two of these studies (1 4) it is impossible to say whether motivational interviewing made the difference or the individualised attention which came with it. Another study which equalised this element found motivational interviewing conferred no extra benefits (study 5). Of the remaining two studies, one found engagement benefits from a group format adaptation (11) but this may have been due to the extra group therapy time rather than the approach taken, and the slight advantage gained might have been due to differences between the offenders who did or do not get allocated to the extra intervention. The remaining study (8) seems a convincing demonstration that staff enthused by motivational interviewing's promise can make a big difference to treatment uptake when this approach is incorporated in to normal assessment procedures.

Though studies have not been able to eliminate alternative explanations for positive findings, observations of the clients have suggested that the motivational approach is an active ingredient, replacing resentment and anger with appreciative surprise at not being burdened with denigrating labels or told what you must do (studies 2 3 4 11). Given that substance use is an appropriate focus, that the patients have the resources to make positive changes, the therapist can remain true to motivational principles, and the patients feel safe to open up to their therapist, motivational interviewing can fulfill its promise with legally coerced populations. Unfortunately,

in these populations, elements are often missing from this aggregation of circumstances.

For services, the practical implications seem to be to assess whether there really is a substance use problem which might benefit from therapy, whether motivation is the main issue holding their legally coerced clients back from engaging with treatment or whether basic needs and psychological problems need addressing, to insulate motivational therapists from reporting-back to legal authorities, and to make sure the patients know this. In settings where dehumanisation and group approaches are the norm, sympathetic, individualised attention to the offender's needs may pay dividends regardless of the particular approach taken. Motivational interviewing offers a way to do this which helps therapists avoid simply duplicating the oppressive nature of the surrounding context and which is capable of enthusing jaundiced staff.

Selecting and training therapists

Work reviewed here and in the previous issue suggests that perceptive therapists who can sense when to push forward, when to hold back, when and with whom take the lead, and when to follow, and who are able to absorb implement the spirit of the motivational interviewing style, will do less harm and make more progress with better outcomes overall. The issue then becomes how such therapists can be selected and how they can be trained and supported. Recent studies have shown that producing a good motivational therapist requires good starting material and a continuing investment in supporting them to stay true to motivational interviewing principles despite the buffetings of clinical practice.

The therapist cannot be ironed out

The aim of this aside is to show how resilient is the impact of the therapist in even the most highly technically specified therapies, and therefore how important selection and training are.

Research on these issues is relatively rare. Researchers commonly attempt to homogenise the impact of the individual therapist by practical means such as careful selection and training and manual-guided programmes, or to eliminate it by statistical techniques which 'partial out' their contribution. The aim is to strip away side issues to gain an uncluttered view of the impacts of different therapeutic programmes.[83] But if the programme is not what matters most, and what does matter are interpersonal styles and personal attributes which are difficult to teach (including an ability to respond appropriately even if that means deviating from the programme), then the baby may be exiting with the bathwater.

Strong indications that this could be happening come from two psychotherapy trials, each the most closely controlled ever conducted with their respective client groups. Both took extraordinary measures to select, train and supervise therapists in the application of detailed manuals, yet were unable to suppress the impact of the individuals doing the therapy, in each case a greater influence on outcomes than the therapies themselves.

MATCH motivationalists vary in effectiveness

The landmark US Project MATCH study of alcohol dependence treatment found that its three therapies resulted in virtually no statistically and no clinically significant differences in drinking either during or after treatment.[84] Though the study was not intended to prove one better than the other (it was about which treatments are better for which patients, not which are better overall), given therapies so different, and of such different intensity, it was a remarkable finding.

Underlying this equivalence was the fact that the supposedly distinct therapies actually worked in similar ways and in those ways, to a similar degree. In all three the clients engaged in the same kinds of thoughts and behaviours to control their drinking[85] and though markedly distinct in their specific techniques, the three therapies generated similarly good client-therapist relationships and the therapists were equally empathic and skilful.[86]

However, there were enduring and statistically significant differences in how well different therap*ists* helped patients curb their drinking.[87] In the arm of the study which took patients typically exiting a short inpatient detoxification programme, the therapist's impact was greatest in motivational interviewing. Moreover, it was in this therapy that the client's satisfaction with treatment was most consistently affected by the therapist, and only here did therapists differ in the degree to which they forged a therapeutic alliance with their clients. Patients who felt satisfied with treatment and felt they had a good relationship with their therapists drank less during and after treatment.[88] [89]

The clients were even more influential. The thought processes, behaviours, and relationships (with the therapist) they used to recover from their dependence were driven largely by their resolve to tackle their drinking even before they had started treatment.[90] Among patients for whom MATCH was their primary treatment experience, this resolve was the single factor most closely related to outcomes. In fact, patients who entered the trial but never attended a single therapy session evinced most of the improvements seen in those who attended every single session, and rather than attendance improving outcomes, it was as much the case patients who from the start were going to do well in curbing their drinking also went on to attend therapy more often.[91]

Patients get what they need

In the treatment of depression, the US National Institute of Mental Health's Collaborative Research Program has a status similar to that of project MATCH. Here too, the therapies had no consistent impact on post-treatment outcomes, in this case, symptoms of depression. Though they benefited from detailed manuals, interpersonal psychotherapy and cognitive-behavioural therapy were essentially no more effective than clinical management – the kind of care any competent clinician could be expected to deliver. But as in MATCH, the therapists did make a difference.[92]

Audiotapes were used to dissect what was happening in the therapy sessions.[93] [94] Despite therapists' adhering to the specific techniques and topics (thoughts and behaviour versus personal relationships) mandated by the therapies, they interacted with the patients in very similar ways. Most striking were the similarities in how the

patients participated – their emotional states and attitudes to the therapists. Rather than the distinctive features of the therapies, It was these cross-cutting, generic patient contributions which were consistently related to outcomes.

The degree to which therapists adhered to the cognitive-behavioural programme (the most highly specified of the treatments) was entirely unrelated to outcomes, but these were weakly related to the therapist's ability to structure the sessions, a generic competency rather than a component of the programme.[95] For the client too, across both structured therapies, outcomes were closely related to generic, non-specific processes including their understanding of the therapy, their positive sense of self, and their attachment to the therapist as a supportive and benevolent helper – a reflection of the therapeutic alliance. As experienced by the patient, in this study as in others, a strong alliance was predictive of good outcomes.[96]

As much as the therapist manipulating the client according to a set recipe, these results look like the client fastening on a supportive, caring relationship focused on their welfare to get what will benefit them, regardless of the recipe the therapist was supposed to follow.

What therapies share is what matters

Both studies highlight the primary role of processes which are important in the interaction between clients and therapists of whatever therapeutic persuasion, to do with the client being ready to change and feeling that the therapist really is a caring, understanding and effective ally in this process. It follows that training the therapist in specific techniques and ensuring they apply them according to a technical manual is less important than choosing people to whom others relate in these ways and supporting and developing these qualities.

Technical training may even impede therapy if it leads therapists to override their instincts and fail to respond to clues emanating from the client, or if it encourages them to adopt the stance of a 'technician' rather than that of someone who genuinely cares. Another implication is that while therapists understandably prefer to see themselves as promoting change, one of the biggest ways they can affect outcomes is by interfering with the impetus for change coming from the client.[97] [98] Above all, motivational interviewing aims avoid fouling up in this way.[99]

Enable trainees to learn from experience

Assessed by the frequency of statements of the kind motivational interviewing aims to promote, and the lack of those it is intended to eliminate, it has been known for well over a decade that being trained and supervised in the approach can lead to the intended changes in what both therapists and clients say.[100] But the study which demonstrated this also showed that this may not lead to significantly greater post-counselling behaviour change.

Since then research has clarified that 'making the right noises' is not enough – they have to be made at the right time and in response to the right clues from the client, and within a relationship which the client values. The latest schedule for assessing therapist competence in motivational interviewing has taken these lessons on board by enabling what was said by the therapist in a counselling session to be related to the client's statements, and in particular to the strength of their commitment to

change.[101] How to coach therapists in this intricate dance has been the subject of a series of studies.

One-off workshops are not enough

Following a two-day workshop led by Bill Miller and his colleague, probation department staff in Oregon gave glowing accounts of their improvements in their understanding of and proficiency in motivational interviewing, a view they sustained over the subsequent four months.[102] Their views were corroborated at the end of the workshop by a paper-and-pen evaluation of how they would respond to sample client statements.

The disappointment came when these in-theory assessments were checked against ratings of audiotapes of how the therapists actually behaved at three stages: before the workshop with a client; at the end with someone acting as a client; and with a real client four months later. Especially when the raters were assessing overall adherence to motivational principles rather than specific techniques, the improvements were quite small and left the trainees falling far short of expert practice, largely because they were unable to suppress their previous interactional styles. On one dimension which attempted[x] to reflect how 'genuine' the therapists were, things had even got worse, seemingly because for them this new approach felt unnatural, making them feel uncomfortable.

By four months later even the post-workshop boost in use of specific techniques had eroded. Clinching this negative picture was the fact that, compared to pre-workshop tapes, their clients too did not 'improve' in the balance of commitment versus resistance to change. It seems likely that the natural way a parole officer relates to real 'clients' is quite far removed from motivational interviewing, and reversion to type was the dominant trend.

Importance of where the trainee is coming from

A study of a similar workshop whose participants were mainly addiction treatment specialists confirmed the rapid erosion of improvements in practice and added an intriguing insight into the importance of choosing the right raw material.[103] Unlike the parole officers in Oregon, these trainees were willing volunteers.

They demonstrated their motivational interviewing skills with actor-clients before the workshop, at the end, and two months later, when most indicators of how far they had absorbed the approach's principles and techniques were no longer significantly elevated. However, this was not the case for all the trainees.

Based on their last audiotapes, eight of the 19 has retained their proficiency in motivational interviewing. The interesting thing was that *even before the training*, these clinicians had been more proficient than the other trainees, in fact, they were already more proficient than the rest would be two months after training. Not only did they start from a higher level, they went on to absorb and retain more of what they had learnt.

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x It was later dropped from the coding scheme presumably as on the of the constructs which was insufficiently reliable and/or discriminable from the other dimensions. Miller W.R. et al. Manual for the Motivational Interviewing Skill Code (MISC). Version 2.0. Center on Alcoholism, Substance Abuse and Addictions, The University of New Mexico, 2003.

On this basis, given a choice between choosing the 'right' people who have not been trained, and the 'wrong' people who have, the right people is the better choice. It seems that some people are more receptive to this approach in their everyday lives and the same people are more able to become yet more proficient. In contrast, within months much of the training was wasted when it fell on less fertile human ground.

Let's try giving feedback as well

Given limited improvements from the standard workshop, Bill Miller's team tried changing it somewhat and adding continuing support which enabled counsellors to adjust in the light of feedback on their performance. This time the practice improvements were sustained.

Addiction counsellors applying for training were randomly allocated to different training regimes.[104] Some were just given a training video and a manual and told to train themselves. They altered their practice little. In comparison, those allocated to a workshop but no follow-up evidenced immediate improvements in counselling proficiency with a client-actor. But, as in previous studies, these had largely been reversed four months later when the trainees submitted tapes of their work with real clients.

The three forms of continuing support trialled in the study largely prevented this deterioration. One took the form of mailed feedback on the trainee's counselling samples, comparing their detailed proficiency profile with that of expert practitioners. The second instead took the form of six 'coaching' phone calls initiated by the trainer to ask about any problems and help solve them, each incorporating role play exercises.

The third consisted of both forms of continuing input, meaning that counsellors could not only gain expert guidance on their problems with clients, but also on the feedback from their sample sessions. Only this third, enriched form of support made enough difference to what the trainees did for this to be reflected in the responses of their clients in increased 'change talk' and diminished resistance.

For the core workshop, the main change was to stress that this was not a complete training regime, but a platform from which trainees could learn by paying attention to and responding to their clients in their everyday work. Signs of commitment to change would indicate that the counsellor is on the right track, while resistance would call for a change of direction. Yet it seemed that without some external guide to help trainees recognise these clues and/or respond appropriately, this attempt at self-generated learning was insufficient.

Such findings are not unique to motivational interviewing or therapy training in general. For example, a teacher-training studies have shown that an off-the-job workshops minimally change classroom practice unless supplemented by on-the-job coaching.[105]

Be empathic, but also be genuine

Post-training, real-client tapes from this same study have been used to analyse client responses to an unusually diverse (in terms of motivational interviewing proficiency) set of therapists. At issue was the degree to which their clients

cooperated with the therapist and opened up emotionally and by disclosing personal information,[106] responses which overlap with therapeutic alliance and signify active engagement in therapy.

Overall, client engagement was unrelated to the frequency with which the therapist made statements compatible (such as open questions) or incompatible (such as warning) with the specific techniques recommended in motivational interviewing, a surprise result. But engagement *was* strongly related to embodying the overall spirit of motivational interviewing and to more general social skills not confined to motivational therapists, including empathy, warmth, supporting the client's autonomy, and coming across as 'genuine', an amalgam of seeming open, honest and trustworthy.

This last quality, being genuine, was difficult for raters to agree on from the audiotapes (videos might have helped), but still about as strongly related to engagement as the other qualities. It also seemed to account for a twist in the findings with potentially far-reaching implications.

As already pointed out, doing the things a diligent motivational interviewer should avoid surprisingly made no overall impact on the client's engagement with therapy. In theory, confronting clients, warning or directing them, and imposing advice or expressing concern without their permission, should have provoked clients to resist therapy.

But when socially skilled therapists 'broke the rules' in these ways, they actually enhanced the effect their skills had on the client engagement. Moreover, it seemed that within (and only within) the kind of empathic, caring context they were able to create, doing things such as warning and expressing uncalled for advice and concern deepened the client's engagement with therapy. Socially skilled therapists tended to avoid these risky manoeuvres, but also had the wherewithal to carry them off without alienating their clients, in fact, the reverse.

Genuineness seemed one explanation for this conundrum. Therapists who honestly and openly expressed the concerns they were feeling and gave advice they felt the client needed without holding their tongues, or trying to manipulate the client into doing the expressing for them, would have rated higher on being genuine, and perhaps also come across this way to the clients. This quality has long been recognised as one of the keys to effective therapy.

By now bells may be ringing in the reader's head, reminders of Bill Miller's earlier study of training parole officers which found that raters felt they were less genuine in their interactions with clients after than before the workshops.[107] Told about this finding the trainees explained that this new approach felt unnatural. It does not take much imagination to realise that within the undeniably unequal and coercive context of the criminal justice system, adopting an 'It's up to you' stance might feel like a false position, and also feel false to outsiders and clients.

A warning from the heart

In a way, none of this is a surprise. Everyone knows the difference between warning, advice and concern which conveys and comes from loving care and respect for one as an equal, and that which comes from and conveys accusation and denigration and an attempt to exert control. We also know that the former is likely

to be listened to and deepen our relationship with the carer, while the latter signifies an alternative agenda rather than common purpose in the pursuit of the hearer's welfare.

Despite intuitively 'making sense', caution is needed here. Despite an echo from the parole officers,[108] these results came from a single study and should not be taken to give the green light to extreme negative responses contraindicated in motivational interviewing like shaming and sarcasm, indicative less of good social skills and a caring attitude than of the lack of them. And though we might expect it, we do not know if deepened client engagement in this study translated in to stronger commitment to curbing substance use and then in actual change. For example, one component of engagement was expressing emotion, yet this is not always related to better post-therapy outcomes.[109]

If we take it at face value, overall this work confirms that learning technical skills and abstract principles is not enough to securely transfer the wisdom experts have gained over many years of practice, reflection and discussion with colleagues, though some willing trainees with a head start in their existing social skills and attitudes to their clients can do well.

As the analysts who found manuals diminish effectiveness put it, "counselors sometimes attend such training in the hope of learning a few tricks to make clients do what they want them to do. MI is nothing of the sort. Rather, it is a complex clinical style for eliciting the client's own values and motivations for change. It is far more about listening than telling, about evoking rather than instilling."[110]

Had they had the latest findings to hand,[111] they might have added that the quality of being genuine can suffer from drilling in "tricks" and in unnaturally withholding normal caring responses, but also that breaking motivational interviewing's rules is risky unless done by a socially skilled therapist who by doing so conveys rather than erodes the empathic concern at the heart of good therapy. therapist responses may be beneficial.[112]

Directiveness is a key factor

As seen in part 3 of the Manners Matter series, mandated by a manual they were required to follow, motivational therapists have directed their clients to engage in set activities or take set decisions at predetermined stages. In the process they created a mismatch between where some clients were 'at' in their decision-making and commitment to action and where the therapist was leading them.

If this can be witnessed within motivational therapy, it should also be apparent when a less directive therapy is compared with a more directive one. For research examining this we have to step beyond induction to studies of full, standalone therapies. Unlike the induction studies reviewed above,[xi] these generally investigated not where the patient is at now in their feeling and thinking, but where they typically are at – their customary ways of relating to the world. What emerges is that those who like to feel in control of their lives and who react against being directed do best in a less directive therapy (like true-to-type motivational

xi None of these studies (14, 15 and 19) tested whether certain personality types responded best to motivational interviewing.

interviewing), while those willing to accept direction do better when this is what they get.

Because a manualised version of motivational interviewing was one of the therapies being tested, the most relevant example comes from the multi-million dollar US Project match study. Compared to therapies which impose a set programme and a set view of the nature of addiction (12-step facilitation and cognitive-behavioural therapies), patients prone to react angrily did best in motivational therapy, at least in the arm of the study where this was the primary treatment.[113] [xii] This much was expected; deflecting anger and resentment is supposed to be motivational interviewing's strength. But unexpectedly, the reverse was also the case – the least angry patients did worse when allocated to the motivational option.

How this happened has been investigated across the five clinics in the relevant arm of the study.[114] It was not because motivational therapy subdued anger any more than the other therapies. But what it did excel at was handling high client resistance to treatment, preventing this from expressing itself in continued drinking, presumably a benefit of the motivational therapists' drilling in 'rolling with resistance' and avoiding provocation. Conversely, it seemed that clients ready and willing to be directed were somewhat let down by the hands-off, 'It's up to you' stance of the motivational therapists.

This picture was pieced together from paper and pen measures rather than how clients actually behaved, but at the match clinic in Providence, videos of counselling sessions afforded a direct, observational measure of both clients and therapists and how they reacted to each other.

Best not to provoke the provocable

Though in the other arm of the match study,[xiii] at this clinic, too, motivational therapy was generally most effective for patients prone to react with anger, least effective for the less fiery.[115] The videos revealed the underlying reason. Across all three therapies, angry clients drank less after seeing therapists who avoided being directive, while the more relaxed did best when given a lead. Motivational therapists were significantly less directive than those implementing cognitive-behavioural therapy (predictable from the manuals; see below) and this accounted for the differences in how patients reacted to the therapies.[xiv]

We get closer to what was happening from observations not just of the therapists, but of the clients. In the first therapy session, raters assessed the degree to which they seemed reluctant to relinquish control and reacted against direction.[116] This was unrelated to how directive their therapist had been during that and subsequent sessions, suggesting that patients who started treatment in 'reactive' mode were not

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xii The findings which follow relate to the 'outpatient' arm of the study and were not duplicated in the aftercare arm, when the three therapies followed intensive in- or out-patient day hospital treatment.

xiii Whose patients had usually just left inpatient detoxification.

xiv But not than 12-step facilitation therapists. The reason might be two-fold. First, in the US context, 12-step based therapy is usual practice, accepted wisdom and familiar to patients. There would be less need to direct and teach than in the less familiar and less 'natural' cognitive-behavioural therapy. Second is the difference in the prescriptiveness of the manuals.

responding to the therapist; it was simply how they were – at least at that time and in that situation. It also suggests that therapists too were more or less directive in style regardless of how the patients reacted.

The more the therapists had adhered to a motivational-style, non-directive stance, the less these 'reactive' patients drank in the year after therapy ended. Findings were consistent whether the outcome was the number of drinking days or the amount drunk on each of those days. It seemed particularly important for therapists to avoided confronting reactive patients, trying to unilaterally set the agenda, asking closed-end questions, or offering interpretations of the client's resistance rather than 'rolling with it'.

This effect was seen in all three therapies, but was most apparent during motivational interviewing, perhaps because such tactics violate its essence in a way they do not for the other two therapies. Interestingly, a more neutral form of directiveness, providing information or assuming the stance of a 'teacher',[117] did not lead to a backlash among reactive patients.

Same view beyond motivational interviewing

By now a fairly clear picture is emerging. Whether or not the therapy is motivational interviewing, if in practice the therapist is directive they risk a backlash from patients who by nature resist direction. Conversely, patients who welcome direction thrive best when they get more of a lead. When direction is pre-structured and inflexibly applied, there is a risk of fouling things up both with those most, and those least, committed to tackling their substance use problems, when the programme's mandate fails to match their state of mind.

So far this picture has emerged from studies which have included motivational interviewing either as an induction technique or as a standalone therapy. The landscape remains familiar when we widen the view to studies which have not involved an identified motivational approach.

First is an analysis of alcohol patients engaged in two sorts of outpatient couples therapy, one cognitive-behavioural, the other family-focused.[118] Both were intended to span five or six months of which the last three or four were a 'maintenance' phase intended to sustain the gains made earlier. The outcome was how far drinking during this phase had changed compared to pre-treatment levels.[xv] This was related to ratings made from videoed sessions of how directive therapists had been in the earlier phase.[xvi]

Regardless of which type of therapy they were in, patients prone to defensively resist attempts to influence them[xvii] drank least when the therapist had been non-directive, most when they had tried to take the lead. For patients willing to embrace overt influence and direction, the reverse was the case. They drank least when this is what they got from the therapist, most when the therapists avoided being directive and/or adopted non-directive tactics, a typical motivational interviewing

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xv Pre-treatment drinking was a co-variate in the analyses.

xvi Using the same scale as at the Providence clinic for the match sessions.

xvii Assessed before treatment using questionnaires intended to measure this concept.

style. Again, how patients were prone to react and how the therapists behaved were unrelated,[xviii] suggesting that therapists were not simply reacting to the patients.

These findings are compromised somewhat by an inability to re-assess 27 of the 75 patients who started the study. But had these been followed up, the results might have been even more clear cut, because these were the patients who tended to react most defensively and who had seen the most directive therapists.

For God's sake take a lead

A similar picture emerges from a study of a very different set of patients, not mainly white employed drinkers, but poor, black, single unemployed men seeking outpatient treatment at an inner-city clinic in Philadelphia, where cocaine was the dominant drug problem.

How far they resisted direction was not directly assessed but a quite similar characteristic was. People characterised by 'learnt helplessness' feel unable to control their lives, in particular that it is futile for them to try to initiate positive changes. They seem like the people who in other studies who would welcome direction from others. At the opposite end of learnt helplessness are people confident in their own abilities to initiate positive change, the ones who seem most likely to react against the therapist doing the initiating.

The Philadelphia patients were randomly allocated to 12 weekly sessions of two kinds of individual therapies designed to be in some ways at opposite poles. In one the counsellor structured the therapy, leaving little room for the patient to take the lead. They directed the client to identify concrete behavioural goals, taught cognitive-behavioural strategies for reaching those goals, and reviewed progress. In the less structured therapy, counsellors instead provided a sounding board for exploration of feelings and the development of the client's own awareness and understanding rather than leading them through a set agenda. Though the same counsellors delivered both therapies, video-based ratings by observers and feedback from clients confirmed that the therapies differed in the intended ways.

At the time of an earlier report,[119] 80 patients had been randomised and later 120 and post-treatment follow-up data was available.[120] Both reports found neither therapy preferable overall, but that this masked a very different impact on different types of clients. Those characterised by learnt helplessness did much better when the therapy required the counsellor to take the lead, while clients who felt more in control of their lives did better when the less structured therapy allowed them to set the agenda. During treatment the effect was seen in patient and therapist ratings of benefit, retention, and number of drug-free urines; in the six months after treatment, in measures of drug, family, social and psychiatric problems.[xix]

More depressed clients also did best in the more structured therapy and worst when required to take the initiative, again potentially related to their tolerance for direction: depressed clients seem unlikely to be prone to angry defensiveness. However, depression did not account for the impact of learned helplessness: when

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xviii See page 790 – correlations between patient and therapy variables very low.

xix Though these interactions narrowly missed the conventional threshold for statistical significance.

depression was statistically ‘evened out’, learned helplessness remained just as or even more significant.

By the time of a third report,[121 143] clients had been recruited to the study but the results seen earlier still held up.[122] The main reservation over this study is a low follow-up rate, just 85 of the 120 patients in the most relevant of the reports,[123] a shortfall attributed to the indigent nature of the caseload.

A message from Albuquerque

Comments from Bill Miller on an earlier draft of this review

Something going on with the therapists

One of the puzzles in our meta-analysis of 72 studies[124] is the substantial variability of effect sizes for motivational interviewing across sites and studies. The same also seems to be true for therapists within the same study. In the largest study of therapist effects,[125] we found substantial differences attributable to therapists after controlling for sites and patient characteristics. The spread was clearest with motivational therapy.

These therapists had been trained together, intensively supervised for fidelity, used the same manual, and yet a large determinant of a patient's outcome was still the therapist to whom they had been assigned. At the same time, I continue to be surprised at how robust motivational interviewing seems to be – interventionists can receive relatively modest training and still produce effects. Anyhow, there is something going on in the delivery of motivational interviewing that affects outcomes, and clearly it is not just differences in patient populations.

Making it more concrete

Though the best known, motivational interviewing is not the only way to boost the motivation of offenders ordered in to treatment. Alternative methods have been devised specifically tailored to criminal justice settings and populations where group formats and mandatory procedures are the norm and the 'clients' are often poorly educated offenders unsused to the abstract, verbal explorations involved in motivational interviewing.

The most persistent and systematic attempt to engineer such interventions has been undertaken by the 'Cognitive Enhancements for the Treatment of Probationers' (CETOP) project in Texas. The same research team from the Texas Christian University is now helping England's National Treatment Agency trial similar enhancements.[126] Though informed by motivational principles among others, their interventions attempt to enhance "readiness" for treatment more broadly, seen as consisting of knowledge of what it takes to change, the personal and external resources needed to do so, self-confidence in the ability to change, and willingness to accept and even welcome the process and consequences of implementing change. The aim is to lead participants to construct their *own* reasons for engaging in treatment beyond simply having to do so because a judge has ordered them, and then to bolster the knowledge and resources needed to make the most of the experience, countering the jaundiced view of treatment and the lack of self-confidence typical of offender populations.

In terms of delivery methods, the emphasis is on engaging, hands-on, practical activities and 'games' requiring only basic reading and verbal skills. These must be capable of being conducted in the group formats typical of criminal justice settings and easily integrated in to existing programmes – one reason for development of detailed manuals and ready-made or easily reproduced resource materials, and for the creation of a set of compatible but self-contained intervention modules which services can 'plug in' without disrupting the main programme. Though these can be used as provided there is also the opportunity to customise and add to the materials.

Helps less intellectual offenders

To date research on these interventions has found gains in indices of engagement with treatment and expectations of post-treatment success but no study has yet extended far enough to test whether there are also post-treatment improvements in substance use problems. The impacts were modest, but so too was the investment – in the major studies, the training occupied at most eight out of about 720[xx] hours of programming. Importantly, there were indications that, as expected, it particularly helped less well educated offenders and those averse to having think things through without the concrete, engaging supports provided by the training.

In an early study, offenders on probation who were being treated in a residential programme were required to complete a task listing the negative consequences of drug use and the positives of abstinence.[127] As long as this was done after they had

xx 45 hours per week for 16 weeks.

time to come to terms with the new regime (after a month rather than ten days), the result was to heighten indices of motivation.

Under the CETOP banner, the approach became far more sophisticated. The main test bed was a substance misuse therapeutic community at a community prison in Mansfield, Texas. Residents live at the centre in communities of 30–40 residents for four months of intensive therapy, training and education followed by non-residential support.[xxi] [128] [129] Residents are mainly offenders ordered there because they have violated their parole or probation order due to (or at least in association with) substance use problems. Though typically with a history drug-related offending, as a whole their drug use before starting treatment was less severe than among people seeking treatment voluntarily.[xxii]

The first CETOP study involved 500 offenders admitted to the 16 communities in 1996 and 1997. A randomly selected eight of the communities continued with normal procedures. In the other eight these were supplemented by four, two-hour "readiness training" sessions conducted in the fourth and fifth weeks of the programme.

In the first the offenders completed the *Tower of Strengths* exercise and *Weekly Planner*. In the second they played the *Downward Spiral* board game and drew 'maps' of the personal changes they have already made or wish to make. During the third session they were guided through the development of a *Personal Action List* to help them take on a positive view of treatment and identify important actions that they can take during their stay. The final session addressed ways to make the most of treatment by providing a set of techniques for enhancing memory and improving performance on cognitive or physical tasks.

Eight weeks into the programme (so two or three weeks after completing readiness training) residents in the communities which had undergone the training were more likely to see themselves and their co-residents as actively engaged in treatment, to be positive about their communities, to see their counsellors as helpful, caring and effective, and to value the community meetings which focused on substance abuse issues.[130] [131] Unexpectedly, measures reflecting the degree to which residents experienced each other as supportive and trustworthy people and a positive influence were unaffected[132] and the training was no more effective for the residents who were presumably most in need of it, the ones who at the start were least committed to treatment, a result which could have been due to the generally low commitment of the entire caseload.[133] But, as expected, these concrete supports to thinking through why treatment was needed and how to make the most of it were most helpful for the last well educated offenders.[134] When the sample was divided into those who had or had not gone further than tenth grade at school, only the group who had not reacted more positively to the training than to normal procedures. Asked to compare how they felt two or three weeks after the training to how they felt on entering the centre, they saw themselves as felt now more motivated to engage in treatment, confident that they would do so and get something positive out of it, and more motivated and confident that they could

xxi For a further three months in the first sample and two weeks in the second.

xxii In the first sample at most 38% used cocaine or heroin daily.

resist relapse to drinking or drug use. It was the reactions of the less well educated residents which on these measures created an overall advantage for the communities which had received the training.

In all these reports, though training was applied to entire communities of 30–40 residents,[135] the analysis of its effects was done in terms of how each individual responded rather than how each community had responded – a mismatch which risks overestimating the statistical significance of the findings.[136] At the same time, applying the training to entire communities which retained the same residents throughout the four months maximised the chances of influencing the therapeutic environment. The resultant effects were not large but they were consistently positive.

By the time of the second study (of residents admitted in 2000–2001), each of the centre's six communities took in batches of four or five offenders a month,[137] and it was these batches who were randomly allocated to receive readiness training or not rather than an entire community.[138] Perhaps for these reason and perhaps too because the sample (at most 210 residents) was smaller, significant overall impacts from the training (now reduced to three sessions) were few. Towards the end of the residential phase they were apparent in higher ratings of how far each resident felt their motivation to get involved in treatment and resist drug use or infection risk had increased since entering the programme.[139] In relation to the same issues their confidence too had increased more but not significantly so while there were no significant differences in the same measures taken at the middle of the residential phase or during aftercare.

This report was restricted to the 146 participants still in aftercare at the time the last measures were taken. Another taking in all 210 residents in the sample found no overall benefits from the training in their perceptions of how involved they were in treatment, whether they were disruptive or a bad influence, how much they cared for their fellow residents, or their expectations of success on leaving the programme.[140] This was the case for measures taken at the middle and the end of the residential phase and remained so even for the roughly half of the residents who had not graduated from their high schools, failing to duplicate the benefits for poorly educated offenders seen in the first study.

However, significant gains on all these measures did emerge when the residents were split into those who saw thinking things through and learning new ways as a chore versus those who welcomed 'hard thinking' work. The training had particularly helped those more averse to hard thinking, presumably because its engaging, concrete activities provided the supports they needed to get to grips with their situation and with treatment without having to think things through in ways they found hard to do. Though not large, several of the differences were statistically significant and the overall pattern of the findings from these residents was more positive after training, a pattern not seen among the other residents less in need of such supports.

When Mansfield moved to an outpatient programme, the study transferred to Wilmer in Texas which where a centre provides six months of residential treatment to offenders on probation. As yet unpublished findings indicate that the

interventions improved residents' ratings of their counsellors and of the programme.[141]

Key exercises and games

During the *Tower of Strengths* exercise, participants leaf through a pack of 60 cards each with a word or phrase describing a personal strength from six 'suits': social (eg, friendly); behavioral/physical (eg, musical); motivational (eg, determined); cognitive (eg, organized); emotional (eg, good sense of humor); and spiritual/philosophical (eg, ethical).[142] They choose ten of their existing strengths and five they'd like to have and slot these into the tower of strengths diagram. Then this is used to structure a small group discussion exploring the importance of these attributes and how they can used and developed to improve one's situation.

In the *Weekly Planner* exercise each individual selects seven inspirational quotes from a pack of 87 quote cards, one for each day of the week. The trainer asks participants to select quotes relevant to their goals and to attach these to particularly relevant days before a group discussion of what the quotes mean and how they can help. The quotes are entered on to the individual's personal weekly planner to be referred to each day.

The *Downward Spiral* board game is intended to motivate players by engagingly facing them with the potential consequences of continued substance abuse without being directly confrontational.[143] Five or six participants take on the roles of people committed to a life of substance abuse. Players move across a board filled with potential downfalls related to family, health, friendships, finances, self-esteem, and legal consequences, described on cards which players collect. The aim is to be the last player alive. Due to substance abuse, throughout the game players lose social support, health, money, and their sense of self-value. Just staying alive becomes more challenging the longer the player stays in the game.

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