DRUG & ALCOHOL FINDINGS *Hot topic*

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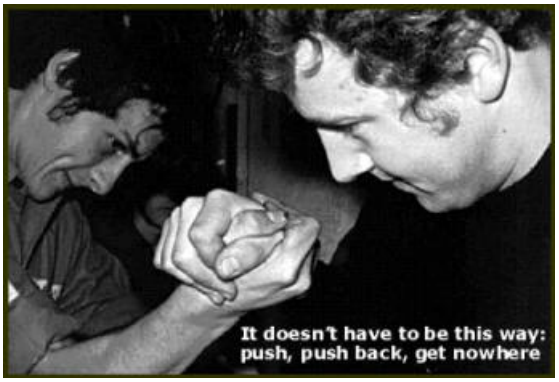
GO Motivational interviewing: fast and flexible counselling style

Said to have "conquered the addiction treatment field", motivational interviewing was first formally documented in 1983 when William Miller noted that many drinkers resist treatment because they reject stigmatisation as an 'addict' or 'alcoholic' and the loss of control implied by being a patient. 'Bill' Miller developed an approach which explicitly avoided these and other deterrent interactions, instead amplifying aspects of the client's ambivalence towards their substance use to nudge them in a seemingly non-directive (but actually directive) manner towards finding their own reasons to cut back.

A key shift was from seeing motivation to change substance use as a fixed characteristic, to seeing it as an interpersonal process that could be affected through therapy. Anyone taking this reformulation seriously could no longer dismiss the addict as unwilling to change; the onus shifted to the counsellor's ability to elicit motivation by highlighting discrepancies between the client's substance use and their valued goals and beliefs.



An initial randomised trial from Bill Miller's team published in 1993 ended by seeming to vindicate the approach for problem drinkers, but the findings were disappointing. Clients allocated to the empathic motivational interviewing style did further curb their drinking compared to those allocated to an explicitly directive, confrontational approach, but effects were small and failed to reach conventional levels of statistical significance.

What rescued the approach was when (with the aid of audiotapes of counselling sessions) the researchers focused on how counsellors *actually* behaved rather than how they were meant to. The more the counsellor had confronted (arguing, showing disbelief, being negative about the client), the more the client drank a year later. Drinking was also elevated to the degree that the client had exhibited 'resistant' behaviours like interrupting the therapist, arguing, avoiding therapeutic interactions, or being negative about their need to change or prospects for changing. These relationships were very strong and highly statistically significant, but (see our commentary) the way they were generated meant they lacked the reassurance of a playing field levelled by randomisation.

Not easy to pin down and not easy to learn

Bill Miller's 1993 study exemplified a key strength of the approach for practice – and a major headache for researchers who need to pin down whether what they are evaluating really is motivational interviewing. A counselling style rather than a counselling programme, motivational interviewing's originators did codify broad principles, and some associated techniques (like decisional balance – pros versus cons – exercises) became commonly applied, but it remains a fluid approach heavily dependent on the skill of the counsellor and adaptable to many different situations. No attempt was made to license it as a defined product controlled by its owners. For researchers and reviewers, this posed the difficulty of deciding whether in any particular study the adaptations went so far that the counselling no longer embodied the (as it came to be called) 'spirit' of motivational interviewing, or whether counsellors had actually been unable to sustain what to many is an unnatural stance.

> *Handing staff an expert manual and ensuring they follow it undermines the approach*

That leads to another key characteristic of motivational interviewing: that it is best learnt by being coached over time via expert feedback and guidance, much as a sports coach might review with the players a video of the last game, reinforcing the good points, pointing out where they fell short, getting them to practise how they could have done it better, then checking a later video to see if the tips had been absorbed. Quick fixes are at best suboptimal and for patients may be useless. Handing staff an expert manual and ensuring they follow it undermines the approach (▶ below), and the typical one-off workshop needs to be supplemented by performance feedback and expert coaching before substance use patients feel the benefit, a finding supported by a synthesis of research on the impact of motivational interviewing training on clinicians' behaviour.

Treatment seekers versus non-seekers

Not predicated on a motivated, treatment-seeking client, and defined broadly in terms of spirit and principles, motivational interviewing's great advantage is its wide applicability. Targets range from risky but as yet non-problematic drinkers or drugtakers identified by screening programmes, to established addicts who recognise they need help, but welcome being afforded the dignity of self-definition and self-control. It is, however, important to separate out these applications. The motivational state of people who decide they have a drinking problem and seek treatment is likely to be very different from that of people intercepted while (for example) visiting their GPs for something else entirely.

Appropriate comparators also differ. For people seeking intervention, the key issue is whether motivational interventions are preferable to other treatments. When all relevant studies are amalgamated, the answer seems to be, not much, but they do usually take less time. A similar message emerged from the most definitive trials in the USA and in Britain, which also generally failed to find the expected 'matches' between different types of patients and different types of

also generally failed to find the expected 'matches' between different types of patients and different types of therapies, including therapies based on motivational interviewing.

For people identified through screening, the main issue is whether having a motivational intervention 'seek them' is better than nothing. Across relevant studies, usually it is better, but that depends to a surprising degree on who is doing the motivating, a finding which emerged from studies as different as one in London involving cannabis-using students, and one in Switzerland involving heavy-drinking emergency patients. In both cases, how far counsellors embodied the spirit of motivational interviewing in their comments and tone, and in particular the skill of 'reflective listening', were among the factors which made a difference.

Also assessed by reviewers is whether brief alcohol interventions based on motivational interviewing reduce drinking more than other approaches. The first problem for the review was the relative paucity of studies in which motivational interviewing was *not* a basis for the intervention – 12 out of 52, a sign of how far the approach has pervaded research. Key finding was that whether motivational interviewing was the basis made no statistically significant difference to an intervention's impact on drinking. In fact, when it came to quantities consumed, non-motivational brief advice had a slight edge. For frequency of drinking, the position was reversed, motivational interventions having a slightly greater impact. Overall, there was little support for motivational interviewing comprising an important active ingredient of brief interventions, in the absence of which their impacts are significantly weakened.

The review's findings are in line with those from the English SIPS brief intervention studies conducted in GPs' surgeries, emergency departments and probation offices. In all three settings, relatively unsophisticated and brief advice was no less effective than longer interventions which drew on motivational interviewing.

Sometimes best to break the rules

Motivational interviewing was built on Carl Rogers' classic formulation of the six "necessary and sufficient conditions" for psychotherapy clients to get better, including communicating genuineness, unconditional positive regard, and empathic understanding of clients in need of help to get their actions, thoughts and self-perceptions in line. What Bill Miller added to this foundation was directive strategies and techniques geared to moving the client in the desired direction, including: sharpening their perception that how they actually behave is not how they wish to; generating client statements indicative of a desire, intention and ability to move in this direction; and securing a commitment to do so – the last two categories constituting 'change talk', for motivational interviewing, the crucial precursor of actual change. During this process, resistance to change is also expected to wilt as it finds no grist in the form of confrontation or other therapist behaviours incompatible with motivational interviewing, and as the client finds reasons not to resist.

Motivational interviewing's record was explored in our reviews of the approach as a preparation for addiction treatment and of findings on matching counselling styles to the client. We discovered it has worked best when therapists have not been tightly constrained to work to a manual, findings later confirmed by a synthesis of outcomes from relevant research. Unexpectedly, we also found that motivational interviewing can actually be counterproductive among patients who welcome explicit direction or who are already committed to a way out of their substance use problems.

The implication is that sometimes it really is best just to tell patients what they should do or otherwise break motivational interviewing's 'rules' rather than inflexibly following the manual. One explanation is that the quality of seeming genuine, long recognised as one of the keys to effective therapy, can suffer from drilling in techniques and in withholding normal caring responses in order to adhere 100% to motivational principles. In certain circumstances, avoiding explicitly directive advice and warnings can seem as uncaring and unnatural as suggesting to a pedestrian heading blindly towards a pit that they consider the pros and cons of stepping forward, but in the end it is up to them; the natural and caring response is to shout, 'Stop!'

Even if deprecated in motivational interviewing, in some situations, the natural and caring response is to shout, 'Stop!'

Active ingredients

In 2016 a systematic review investigated whether motivational interviewing's proposed mechanisms had been supported by research, breaking this down into the influence of the Rogerian qualities of empathy and embodying the spirit of motivational interviewing, versus using the approach's more interventionist or directive techniques like selectively reflecting back the client's comments, open questions, offering affirmations and support, and emphasising client control. Of the 37 studies found for the review, 29 were of drinking or drug use. In some the approach had been the basis for a brief intervention for risky substance users identified through screening, in others, a component of treatment for problem/dependent users.

The review found that using motivational interviewing techniques was fairly consistently related to the generation of change talk, and change talk was fairly consistently related to actual change – the expected causal chain. But using these techniques more often did not consistently have the desired results, such as greater reductions in substance use. Unlike motivational techniques, greater levels either of empathy or of embodying the spirit of motivational interviewing did not consistently generate change talk. But like the techniques, the relationship to outcomes was inconsistent, though stronger when both qualities were enhanced rather than one or the other.

Overall, the studies included in the review seemed to suggest that talk about change can be elicited by motivational techniques, among which selectively reflecting back the client's comments is the most consistently effective, but that increasing use of these techniques or greater adherence to the spirit of the approach are often unrelated to final outcomes.

Key 'mechanism' studies

Such reviews are, however, no substitute for definitive studies, and for motivational interviewing, the most definitive was a rare randomised trial of its distinct and supposedly active ingredients. Though a small study and partially contradicted by a predecessor, the findings cast doubt on whether motivational interviewing's distinct mechanisms really are active ingredients, turning the spotlight (at least among treatment-seeking, stable, and not very dependent drinkers) on the patient's own impetus to change. It also seemed that change talk did not *cause* change, but was a sign of the impetus to change, a sign elicited by motivational techniques.

Recruiting mainly via ads, the trial had netted 89 generally stable, moderately dependent drinkers, who were aiming to cut down on their drinking rather than stop altogether. At random they were allocated either to fully-fledged motivational interviewing combining its Rogerian spirit with directive techniques, to just the non-directive or Rogerian

motivational interviewing combining its Rogerian spirit with directive techniques, to just the non-directive or Rogerian elements, or to a self-change option in which participants were told to try to change on their own over the next eight weeks, after which they would be offered treatment. Self-change participants were told some people could cut down without professional support, and that monitoring their drinking and being interviewed for research purposes might help.

Generally, the directive elements made no further difference to the drinking reductions achieved by the patients, and neither version of motivational interviewing led to significantly greater reductions in drinking than the self-change option. However, fully-fledged motivational interviewing may have accelerated those reductions. Confusingly, a previous similar study had found the directive elements augmented the intervention's impact on frequent heavy drinking. The supplementary text in our commentary explored possible reasons for the discrepancy.

For non-treatment seekers identified through screening and offered a brief alcohol intervention, the definitive studies are a series (highlighted in cell B1 of the Alcohol Treatment Matrix) which capitalised on the fact that at age 20 Swiss men are assessed for fitness to be conscripted into the army. One of the studies set out to reveal the impact of the counsellors rather than the intervention by recruiting 18 who differed widely in professional status, clinical experience, and experience of motivational interviewing. Left to their own widely differing devices, best results came from the more experienced counsellors, those who were more confident of their motivational interviewing abilities and of the efficacy of the approach, and/or who were rated as especially proficient. On average, it could not be shown that counsellors and sessions outside these upper ranges were any better at reducing risky drinking than no counselling at all.

> *Saying lots of the 'right' things matters little, but just one 'wrong' comment can be destructive*

That much was perhaps not unexpected, but it was the details in this study which were thought-provoking. Experience was important, but only because it was associated with better motivational interviewing skills, an amalgam of demonstrating acceptance of and empathy with the client and embodying the collaborative spirit of the approach. So-called 'complex reflections' – the times when the counsellor reflected back the client's feelings or comments, but with a spin which extended or deepened their meaning – seemed particularly important. When these formed a relatively small portion of all the reflections whether simple or complex, the brief intervention made no difference to drinking; when a larger portion, drinking was reduced.

In surprising contrast, simply accreting more of the other responses considered compatible with motivational interviewing actually seemed counterproductive. It seemed that frequent interjections by the counsellor which conveyed support, affirmation, straightforwardly reflected back the client's comments, and so on, were fine, but when these became *very, very* frequent, something was happening to make the session ineffective.

The other side of the equation was counsellor comments *in*compatible with motivational interviewing. These were very *un*common – usually one or none per session – but when they happened, that session was no more effective at moderating drinking than no counselling at all.

In cell B1 of the Alcohol Treatment Matrix, these and other findings led us to ask, "Is it what you *don't* do that matters?" Generalising across the studies listed in the cell, it seemed that that saying lots of the 'right' things in a brief motivational intervention matters little, while just one lapse to the 'wrong' sort of comment can be destructive.

Our commentary on another Swiss study which corroborated some of these findings explored the implications of these and other studies of how motivational interviewing works. One implication was confirmed by a US training study: that recruiting clinicians who have not been trained in motivational interviewing, but take to it naturally, will net you more competent therapists than trying to turn round less promising recruits through training. Not only were the promising recruits better to begin with, they also gained most from the training.

Choose your search

Taking to heart the distinction made above between applying motivational interviewing to treatment seekers versus non-seekers, we offer different search strategies for finding more information in the Effectiveness Bank. To narrow in on treatment-seekers run this search; for non-treatment seekers identified through screening, run this search. For both, run this omnibus search.

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