ALCOHOL DRUG FINDINGS *Research analysis*

This entry is our analysis of a study considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original study was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. Links in blue. Hover over orange text for notes. Clicking underlined text highlights passage referred to. The Summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

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Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles.

Miller W.R., Benefield R.G., Tonigan, J.S.

Journal of Consulting and Clinical Psychology: 1993, 61, p. 455–461.

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Probably more than any other, this seminal study heightened the profile of the therapist's interpersonal style in substance use counselling, seeming to confirm that by not provoking resistance, the non-confrontational style mandated by motivational interviewing reduced drinking compared to the then more typical blunt and challenging approach.

SUMMARY This account is adapted from the Findings review The motivational hello.

Motivational interviewing was developed as counselling style which would avoid resistance-provoking confrontation and instead 'non-directively' stimulate and take advantage of the client's own ambivalence to bolster motivation to change. The very first trials were conducted by the co-originator William Miller's research team based at Albuquerque in New Mexico. While they had the unique benefits of his expert tuition and oversight, at this stage there was no manual for them to follow.

The first two tests of motivational interviewing were as a standalone brief intervention combined with the Drinker's Check-up, a two-hour battery of tests of alcohol use and related physical and social problems. In the first study, heavy drinkers responded to ads offering the check-up, which was followed a week later by a single session feeding back the results in a motivational interviewing style. Two-thirds had their check-ups without delay while a randomly selected third had to wait six weeks. Over this period there seemed no change in their drinking, while in the six weeks following feedback alcohol consumption fell by 27%, a reduction sustained for at least 18 months. However, about two-thirds were still drinking heavily and experiencing alcohol-related problems. During this time a third of the sample had sought further help when few had done so before.

These outcomes suggested that motivational feedback was often insufficient in itself, but could serve as a useful motivator of change and treatment entry in this type of population – drinkers a long way from seeing themselves as alcoholics (most saw themselves as 'social drinkers') but concerned enough to respond to the offer of a check-up. After years of alcohol problems, it seemed the offer of a 'check-up' had enabled them to take a first step towards seeking help without violating their self-image as non-alcoholics.

The next (and the featured) study was similar, except that feedback was provided in one of two styles. One was the empathic motivational interviewing style, the other the supposedly counterproductive style this aimed to improve on: explicitly directive, confronting client resistance, arguing when they minimised their problems, and (when the cap fitted) telling them they were alcoholics. Again, feedback was followed by substantial reductions in drinking not seen in those who had to wait six weeks.

As expected, giving feedback in the empathic style did result in greater reductions in drinking, but the effects were small and failed to reach conventional levels of statistical significance. One reason may have been that, though they did differ in the intended ways, analysis of audiotaped sessions revealed considerable overlap between the two styles, which were delivered by the same therapists. For example, confrontation was practically absent in the motivational style and noticeable in the directive, yet even here it was rare. Conversely, though there was more 'restructuring' in the motivational sessions, this core technique was rarely deployed compared to simple listening or 'teaching', responses not characteristic of motivational interviewing.

Only when the researchers focused on how therapists and clients had *actually* behaved did significant findings emerge. The more the therapist had confronted (arguing, showing disbelief, being negative about the client), the more the client drank a year later. The same was true of 'resistant' client 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. During sessions these behaviours seemed to feed off each other resulting in them being highly correlated. In general, client resistance behaviours were strongly correlated with therapist confrontational responses, while positive, self-motivational client responses were related to therapist listening and restructuring.

There was also a statistically significant indication that the motivational style was most effective with drinkers who did not believe their own or other people's frequent heavy drinking was a manifestation of the disease of alcoholism, but rather that is was more like a bad habit. This effect was absent for the directive counselling style.

FINDINGS COMMENTARY Despite their strength, what the relationships between actual client and therapist behaviour and later drinking meant is unclear, because there was no way to pin down what was cause and what effect. For motivational interviewing, the favoured interpretation is that when therapists confronted, clients were provoked in to hitting back or withdrawing, rare but powerfully

counterproductive interactions. In this scenario, by adopting motivational interviewing's non-

counterproductive interactions. In this scenario, by adopting motivational interviewing's non-confrontational style, therapists would avoid provocation and improve outcomes.

But the causal chain could have been the other way round: perhaps clients who were always going to resist change argued and interrupted more, provoking therapists to argue back. We know this can happen from a British study which used actors to mimic either highly resistant smokers angry about being referred for counselling, or more contrite ones keen to reverse a relapse. The former provoked counsellors into non-motivational-style responses including unilateral agenda-setting, confrontation, and closed-end questions, all related to poorer outcomes with this kind of resistant patient.

Whether the Albuquerque therapists were also provoked by resistant clients is unclear. Arguing against is the fact that therapist and client behaviours *were* changed by the assigned therapist style – they were not simply determined by whether the client was difficult to begin with. From the client, the motivational style elicited twice as many statements acknowledging their problems and fewer resistant behaviour such as arguing, interrupting and introducing irrelevant topics. And though not possible in this study, some key studies of the impact of therapist behaviours have been able to eliminate the possibility that were simply reacting to the clients (1 2 3 4).

Conceivably, a combination of both processes – therapist influencing client and the reverse – explained the results in Albuquerque. Whatever the truth, probably more than any other, this study heightened the profile of the therapist's interpersonal style in substance misuse research, seeming to confirm that the style mandated by motivational interviewing was preferable to confrontation.

In this early study we also have an indication that certain types of patients are best suited to a motivational style – those whose views of 'alcoholism' chimed more with its non-directive approach. It seems understandable that clients convinced they were instead talking about a disease process would not be put off by – in fact, would probably expect – medical-type directiveness in diagnosis and remedy from an expert in this disease, just as they would if they went to a doctor with a physical complaint. The 'It's up to you – what do you think?' stance of motivational interviewing might well feel inappropriate to the urgency and danger of a progressive disease which required specific responses. Other studies have investigated and corroborated similar matching effects.

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