Motivational Interviewing in Addiction Treatment

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Overview

1. Brief introduction to MI (as of 3rd edition, 2013)
2. MI as a freestanding intervention
3. Adding MI to other treatment
4. MI as “intake” and an alternative to waiting
5. MI as an integrative clinical style for treatment
6. Developing MI skills

1. A Brief Overview of MI

Ambivalence

STATUS QUO

CHANGE
THE RIGHTING REFLEX

Persuasion: What Goes Wrong?

What happens when . . .

The Righting Reflex Ambivalence

What is MI?
Motivational interviewing is a collaborative conversation style for strengthening a person’s own motivation and commitment to change.

Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change.
Four Fundamental Processes in Motivational Interviewing:

1. Engaging
2. Focusing
3. Evoking
4. Planning

OARS: Basic Engaging Skills

- Open questions
- Affirm
- Reflect
- Summarize
Evoking: The Heart of Motivational Interviewing

What is Unique to MI?

- Intentional, differential evoking and strengthening of change talk
- Strategic goal-directed use of client-centered counseling methods (reflection, summary)

Change Talk Skills: How to . . .

Recognize Change Talk
Evoke Change Talk
Respond to Change Talk

CHANGE TALK AND SUSTAIN TALK

Opposite Sides of a Coin
Recognizing Change Talk

- Change talk is any client speech that favors movement in the direction of change
- Change talk is by definition linked to a particular behavior change goal

Preparatory Change Talk
Four Examples

- **DESIRE** to change (want, like, wish...)
- **ABILITY** to change (can, could...)
- **REASONS** to change (if... then)
- **NEED** to change (need, have to, got to...)

Mobilizing Change Talk
reflects resolution of ambivalence

- **Commitment** (intention, decision, promise)
- **Activation** (willing, ready, preparing)
- **Taking steps**

CATs

Examples of Change Talk
about smoking cigarettes

- I wish I could stop smoking. (D)
- I think I could do it. (A)
- I would save a lot of money. (R)
- I really need to quit. (N)
- I am going to quit. (C)
- I am willing to quit. (A)
- I bought those nicotine patches. (Ts)
Examples of Sustain Talk
The other side of ambivalence

- I really like smoking (D)
- I don’t think I can quit (A)
- I have to smoke to relax (R)
- I don’t think I need to quit (N)
- I intend to keep on smoking and nobody can stop me (C)
- I’m not willing to quit (A)
- I bought four cartons this week (Ts)

Change Talk Challenge

Listening for Change Talk

- The change target is improved glycemic control
- Possible health behaviors:
  -
  -
  -
  -

Listening for Change Talk

If it’s Preparatory change talk (DARN)
Drum!

If it’s Mobilizing change talk (CATs)
Applaud!

If it’s not change talk,
Keep quiet!
9 counselors switched every 12 minutes between:
- MI: Seeking to evoke change talk and
- FA: Functional analysis of drinking
- in conversations with 47 people about their drinking concerns
- Coded change talk (CT) and sustain talk (ST)

Higher client change talk and lower “resistance” predicts treatment outcome (behavior change) – and not just in MI
- Client change talk increases and “resistance” decreases with MI-consistent practice
- Counselors can increase or decrease client change talk, sustain talk, and discord
- Accurate empathy matters

Glynn & Moyers (2010), Journal of Substance Abuse Treatment 39: 65-70
Sustain Talk and Discord

- **Sustain Talk** is about the target behavior
  - I really don’t want to stop smoking
  - I have to have my pills to make it through the day
- **Discord** is about your relationship
  - You can’t make me quit
  - You don’t understand how hard it is for me
- **Both predict lack of change**
- **Both** are highly responsive to counselor style

Deconstructing “Resistance”

- **Sustain Talk**
- **Discord**

SO IT’S MI WHEN . . .

1. The communication style and spirit involve person-centered, empathic listening (Engage) AND
2. There is a particular identified target for change that is the topic of conversation (Focus) AND
3. The interviewer is evoking the person’s own motivations for change (Evoke)
A taste of MI

**Listener**
- Listen carefully with a goal of understanding the dilemma; Give no advice
- Ask these four open questions:
  - Why would you want to make this change?
  - How might you go about it, in order to succeed?
  - What are the three best reasons for you to do it?
  - On a scale from 0 to 10, how important would you say that it is for you to make this change?
  - Follow-up: And why are you at ___ and not zero?
- Give a short summary/reflection of the speaker’s motivations for change
- Then ask: “So what do you think you’ll do?”

**A Change of Role**
- You don’t have to make change happen.
  - You can’t
- You don’t have to come up with all the answers
  - You probably don’t have the best ones
- You’re not wrestling
  - You’re dancing

**Speaker**
- Something that you
  - want to change
  - need to change
  - should change
  - have been thinking about changing
- but you haven’t changed yet
- i.e. – something you’re ambivalent about
Some examples of where MI has been applied and tested:

- Brief intervention in primary health care
  - ("opportunistic intervention" such as SBIRT)
- In emergency departments and trauma centers
- As early preventive intervention
  - (the "drinker’s check-up")
- With alcohol-referred college students (BASICS)
- In health promotion efforts
  - (e.g., water purification adoption in Zambia)

What is Motivational Enhancement Therapy (MET)?

- MET = MI + Personal assessment feedback
- Began with the “drinker’s check-up”
  - Almost no one went to treatment, but most significantly reduced their alcohol use
- Became MET in Project MATCH
  - Compared with CBT and 12-step Facilitation
  - Equivalent outcomes throughout 3 years
- In meta-analyses (e.g., Apodaca, Hettema) assessment feedback does not moderate outcomes of MI

Publications on MI by Year (Cumulative, from Google Scholar)
**MI Outcome Research**

- > 200 randomized clinical trials published
- About 60% of trials show significant benefit
- Average effect size in small to medium range
- High variability in effectiveness across therapists, sites, and studies
- MI is more effective when
  - Fidelity of practice is high
  - No therapist manual is used
  - Clients are less ready to change
  - Clients are from ethnic minorities

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**Therapist Empathy**

Miller, Taylor & West (1980) JCCP 48:590-601

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**Client Drinking Outcomes Accounted for by Therapist Empathy**

<table>
<thead>
<tr>
<th>Time</th>
<th>Empathy Level</th>
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<tbody>
<tr>
<td>6 months</td>
<td>100%</td>
</tr>
<tr>
<td>1 year</td>
<td>75%</td>
</tr>
<tr>
<td>2 years</td>
<td>75%</td>
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<td>3 years</td>
<td>33%</td>
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<td>7 years</td>
<td>40%</td>
</tr>
<tr>
<td>8 years</td>
<td>25%</td>
</tr>
<tr>
<td>9 years</td>
<td>25%</td>
</tr>
</tbody>
</table>

6 months: r = .82  
1 year: r = .71  
2 years: r = .51

Miller & Baca (1983) Behavior Therapy 14:441-448

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**Counselors’ Interpersonal Skill (Rogers) and Clients’ Drinking Relapse Rates**


Patients in treatment for alcoholism were randomly assigned to counselors with:

- LOW levels of empathy and related skills
- MEDIUM levels of empathy and related skills
- HIGH levels of empathy and related skills

What percentage of patients relapsed?
Responding to Change Talk
All EARS

- Elaborating: Asking for elaboration, more detail, in what ways, an example, etc.
- Affirming – commenting positively on the person’s statement
- Reflecting, continuing the paragraph
- Summarizing – collecting bouquets of change talk

Preparation

- Write down a few statements about some change that you are thinking about making within the next six months:
- D: Why you want to make this change
- A: How you could do it
- R: A good reason for making the change
- N: How important it is, and why
- C: What you intend to do
- A: What you are ready or willing to do
- T: What you have already done
**Easy as 1-2-3: Groups of 6**

- Sit in a circle of 6
- 1. One speaker offers a change talk statement
- 2. Person to the right (listener) responds *once* by E, A, or R:
  - Speaker responds naturally
  - Next speaker to the right – Affirm
  - Speaker responds naturally
  - Next speaker = Summary of change talk
- Then the person to Right of the speaker becomes the next speaker

**One observer:**

- Observer is not a speaker or listener
- For each 1-2-3 sequence record:
  1. Was it change talk (+/-)
  2. How did the listener respond? E, A, R, or X (other)
  3. Was the speaker’s reply change talk? (+/-)
- Challenge: When you hear a change talk statement, was it DARN, CATs or something else?

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**3. Adding MI to Treatment**

MI or MET as a separate component added to other treatment

Does it increase the effectiveness of treatment?

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**Combining MI with Other Evidence-Based Treatments**

- Additive rather than horse-race research
  - Competitive: MI vs. Treatment X
  - Additive:
    - MI vs. MI + Treatment X
    - Treatment X vs. MI + Treatment X
- When MI is added to another EBT, both treatments tend to work better
- Medium effect size of MI endures over a year of follow-up when added to an EBT
Effect Size of MI Over Time
(Hettema et al, 2005 meta-analysis)

Follow-up Months

Randomized trials with >2:1 abstinence advantage when adding MI to addiction treatment

  Brown & Miller (1993)

ENGAGING

- This is task #1 – often overlooked
- Client-centered counselor skills predict outcome in addiction treatment
Some Guidelines with Questions in Conversations about Change

- Ask fewer questions!
- Don’t ask three questions in a row
- Ask more open than closed questions
- Offer two reflections per question asked
- Think engagement rather than assessment as your initial task.

“Intake” and the Assessment Trap

- Feeling like a lot of information is needed before being able to help
- Intake as an assessment prerequisite rather than the beginning of treatment
- Patient in a passive and one-down role
- Provider controls the session and the patient responds with short answers
  - Giving short simple answers
  - Active expert and passive patient
  - Little opportunity to explore their own motivation and offer change talk
  - Not able to talk him/herself into change.

The Expert Trap

- Information in/Answer out
  - Once I’ve collected enough information I will have the answer....
- Uneven power relationship
- An expert role doesn’t work well when personal change is needed
  - You don’t have the answers for clients without their own expertise and collaboration

The Pernicious Waiting List

Harris & Miller (1990) Psychology of Addictive Behaviors, 4, 82-90
Groups of Three:
   Speaker, Interviewer, and Observer

Speaker’s topic:
   A change that you want to make.
   PS. It doesn’t have to be a problem!

Ask open questions to evoke change talk.

When you hear change talk, respond with EARS:
   E: Ask for an example of elaboration
   A: Affirm
   R: Reflect the change talk
   S: Offer summaries of the change talk

Some examples of open questions:
   D: What change do you want to make?
   A: Given what you know about yourself, how might you go about it in order to succeed?
   R: What are some good reasons for ______?
   N: On a scale from 0-10, how important is it for you to ______? ... Why that number instead of 0?
   A: What you are ready or willing to do?
   T: What you have already done?
   C: What you intend to do?
Talk to the speaker
Describe all the change talk that you heard
What you are doing in essence is giving an MI summary

If MI were integrated into CB treatment?
  • What WOULDN'T change?
  • Would clinical style change across integration?
  • How might clinicians approach CB tasks
    ◦ Homework
    ◦ Roleplay
    ◦ Patient “refusal”

MI not just as an added module, but as a clinical style that permeates treatment
  • Combined Behavioral Intervention (NIAAA)
  • Marijuana Treatment Project (NIDA)
  • MI + Community Reinforcement Approach
    ◦ Zuni
    ◦ Denmark
  • Psilocybin study
    ◦ MI + Interactive Journal + Medication
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**Therapy “Homework”**

Assigning vs. negotiating via EPE

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**Cognitive Restructuring: Contrasting Approaches**

- Didactic vs. Socratic approach
- ABC links: Evoking examples of B-C links
- Generating alternative thoughts (B)
- Evoking consequences of alternative thoughts or assumptions

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**6. Developing MI Skills**

- Therapist MI skills can be measured reliably from practice recordings
- MI skills increase with training
  - Reading or workshop alone yield little change
  - Ongoing feedback and coaching are important
- Client change talk increases with therapist training
- Years of postgrad education unrelated to ability to learn MI

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Evaluating Methods for Motivational Enhancement Education (EMMEE)


Funded by NIDA

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**Study Design**

140 clinicians randomly assigned to:
- W: 2-day CPE workshop only
- WF: Workshop + Feedback from practice samples
- WT: Workshop + 6 Telephone Coaching sessions
- WFT: Workshop + Feedback and Coaching
- SC: Self-Training Control (waiting list)

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**Did clinicians learn the treatment method?**

- Trained groups > control at 4 months, p < .001
- All enhanced training groups exceed criterion
  - Due mostly to decreased MI-inconsistent responses

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**Percent MI-Consistent Responses**

- Trained groups > control at 4 months, p < .001
- All enhanced training groups exceed criterion
  - Due mostly to decreased MI-inconsistent responses
Did their clients respond any differently?

No significant increase except in Group WFT

### Continuing to Learn MI

- Seek additional training
- Let your clients teach you: Attend to change talk and commitment language
- Record sessions and listen to or code them
- Have a practice sample expert coded
- Obtain some expert coaching
- Form a peer interest/supervision group to discuss, view training or practice tapes, etc.
- Access materials from the MI website

### Learning Communities

- Learning MI requires practice
- People learn from each other
- Form a learning community
  - Facilitated (expert present) or Peer
  - Always listen to and discuss work samples
After 30 years of research we have a clinical method that is:

- Evidence-based >200 clinical trials
- Relatively brief
- Specifiable (but be careful with manuals)
- With specifiable mechanisms of action
- Verifiable – Is it being delivered properly?
- Generalizable across problem areas
- Complementary to other treatment methods
- Crosses cultures well (47 languages)
- Learnable by a broad range of providers