

# MOTIVATIONAL INTERVIEWING

## Engaging People into Treatment and Change

Allan Zuckoff, PhD

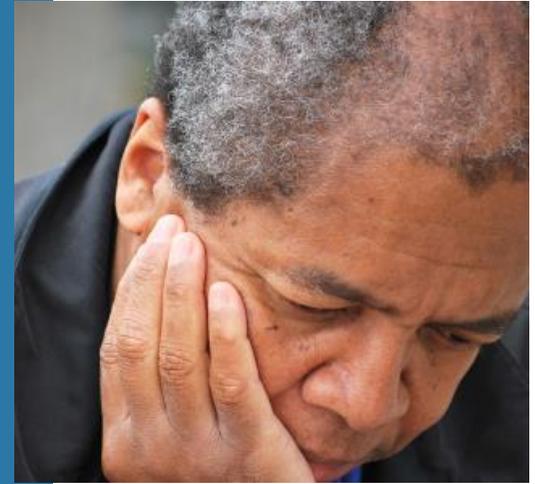
Lecturer in Psychology and Psychiatry

University of Pittsburgh

Past Chair, Board of Directors

Motivational Interviewing Network of Trainers

[zuckoffa@pitt.edu](mailto:zuckoffa@pitt.edu)



# *Engagement in Alcohol & Drug Treatment*

- ◆ Deane, Wootton, Hsu, & Kelly, 2012
  - Measured dropout by 3 months from 8 residential (modified therapeutic community) drug and alcohol treatment programs run by the Australian Salvation Army (N = 618)
    - ◆ 10 month program

# *Engagement in Alcohol & Drug Treatment*

- ◆ Deane, Wootton, Hsu, & Kelly, 2012
  - 57.3% dropped out before 3 months
    - ◆ Minimum length of treatment sufficient to result in significant improvements (e.g., Simpson, 1979)
  - This is at the low end of the range for dropout from long-term programs
    - ◆ 50 – 80%

# *Engagement in Alcohol & Drug Treatment*

- ◆ In randomized controlled trials of outpatient alcohol treatment, 18% of patients drop out after 1 visit, 26% from 1-4 weeks, 30% from 2-5 months; 25% of patients remained after 6 months
  - Carroll (1997)

# *Engagement in Mental Health Treatment*

- ◆ 40% of clients in 12 psychotherapy studies did not attend a single session
  - Hampton-Robb, Qualls, & Compton (2003)
- ◆ 47% of clients in 125 psychotherapy studies dropped out prematurely
  - Wierzbicki & Pekarik (1993)

# *Engagement in Mental Health Treatment*

- ◆ 20% of clients in 669 psychotherapy studies (26% in effectiveness studies) discontinued prematurely
  - Swift & Greenberg (2012)
- ◆ In the US, the average number of sessions attended in employee assistance, university clinic, local and national HMO clinic, and community mental health settings was 3-5
  - Hansen, Lambert, & Forman (2002)

# *Engagement in Alcohol & Drug Treatment*

- ◆ Deane, Wootton, Hsu, & Kelly, 2012
  - Why? Looked at 11 possible client factors
    - ◆ Age, Gender, Primary substance used, Criminal involvement, Alcohol or drug cravings, Symptom distress, Self-efficacy to abstain, Spirituality, Forgiveness of self, Forgiveness of others, Life purpose
  - All of these together explained less than 10% of the variance in dropout

# *Engagement in Alcohol & Drug Treatment*

- ◆ Deane, Wootton, Hsu, & Kelly, 2012
  - Why were they surprised?
    - ◆ “Finding reliable predictors of dropout and retention in drug treatment has proven difficult in prior settings... Numerous other empirical studies have found few client-related predictors, and, of these, the amount of variance explained has been moderate at best... Furthermore, individual predictors have generally been found to be inconsistent across studies...”

# *Engagement in Mental Health Treatment*

- ◆ No patient characteristics have been consistently supported in research on anxiety disorders treatment
  - Taylor, Abramowitz, & McKay (2012)
- ◆ Younger, less educated clients dropped out of therapy at slightly higher rates
  - Swift & Greenberg (2012)

# *Engagement in Medical Treatment*

- ◆ No appreciable or predictable effect sizes have been uncovered as a consequence of patient characteristics, personality traits, or demographic factors
  - Christensen & Johnson (2002)

# *Engagement in Treatment*

- ◆ Looking for the reasons for failure to engage in treatment and change in client characteristics is not the answer

*Why don't clients engage in  
treatment and change?*

# *Against Change*

- ◆ The benefits are outweighed by the costs
  - The unfamiliar is scary
  - Loss of ease/pleasure/satisfaction
  - Current behavior helps cope with stress
  - Impact on lifestyle and other priorities
  - Effect on social connections / relationships
  - Guilt and shame
  - Threat to sense of self
- ◆ Fear / expectations of failure

# *Against Treatment*

- ◆ Low Motivation for Change
- ◆ Practical Issues
  - Finances
  - Access
  - Conflicting Obligations
  - Safety
- ◆ Symptom Issues
  - Vegetative
  - Affective
  - Cognitive
- ◆ Functional Issues
  - Life in chaos
  - Multi-tasking
  - Demands of substance use

# *Against Treatment*

## ◆ Treatment Characteristics

- Intensity
- Modality
- Quality

## ◆ System Factors

- Provider overload
- Service fragmentation

## ◆ Negative Expectancies

- Efficacy
- Aversiveness
- Necessity

## ◆ Negative Experiences

- Personal
- Vicarious

# *Against Treatment*

## ◆ Help-Seeking Attitudes

- Privacy vs. Self-disclosure
- Self-reliance vs. Dependency
- Care-giving vs. Self-care

## ◆ Relationship Expectancies

- Authoritarian/Controlling vs. Authoritative/Guiding
- Exploitative/Intrusive vs. Respectful/Supportive
- Incompetent/Uncaring vs. Nurturant/Involved

# *Against Treatment*

- ◆ Cultural issues
  - Stigma
  - Community preferences
  - Client / Clinician differences
    - ◆ Race
    - ◆ Religion
    - ◆ Ethnicity
    - ◆ Gender
    - ◆ Age
    - ◆ Class

# *When Do People Engage in Treatment and Change?*

*“Ready, Willing, and Able”*

## ◆ Importance

- Problem recognition
- Favorable Cost/Benefit Expectancies
  - ◆ Expected benefits outweigh the costs
  - ◆ Expect decision to make things better
- Values
  - ◆ Decision supports what matters most

# *When Do People Engage in Treatment and Change?*

*“Ready, Willing, and Able”*

## ◆ Confidence

- High self-efficacy (believe change is possible)
  - ◆ Specific
  - ◆ Global

## ◆ Commitment

- Form an intention to change
- Make change a priority

# *Treatment and Change*

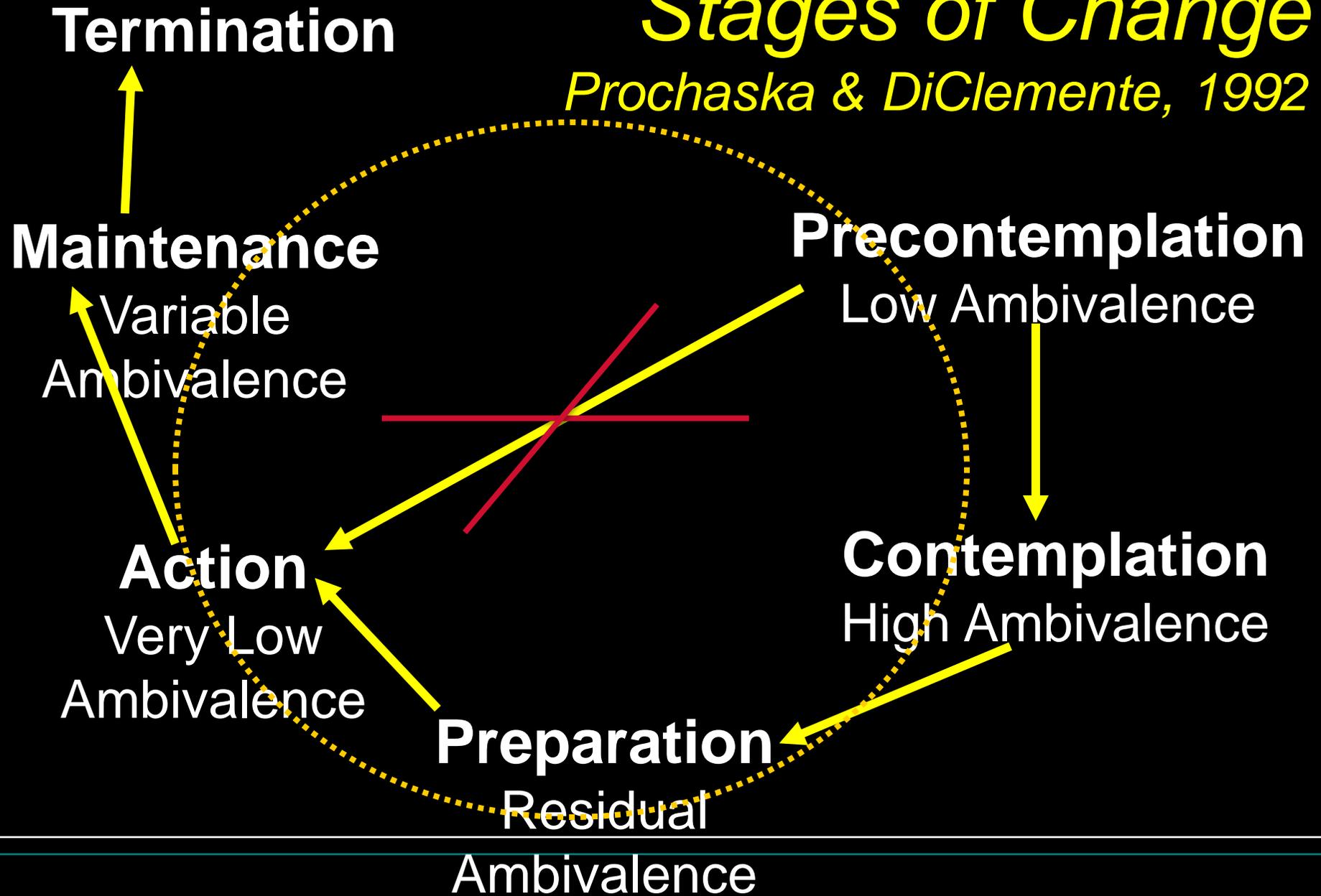
## ◆ Ambivalence

### ● Conflict between...

- ◆ Preference for two or more mutually exclusive objects or actions
- ◆ A preferred object or action and the belief that it is unobtainable or impossible

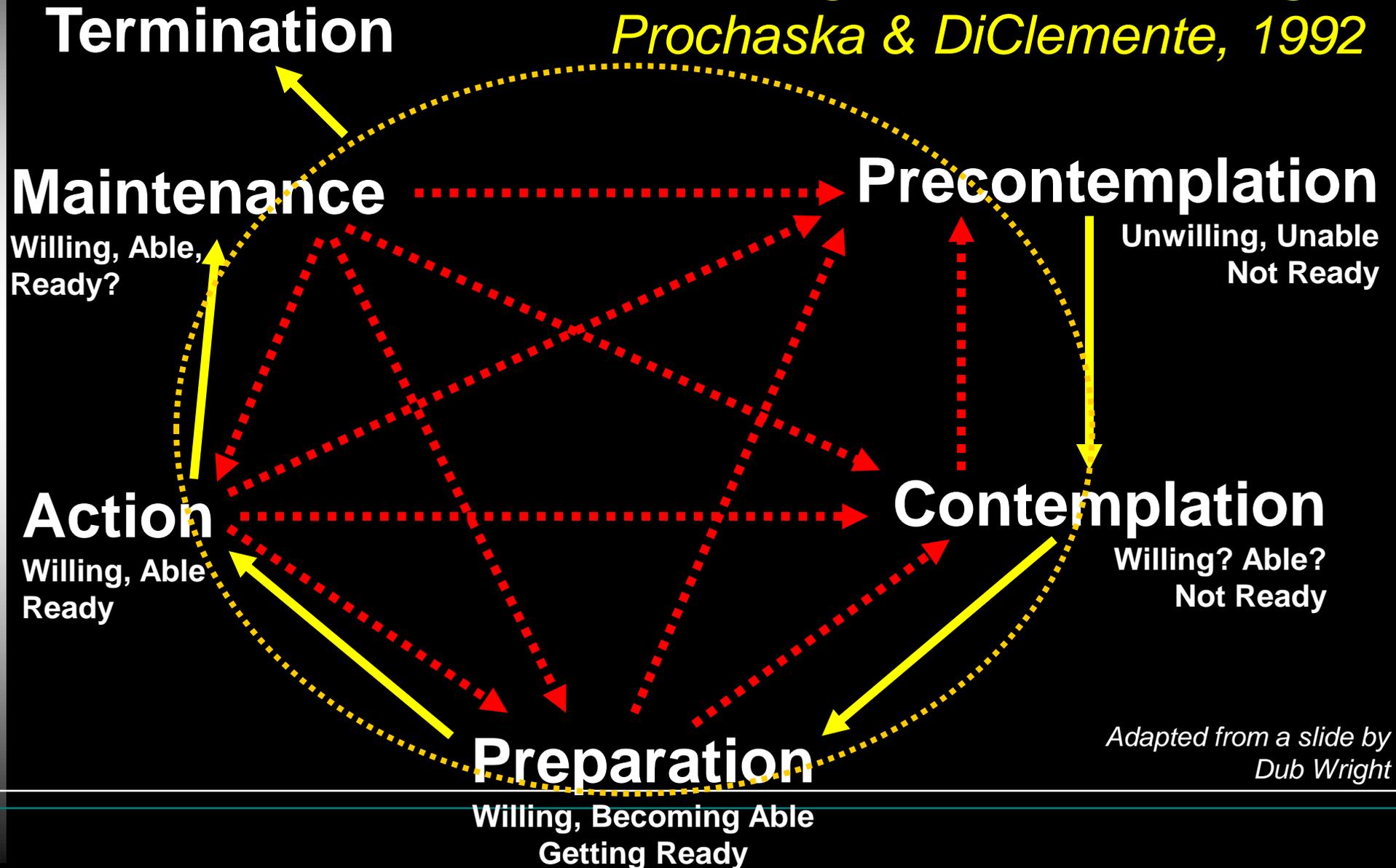
# Stages of Change

*Prochaska & DiClemente, 1992*



# Stages of Change

*Prochaska & DiClemente, 1992*



*Adapted from a slide by  
Dub Wright*

# *Talking with People about Change*

## *Precontemplative*

- ◆ Don't see a problem, believe benefits of change outweigh the costs, or believe they can change
- ◆ Five R's (adapted from DiClemente, 1991)
  - Reluctant
  - Rebellious
  - Rationalizing
  - Resigned
  - Receptive/Deceptive

*How Many Of You Have Ever...?*

# *Talking with People about Change*

## *Contemplative*

- ◆ Facing a decision about change, people consider their options and contemplate the pros and cons of making different choices

# *Talking with People about Change*

## *Contemplative*

- ◆ Stuck in ambivalence
  - Don't know what they want/need to do  
(conflicting options have advantages/disadvantages)  
and/or
  - Don't believe they can do what they want/need to do  
(succeed at accomplishing a desired choice)

# *Ambivalence Under Pressure*

## ◆ Six R's

- Reluctant
- Rebellious
- Rationalizing
- Resigned
- Receptive/Deceptive
- Relieved

# *The Righting Reflex*

- ◆ Urge to set things right (fix)
  - Advice, education, persuasion, direction, confrontation
- ◆ Triggers reactance
  - Defending autonomy by resisting control
- ◆ Triggers defensiveness
  - Protecting self-esteem by rejecting criticism

# *Resistance & Therapist Behavior*

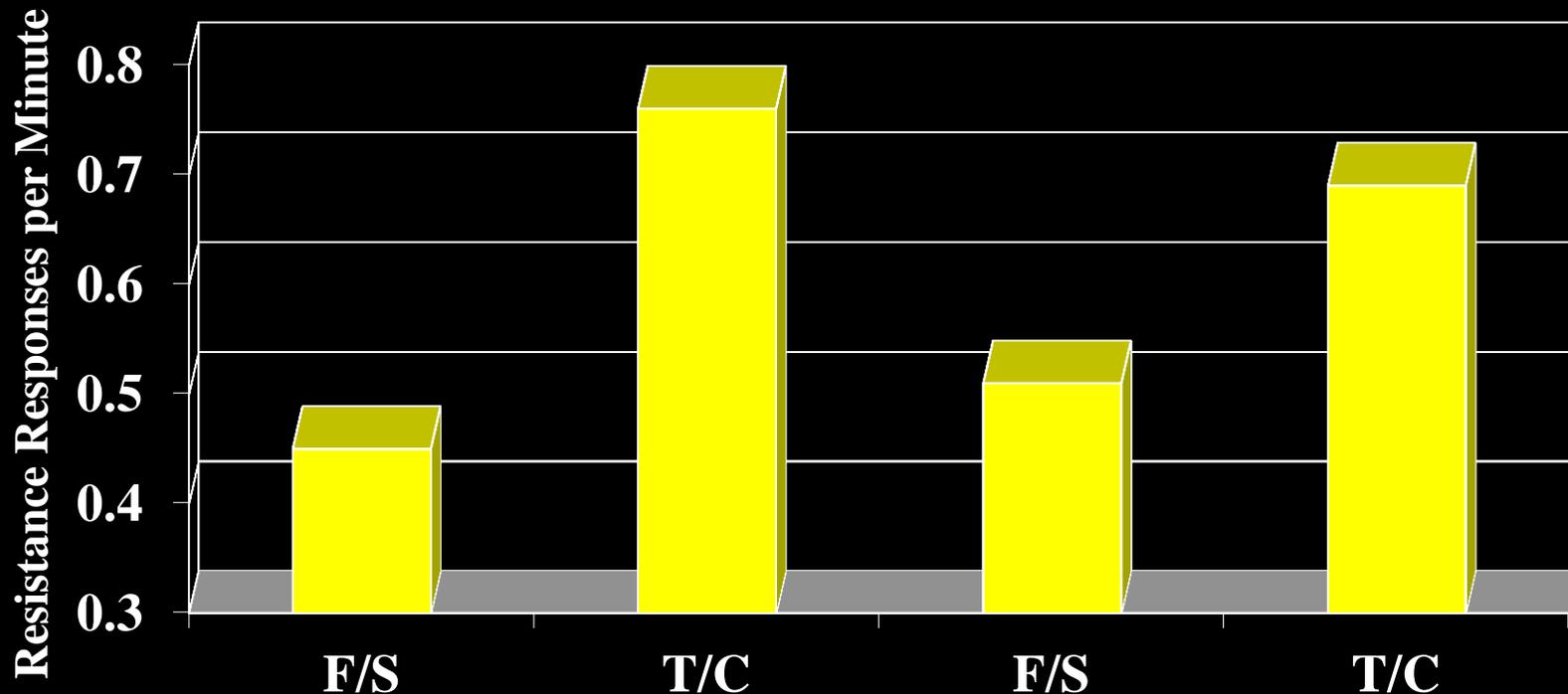
*Patterson & Forgatch, 1985, 2001*

## ◆ Family Therapy Studies

- 12 families with aggressive children age 3.8–13.1
- Coding systems for therapist and client behavior
  - ◆ Observation of videotaped sessions
    - ◆ “Teach” & “confront”: increased resistance
    - ◆ “Facilitate” & “support”: decreased resistance
  - ◆ What if you had therapists systematically alternate between these two kinds of responses?

# *Patterson & Forgatch, 1985*

## Manipulation (ABAB) of Facilitate/Support & Teach/Confront



# *Resistance and Change*

- ◆ **Drinker's Check-Up: Confrontational Feedback vs. Client-centered Feedback (Miller, et al., 1993)**
  - More confrontation = More drinking at 1 year
  - More confrontation = More patient resistance
  - More resistance = More drinking at 1 year
- ◆ **Project MATCH (Karno & Longabaugh, 2005)**
  - High-reactance patients: directiveness (interpret, confront, introduce topics) = worse outcomes

# *Ambivalence, Resistance, Motivation*

- ◆ It's normal (though unpleasant and undesirable) for people to get stuck in ambivalence
- ◆ Motivation for change is influenced by interpersonal interactions
- ◆ Interpersonal pressure (unsolicited advice, persuasion, direction, confrontation) makes ambivalent people sound and feel “resistant”

# *Ambivalence, Resistance, Motivation*

- ◆ “Resistance” tends to elicit unhelpful reactions (negative communication cycles)
- ◆ “Resistance,” therefore, is not a client problem – it is a practitioner problem
- ◆ Accepting and understanding ambivalence is the first step toward helping clients resolve it

*If ambivalence is not overcome  
through education, persuasion,  
direction, or confrontation,  
how is it resolved?*

# *Motivational Interviewing*

- ◆ Collaborative, goal-oriented style of conversation for strengthening a person's own motivation and commitment to change
  - Person-centered counseling style
  - Address ambivalence about change
  - Attention to the language of change

*If ambivalence is not overcome through education, persuasion, direction, or confrontation, how is it resolved?*

## The Pressure Paradox

Acceptance facilitates change as  
pressure to change elicits resistance

# *The Spirit of Motivational Interviewing*

## ◆ Acceptance

### ● Absolute Worth

- ◆ Recognizing the natural tendency toward growth
- ◆ Valuing the person for who they are

### ● Affirmation

- ◆ Prizing (unconditional positive regard)
- ◆ Attunement to strengths and positive intentions

# *The Spirit of Motivational Interviewing*

## ◆ Acceptance

### ● Autonomy Support

- ◆ Honoring and supporting the right and capacity for self-determination
- ◆ Recognizing personal responsibility for change

### ● Accurate Empathy

- ◆ Communicating understanding of the person's thoughts and feelings without judgment

# *The Spirit of Motivational Interviewing*

## ◆ Compassion

- Openness to and concern for others' suffering
  - ◆ Wish to relieve suffering and promote well-being
- Sense of shared humanity
  - ◆ It takes courage to make choices without knowing with certainty whether or not they are right
  - ◆ We are all fallible and flawed, bound to make mistakes despite our good intentions and best judgments

# *The Spirit of Motivational Interviewing*

## ◆ Partnership

### ● Active Collaboration

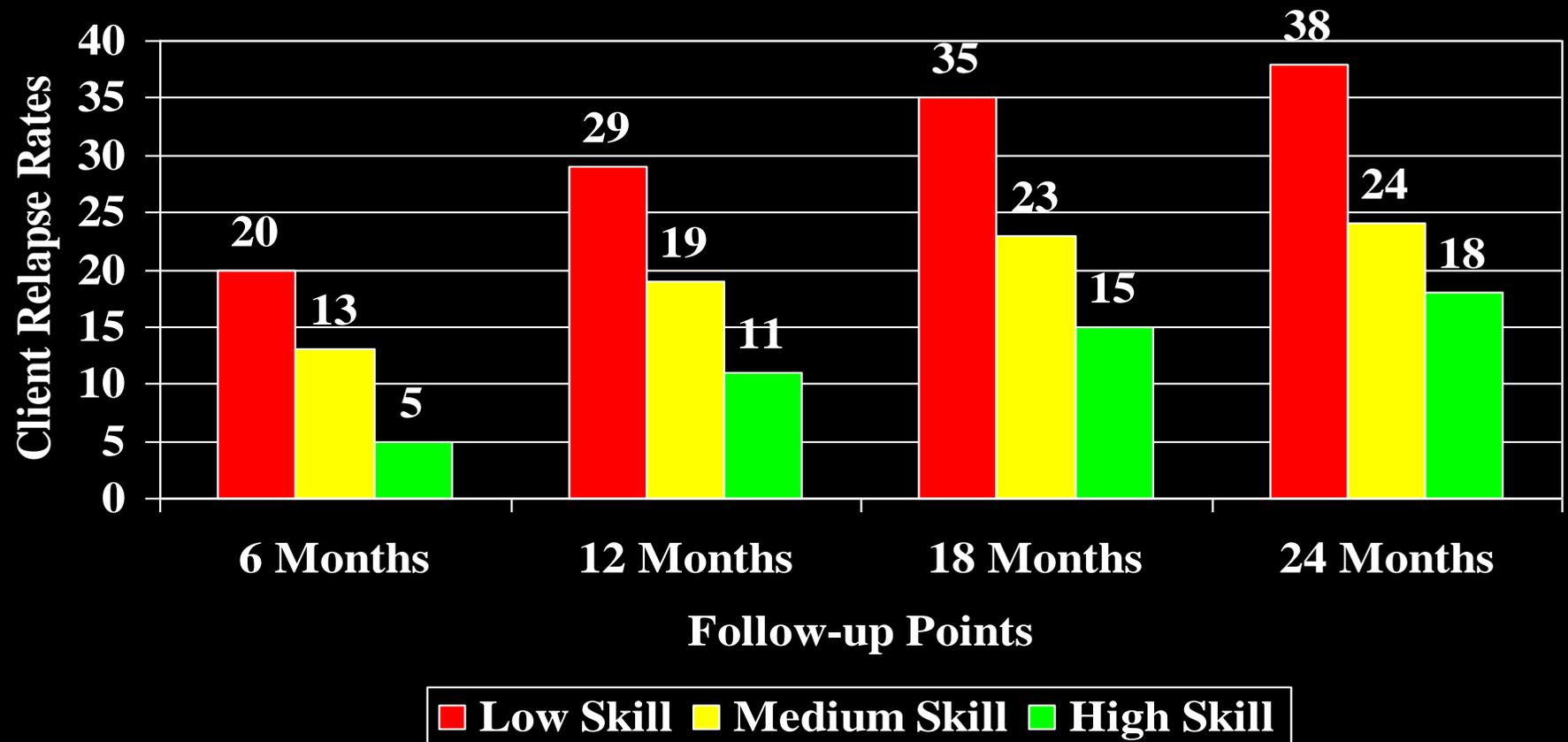
- ◆ Change is most likely where the aspirations of clients and practitioners meet
- ◆ Both members of the relationship have unique expertise that can contribute to the facilitation of change

# *Research Support*

## *Alcohol Treatment*

- ◆ Miller, Taylor, & West (1980)
  - Empathy strongest predictor of outcome in differing behavioral treatments for problem drinkers
- ◆ Moyers & Miller (2013)
  - Review of the research: Low empathy is toxic in substance abuse treatment regardless of counseling approach

# Valle, 1981



# *Research Support Counseling and Psychotherapy*

## ◆ Empathy

- Medium-sized effect across psychotherapies (Elliott, Bohart, Watson, & Greenberg, 2011)

## ◆ Collaboration / Goal Consensus

- Medium-sized effect across psychotherapies (Tryon & Winograd, 2011)

## ◆ Affirmation / Positive Regard

- Medium-sized effect across psychotherapies (Farber & Doolin, 2011)

*If ambivalence is not overcome  
through education, persuasion,  
direction, or confrontation,  
how is it resolved?*

## The Language of Change

We learn what we think  
as we hear ourselves speak

# *The Spirit of Motivational Interviewing*

## ◆ Evocation

- Clients talk themselves into change (or out of it)
- Drawing out and strengthening motivation for change already present, if dormant

# Change Talk

## ◆ Preparatory (DARN)

- Desire *I want to...*
- Ability *I can...*
- Reasons *I should because...*
- Need *I have to...*

## ◆ Mobilizing (CATs)

- Commitment *I might... → I'll try... → I will...*
- Activation *I'm ready to...*
- Taking steps *I've begun to...*

# *Research on Change Talk*

- ◆ Preparatory talk → commitment talk<sup>1,5</sup>
- ◆ Increasing intensity of commitment talk → change<sup>1,5</sup>
- ◆ Change talk → change, sustain talk → no change<sup>4,6,7,8</sup>

# *Research on Change Talk*

- ◆ Training in MI is associated with stronger change talk in clients<sup>2</sup>
- ◆ MI-consistent behaviors increase probability of patient change talk<sup>3,4,6,7,8,9</sup>
- ◆ MI-inconsistent behaviors increase probability of patient counter-change talk<sup>3,4,6</sup>

# *Motivational Interviewing*

- ◆ Collaborative, goal-oriented conversation for strengthening a person's own motivation and commitment to change
  - Evokes movement toward a goal by partnering with people to elicit and explore their own reasons and ability for change within an atmosphere of acceptance and compassion

# *Applications of MI Adults and Adolescents*

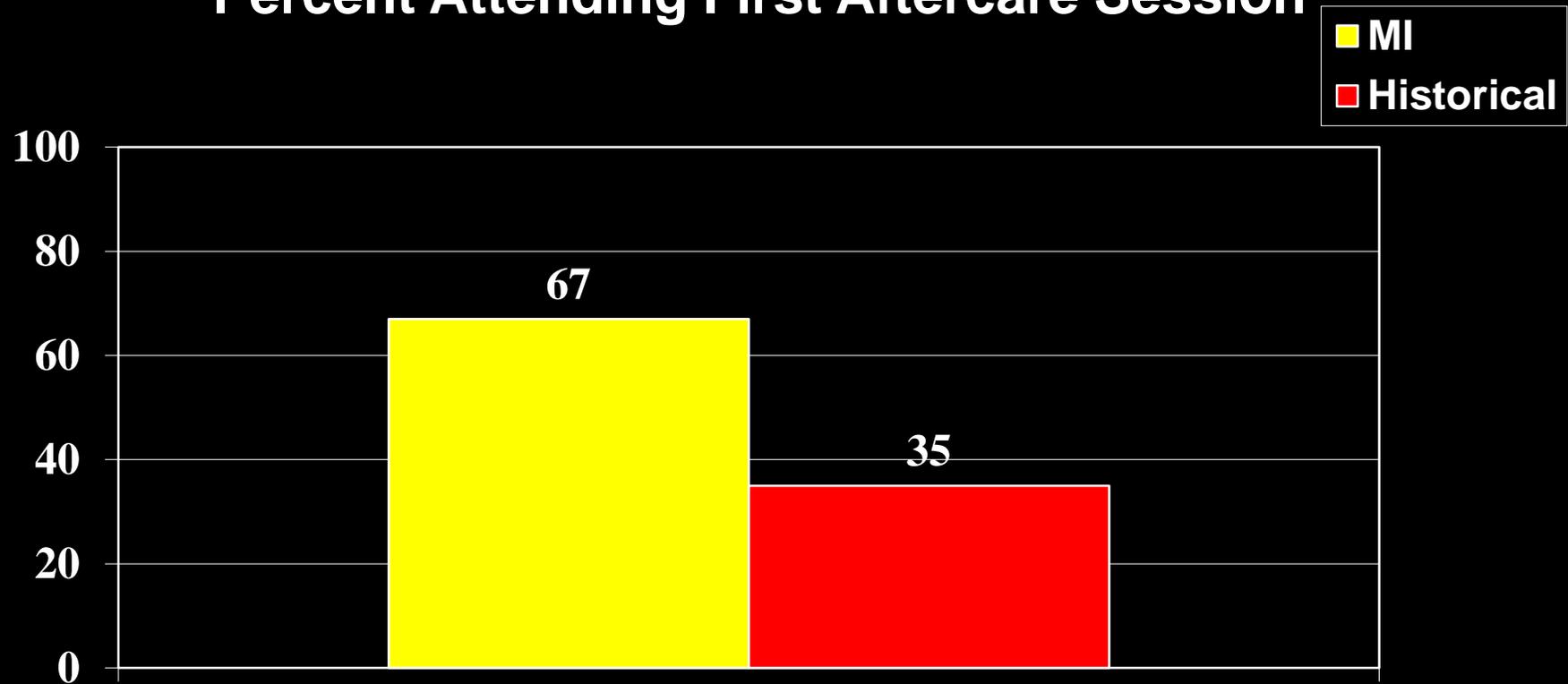
- u Alcohol and Drug Abuse/Dependence
- u Co-Occurring Disorders
- u Eating Disorders
- u Medical Settings
  - l Primary Care, ER, Specialty Care, Dentistry
- u Public Health
  - l Sexual Risk Reduction (HIV), Smoking
- u Criminal Justice
  - l Probation & Parole
- u Psychiatric Disorders
  - l Depression, Anxiety, Psychosis

# *MI for Treatment Engagement*

- ◆ Inpatient to aftercare among non-psychosis dual diagnosis adults (N ≈ 200)
  - Diagnosis: Mood and substance use disorders
  - MI + Treatment-As-Usual vs. TAU
    - ◆ MI = 45-60 pre-discharge “Motivational Engagement” session, individually or in small groups

# *Daley & Zuckoff, 1998*

**Percent Attending First Aftercare Session**

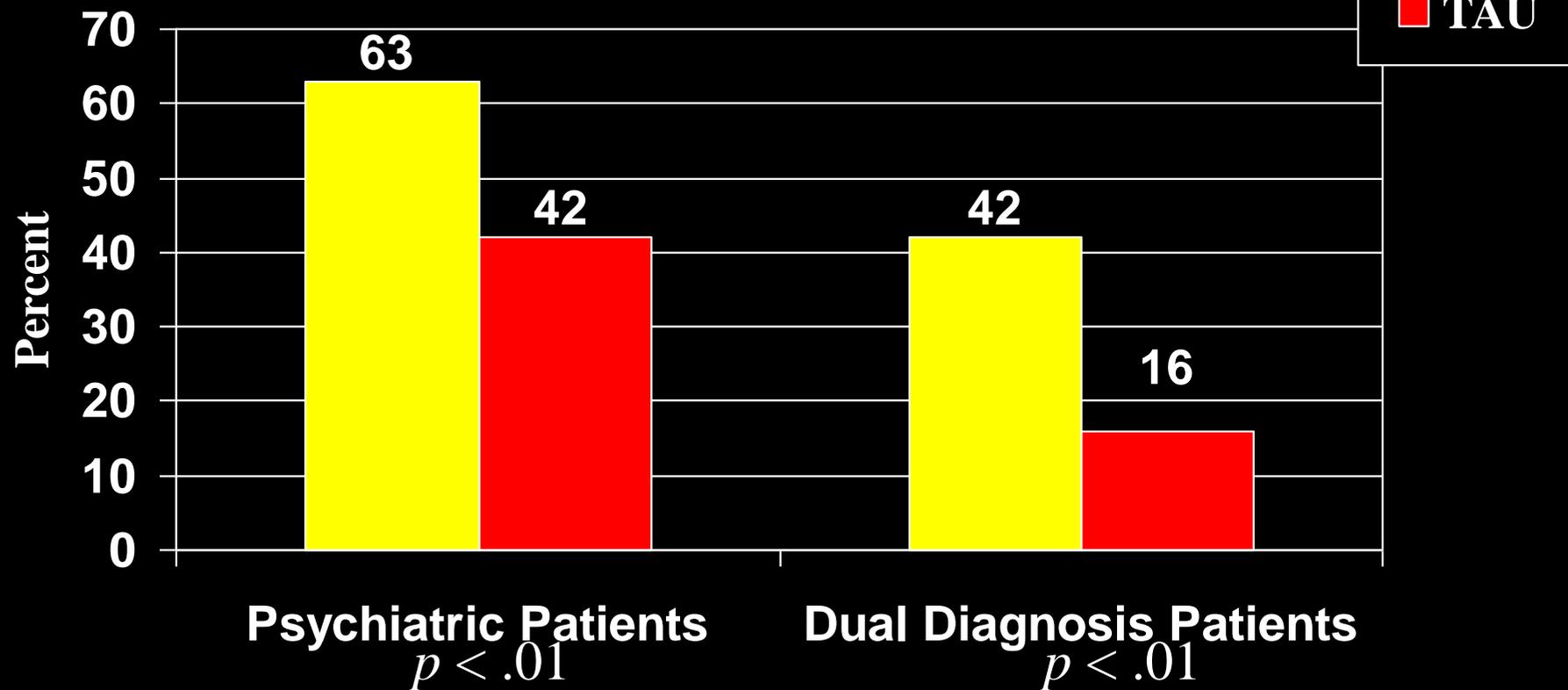


# *MI for Treatment Engagement*

- ◆ Inpatient to aftercare among psychiatric and dually diagnosed adults (N = 121)
  - Diagnosis: Mood, psychotic, and substance use disorders
  - MI + Treatment-As-Usual vs. TAU
    - ◆ MI = Brief feedback meeting + MI session

# Swanson, Pantaloni, & Cohen, 1999

Percent Keeping First Aftercare Appointment



# *MI for Treatment Engagement*

- ◆ MI increased treatment attendance (70% vs. 40%) by inpatients discharged to integrated outpatient treatment for schizophrenia and substance use disorder
  - Bechdolf, et al. (2012)

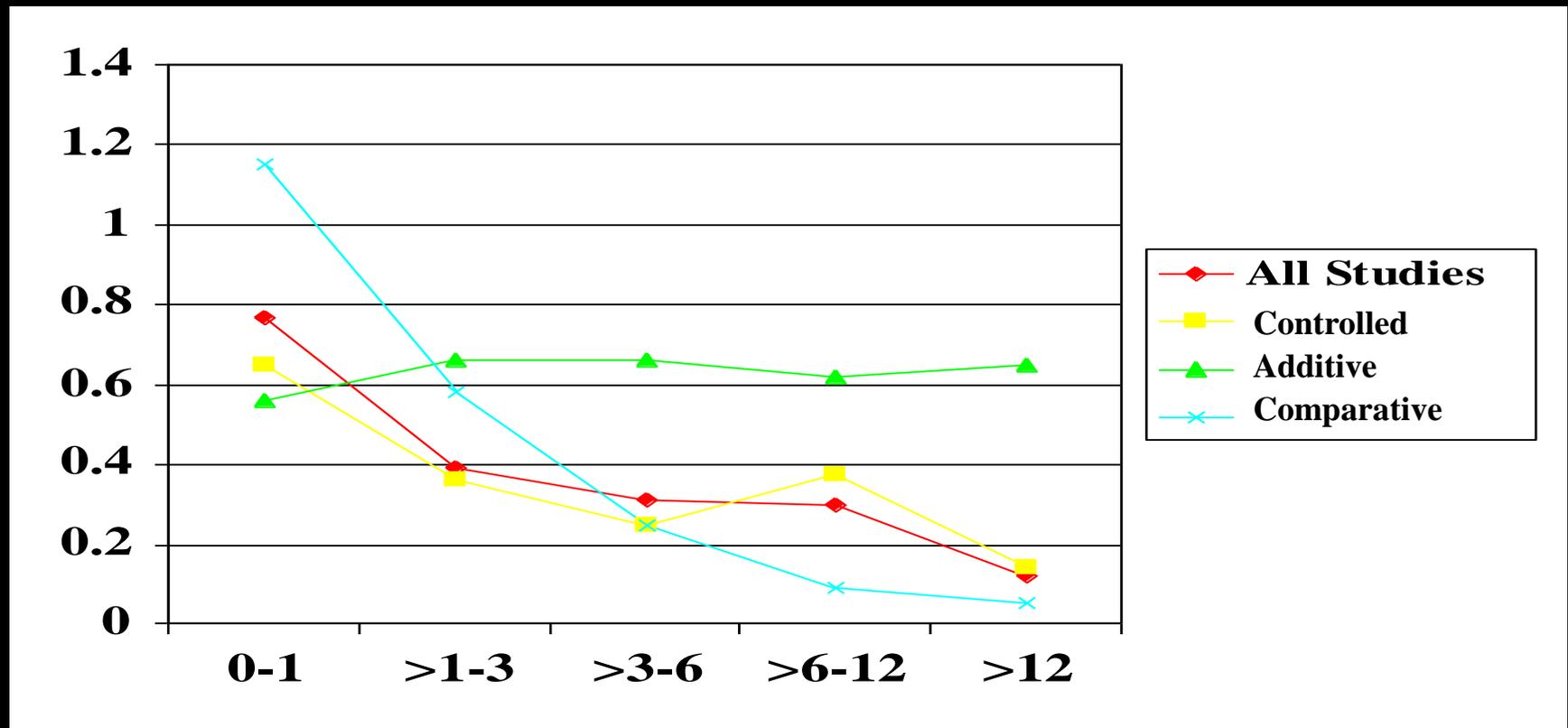
# *Evidence for MI for Engagement*

*Zuckoff & Hettema, 2007, November*

- ◆ Meta-analysis of controlled trials of MI for treatment adherence (N = 29)
  - $d_c = \underline{0.48}$  (medium size effect)
    - ◆ Alcohol and/or drug (21), psychiatric (3), diet and exercise (2), smoking (1), pain (1), sleep apnea (1)
    - ◆ MI sessions = 3.14 (5.20); hours spent in MI = 2.46 (3.53)

# Hettema, Steele, & Miller, 2005

## Effect Sizes of MI over Time



# *Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010*

- ◆ Meta-analysis of controlled trials (N = 119)
  - All Outcomes
    - ◆  $g = 0.22$  (range = -1.40 – 2.06),  $p < .001$
  - Adherence (n = 34):  $g = 0.26$ ,  $p < .001$ 
    - ◆ vs. control (n = 20)  $g = 0.35$ ,  $p < .000$
    - ◆ vs. bona fide intervention (n = 14)  $g = 0.12$ ,  $p = .053$
  - Effects larger with more intervention time
  - Advantage of cost-effectiveness

*How do you do it?*