Top Ten Things to Know About Motivational Interviewing

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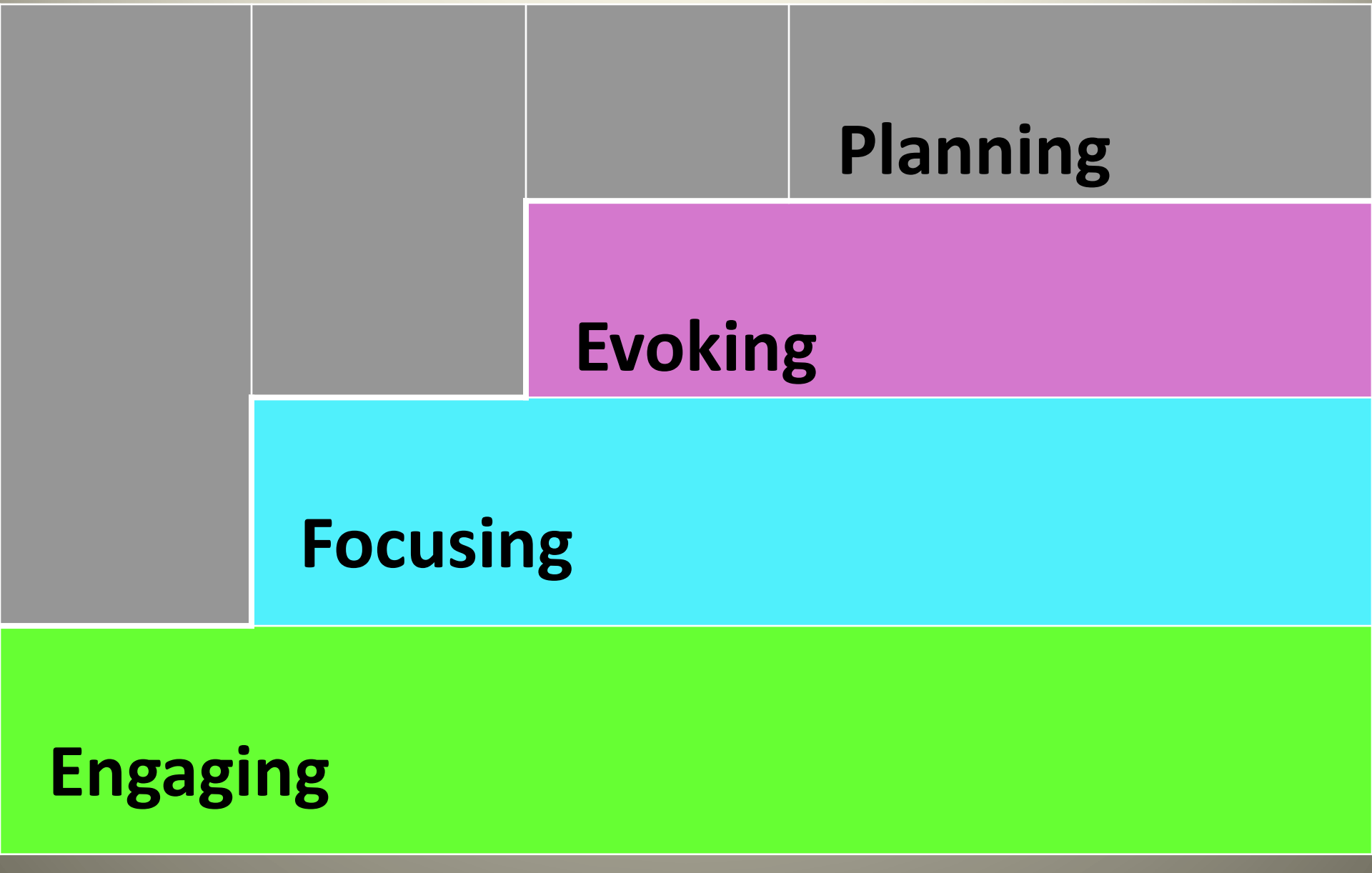
Four Foundational Processes



#1. Motivational Interviewing is not about the content

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- This does not mean that there is no content
  - Emphasizing autonomy and choice
  - Attention to client's values as source of motivation
  - Finding the client's own language about change

#1. Motivational Interviewing is not about the content

- But WHAT you do is not more important than HOW you do it

#1. Motivational Interviewing is not about the content

- Relational and Technical Components
- Evidence at least as strong for relational as technical elements of MI
- MI is a process that happens ***with*** a client; it is not something you do ***to*** a client
- Training and evaluating MI must focus “equal time” on relational and process elements

#1. Motivational Interviewing is not about the content

- This does not mean that we can all relax because MI is easier than more content focused treatments

#1. Motivational Interviewing is not about the content

- Does the clinician have the ability to convey empathic understanding of the client's perspective?
- Does the clinician honor the client's autonomy and choice concerning changes?
- Does the clinician share power and expertise in the interaction with the client?
- Does the clinician actively and persistently attempt to evoke the client's own ideas and values concerning change?
- Does the clinician focus on the change that is "on the table" or wander around in other therapeutic tasks at the expense of a clear direction?

#2. Assessment of the client is not needed in order to use MI successfully

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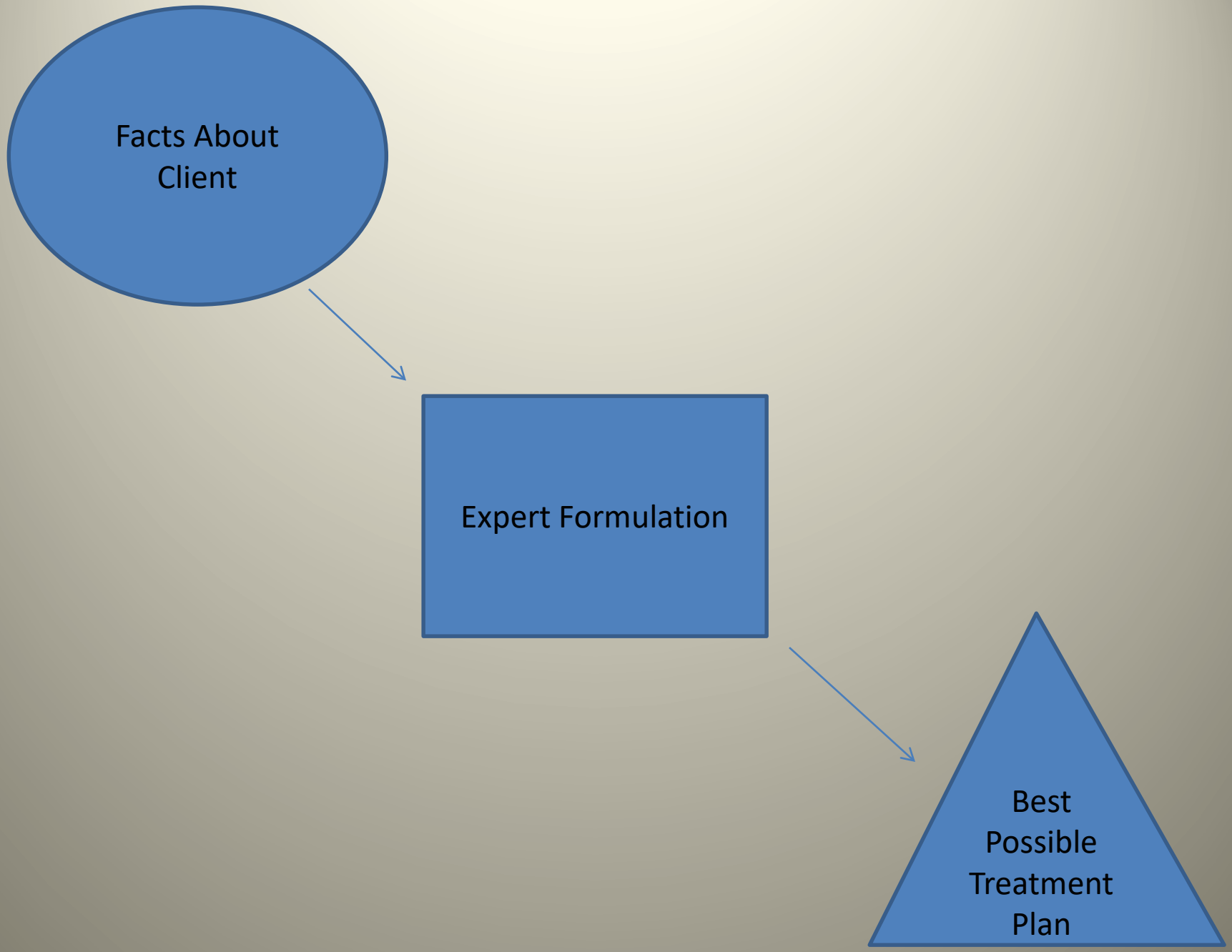
- Front-loading a detailed assessment implies an expert model:


Facts About Client
Expert Formulation
Best Possible Treatment Plan

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- MI focuses on an evoking process
- This involves helping the client bring forward what they ***already know*** about why they would change
- An assessment implies that the clinician, as the expert, will tailor treatment based on the information that is gathered
- MI implies that the client already knows how and why to change, but needs help resolving ambivalence about ***whether*** to change

#2. Assessment of the client is not needed in order to use MI successfully

- This is a different way of thinking about why client's are "stuck in their ways" and how to go about helping

#3. Giving information to the client may or may not be good practice in MI

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- Knowledge rarely helps people change self destructive behaviors about which they are ambivalent
- Objective feedback may be useful to create ambivalence
- MI often confused with Motivational Enhancement Therapy (MET) from Project MATCH
- Does giving the information provoke discord?

What about personalized feedback?

- Might be most appropriate for creating ambivalence (Precontemplation?)
- Not needed for MI

But seriously, don’t you need some information?

- What do you need to BEGIN?
- Assessment sandwich

#4. MI is not the right thing for every client

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- MI most useful for clients who are ambivalent
- Clinicians need a wide variety of skills and treatments for situations where clients are either not ambivalent yet or have already resolved ambivalence and want to move forward (here is where assessment is useful)
- MI is a skill that can be used in certain situations and put down when not needed
- Sometimes clinicians want to “keep” the spirit

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- In some RCT's it works, in others not. Within trials it works at some sites and not others and we know nothing about why this is so
- May be related to active ingredients not being specified
- May be related to quality of the intervention
- Better quality of MI associated with better outcomes

Measuring the Quality of MI

- Necessarily involves measuring the nature and quality of the interpersonal interaction
- Content, not so much

#6. MI can be learned, but not by everyone

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- Four RCT's directly addressing the training of MI
- More than 600 substance abuse therapists with various different learning strategies
- Outcomes verified by audio recordings of doing MI with clients in their work settings after training
- Various measures used: Percent complex reflections, ratio of reflections to questions (R:Q)

Rule of thirds

- A third are “easy learners”
- A third struggle but make substantial gains
- A third improve only a bit or not at all
- Nothing we know about clinicians ahead of time predicts learning, including experience
- Most clinicians do not improve until they have enrichments to their initial learning

Types of enrichments that boost learning of MI

- Expert consultation on a regular basis in the period just after training occurs (about six weeks)
- Numbers from an objective rating system
- Direct observation with feedback
- What kinds of innovative methods might be used to offer these enrichments?
- Distance learning paradigms, virtual patients, etc

#7.Supervising MI requires direct observation of clinicians

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- What clinicians say about what happens in MI sessions has a ***very low*** correlation with what actually happens
- Clinicians are not lying: what they don't notice is often what is most important
- Objections to observation can be overcome with patience and a safe environment
- More than one right way to do this observation

#8. Client Language During Sessions Might Explain why MI works

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- Change talk is client language in favor of change that emerges spontaneously in an empathic, supportive and collaborative interpersonal interaction
- Consistently related to better outcomes
- One hypothesis is that ambivalent clients decide they intend to change as they hear themselves voice arguments in favor of it
- What does this mean about sustain talk?

#9. Clinicians have a lot to do with what clients say during sessions

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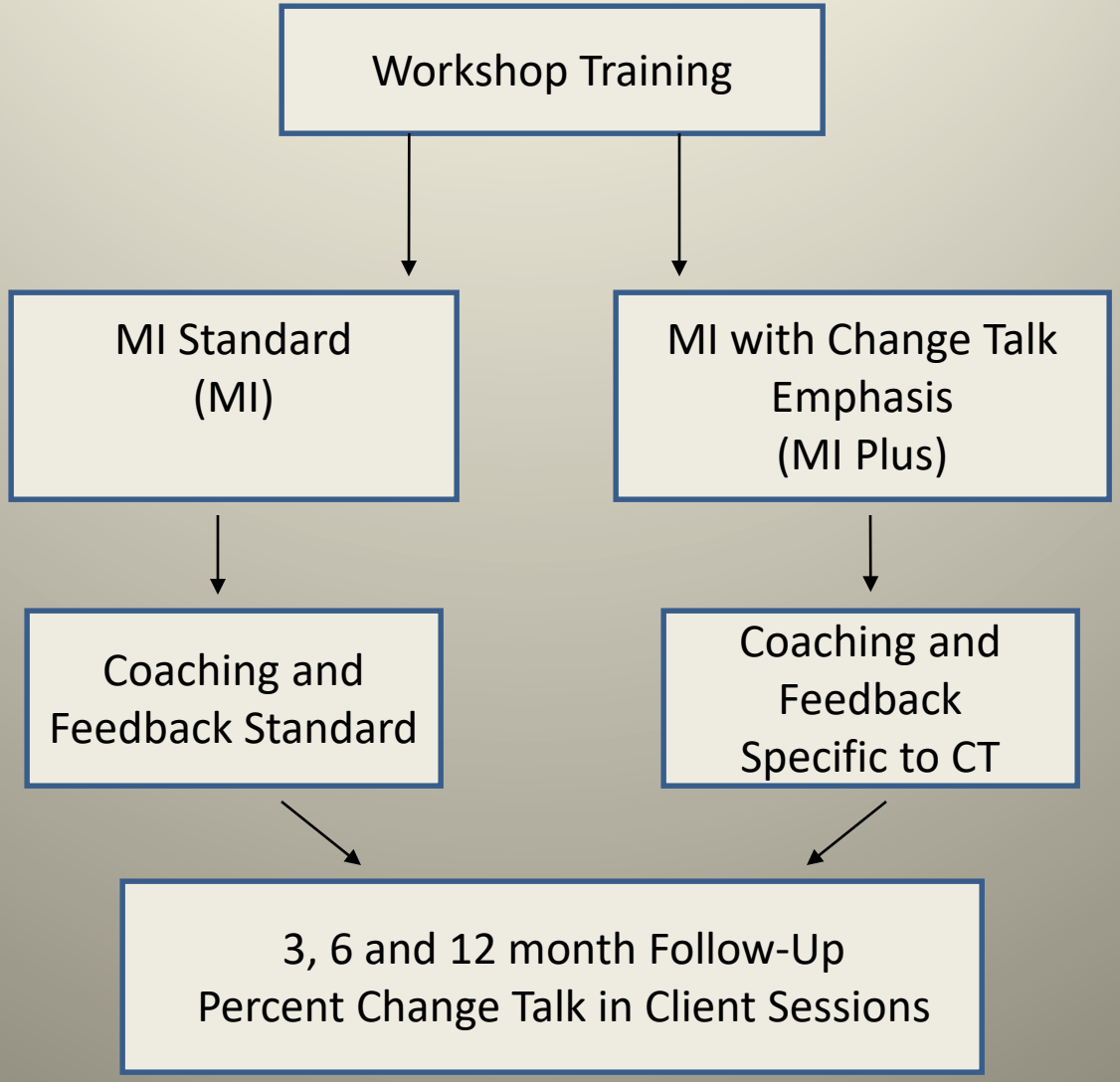
- Ok, change talk predicts outcome, but maybe it is just people saying what they already are going to do
- But we can influence that

Evaluating Language in Clinician Interviewing Training: Project ELICIT



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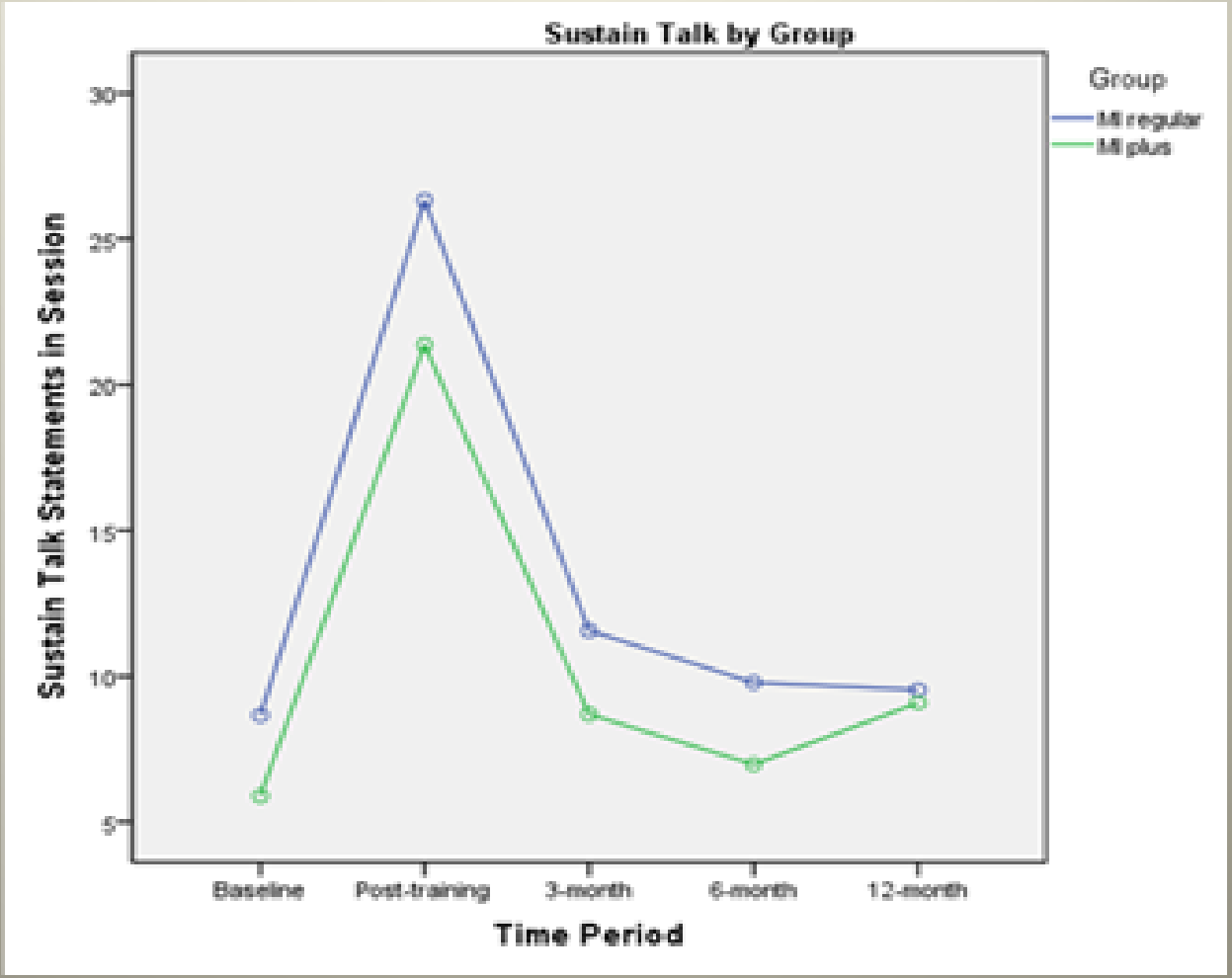

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- MI emphasizes client autonomy
- This means that clinicians must be willing to accept that clients may
  - 1) choose not to change
  - 2) choose to change using methods we don't like
  - 3) fail (and hopefully try again; maybe with us)
- Influence is earned and often depends on client characteristics over which we have little control
- Often it is systems, not clinicians, who fail to grasp these points

Implications for helping professions

- Empirically based treatments require well trained and competent clinicians
- The interpersonal context of the interventions bear much closer scrutiny as a means to improve both client acceptance and efficacy of our treatments
- The magic door of “therapy” has to open
- This will mean changes in the way that providers are selected, trained and compensated
- Clinicians can probably change, but can the systems that hire them?

Thank You